| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505533 | A. Building<br>B. Wing | 12/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Everett Transitional Care Services | 916 Pacific Avenue<br>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) |
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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure respiratory care and services were provided in accordance with accepted professional standards of practice for 3 of 4 sampled residents (Residents 14, 15, and 41) reviewed for respiratory care. Failure to change oxygen (O2) tubing routinely, failure to have appropriate orders for O2 administration and failure to have warning signs posted on resident's doors placed residents at risk for respiratory complications, unmet needs, and a diminished quality of life.Findings included.Review of the facility's policy titled, Oxygen Administration, dated 2025, documented that O2 is administered to residents who need it and consistent with professional standards of practice. Staff shall perform infection controls measures that include changing O2 tubing and nasal cannula (NC - medical tube that delivers supplemental O2 to the nose) weekly. Nebulizer (medical device that turns liquid medication into a breathable mist to be inhaled deep to treat respiratory conditions) tubing and delivery devices are to be changed every 72 hours. O2 delivery devices are to be kept covered in plastic bag when not in use. The policy documented that O2 warning signs must be placed outside the door of the resident's room where O2 is in use.<RESIDENT 14>Resident 14 admitted to the facility on [DATE] with diagnoses to include chronic lung diseases.In an observation on 12/08/2025, at 9:58 AM, Resident 14 was wearing O2 via NC. No label or date was observed on the O2 tubing. There was a nebulizer unit on their nightstand. O2 tubing and mask were connected to the nebulizer unit hanging off of the nightstand. The nebulizer unit was not in a bag, was not labeled, or dated. There was no sign observed on the resident's door indicating O2 was in use in the room.In an observation on 12/09/2025, at 9:27 AM, Resident 14 was not in their room and their O2 tubing was observed on the bed. The tubing was not in a bag, was not labeled, or dated. The nebulizer unit was observed with tubing connected, was hanging off the nightstand, not in a bag, not labeled or dated. Resident's door was observed without an O2 in use sign posted.In an observation on 12/10/2025, at 8:50 AM, Resident 14 was wearing O2 via NC. No label or date was observed on O2 tubing. Resident's door was observed without an O2 in use sign posted.Review of Resident 14's physician orders, dated 12/10/2025, documented no orders to show when the O2 tubing should be changed.In an interview on 12/12/2025, at 1:21 PM, Staff G, Licensed Practical Nurse/Resident Care Manager, stated that Resident 14 did not have an active physician order directing staff when to change their O2 tubing. Staff G stated O2 tubing should be changed weekly and labeled/dated when changed. Staff G stated that an O2 in use sign should be posted outside the room for anyone who was on O2. <RESIDENT 15>Resident 15 was admitted to the facility on [DATE] with diagnoses to include obstructive sleep apnea (sleep disorder where the airway gets blocked during sleep).In an observation on 12/08/2025, at 1:39 PM, Resident 15 was wearing O2 via NC. No label or date was observed on the O2 tubing. The resident's door was observed without an O2 in use sign posted.In an observation on 12/09/2025, at 9:25 AM, Resident 15 was wearing O2 via NC. No label or date was observed on the O2 tubing. The resident's door was observed without an O2 in use sign posted.In an observation on 12/12/2025, at 10:27 AM, Resident 15 was wearing O2 via NC. No label or date was observed on the O2 tubing. The resident's door was observed without an O2 in use sign posted.Review of Resident 15's physician orders, dated 12/09/2025, documented to date and<br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | change the resident's O2 tubing twice a month.Review of Resident 15's November 15th-30th 2025 Treatment Administration Record (TAR), the Licensed Nurse (LN) documented on the TAR with a checkmark indicating the O2 tubing was changed everyday. In an interview on 12/12/2025, at 11:52 AM, Staff H, agency Registered Nurse (RN), stated O2 tubing was normally changed weekly. Staff H stated that Resident 15 did not have a label or date on their O2 tubing and there was no O2 in use sign posted. In an interview on 12/12/2025, at1:21 PM, Staff G stated that Resident 15's physician orders directed the LN to change the resident's O2 tubing twice a month from November 15th to the end of the month. Staff G reviewed Resident 15's November 15th to the 30th, 2025 TAR and stated the checkmarks meant the O2 tubing was being changed daily. Staff G stated that the order was put into the Electronic Medical Record incorrectly and the O2 tubing should be changed weekly to include a label and date when the LN changed it. Staff G stated that a O2 in use sign should be posted outside the room for anyone who is on O2.<RESIDENT 41>Resident 41 was admitted to the facility on [DATE].In an observation on 12/08/2025, at 2:38 PN, Resident 41 was wearing O2 via NC. No label or date was observed on the O2 tubing. Resident's door was observed without an O2 in use sign posted.In an observation on 12/09/2025, at 9:57 AM, Resident 41 was wearing O2 via NC. No label or date was observed on the O2 tubing. Resident's door was observed without an O2 in use sign posted.In an observation on 12/10/2025, at 8:52 AM, Resident 41 was wearing O2 via NC. No label or date was observed on the O2 tubing. Resident's door was observed without an O2 in use sign posted.In an observation on 12/12/2025, at 10:28 AM, Resident 41 was wearing O2 via NC. No label or date was observed on the O2 tubing. Resident's door was observed without an O2 in use sign posted.Review of Resident 41's physician orders, dated 12/09/2025, documented no orders directing staff when to change the resident's O2 tubing.In an interview on 12/12/2025, at 1:21 PM, Staff G stated the Resident 41 did not have a physician order to change the O2 tubing. Staff G stated O2 tubing should be changed weekly and should include a label and date when the LN changed it. Staff G stated that an O2 in use sign should be posted outside the room for anyone who is on O2. In an interview on 12/12/2025, at 2:52 PM, Staff B, Registered Nurse/Director of Nursing, stated that their expectations would be for a resident on O2 to have physician orders for changing O2 tubing weekly and as needed. Staff B stated that resident's on O2 should have an O2 in use sign outside of their door. Reference WAC 388-97-1060 (3)(j)(vi) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop comprehensive care plans to include all provided nursing services for 2 of 3 sampled residents (Resident 41 and 15) reviewed for oxygen (O2) and 1 of 5 sampled residents (Resident 41) reviewed for unnecessary medications related to mental health. These failures placed residents at risk of unmet care needs, decline in condition, and diminished quality of life.Findings included.Review of the facility's policy titled, Comprehensive Care Plans, dated 2025, documented that the facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and time frames to meet the resident's medical, nursing, mental, and psychosocial needs. All Care Area Assessments (CAAs - triggered care areas from the MDS) triggered by the Minimum Data Set (MDS - an assessment tool) will be considered in developing the care plan.Review of the facility's policy titled, Oxygen Administration, dated 2025, documented that resident's care plan should identify the interventions for O2 therapy, based on the resident's assessment and orders, such as: - The type of O2 delivery system. - When to administer and/or discontinue O2. - Equipment setting for the flow rates (the amount of O2 delivered to a person per unit of time). - Monitoring of O2 levels (how much O2 is traveling through the body in the red blood cells). - Monitoring for complications associated with the use of O2. <OXYGEN>RESIDENT 41Resident 41 was admitted to the facility on [DATE].In an observation on 12/08/2025, at 2:38 PM, Resident 41 was wearing oxygen via nasal cannula (NC - a medical tube that delivers supplemental O2 to the nose) at 2 liters per minute (lpm).In an observation on 12/09/2025, at 9:57 AM, Resident 41 was wearing O2 via NC.In an observation on 12/10/2025, at 8:52 AM, Resident 41 was wearing O2 via NC.In an observation on 12/12/2025, at 10:28 AM, Resident 41 was wearing O2 via NC.Review of Resident 41's comprehensive MDS assessment, dated 10/28/2025, documented the use of O2. The CAAs were triggered for O2 use under pressure ulcer/injury and documented Resident 41 was on O2 and would be addressed in the care plan. Review of Resident 41's physicians orders, dated 12/09/2025, documented to apply O2 via NC continuously on 2 lpm that had an active order date of 10/14/2025.Review of Resident 41's care plan, dated 11/10/2025, documented no resident focus areas, goals or interventions for respiratory care.In an interview on 12/12/2025, at 1:21 PM, Staff G, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM), stated that there was no respiratory care plan for Resident 41. Staff G stated they would expect a care plan for a resident on O2. RESIDENT 15Resident 15 was admitted to the facility on [DATE] with diagnoses to include obstructive sleep apnea (sleep disorder where the airway gets blocked during sleep).In an observation on 12/08/2025, at 1:39 PM, Resident 15 was wearing O2 via NC at 1.5 lpm.In an observation on 12/09/2025, at 9:25 AM, Resident 15 was wearing O2 via NC.In an observation on 12/12/2025, at 10:27 AM, Resident 15 was wearing O2 via NC. Review of Resident 15's comprehensive MDS assessment, dated 11/06/2025, documented the use of O2.Review of Resident 15's physicians orders, dated 12/09/2025, documented to apply O2 via NC at 2 lpm continuously to keep O2 rates above 92% and change and date O2 tubing twice a month were active with an order date of 10/31/2025.Review of Resident 15's care plan, dated 10/31/2025, documented no resident focus areas, goals or interventions for respiratory care.In an interview on 12/12/2025, at 1:21 PM, Staff G, stated that there was no respiratory care plan for Resident15. Staff G stated they would expect a care plan for a resident on O2. In an interview on 12/12/2025, at 2:52 PM, Staff B, Registered Nurse/Director of Nursing, stated that they would expect a care plan related to O2 use for residents who were on O2.<MENTAL HEALTH>Resident 41 was admitted to the facility on [DATE] with diagnoses to include dementia (a loss of mental functioning), anxiety, and major depressive disorder (chronic, serious depression).Resident 41's comprehensive MDS assessment), dated 10/28/2025, documented they had antianxiety (medications that calm your nervous system to help<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | feel more relaxed) and antidepressant medications (medications that help balance mood regulating chemicals in the brain). The CAAs documented psychotropic (medications that change brain chemistry to help manage mental health conditions) drug use triggered and documented there was a care plan in place. Review of the level II Preadmission admission Screening and Resident Review (PASRR - an assessment to screen individuals for mental illness), dated 10/22/2025, documented Resident 41 had serious mental illness. The assessment also stated that Resident 41 met the criteria of a severe cognitive impairment.Review of Resident 41's care plan, dated 11/10/2025, showed no resident focus areas, goals or interventions for dementia or mental health needs.In an interview on 12/12/2025, at 2:52 PM, Staff B, stated that mental health was not addressed in Resident 41's care plan. Staff B stated they would expect mental health to be addressed in the resident's care plan since it was triggered on the CAAs. Reference: WAC 388-97-1020(1)(2)(a) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on observation, interview and record review, the facility failed to ensure proper storage and labeling of insulin (a medication that controls blood sugars) in 1 of 4 medication carts (Cart 4) when reviewed for medication storage. This failure placed residents at risk of receiving expired medications, ineffective treatment, and a diminished quality of life. Findings included.Review of a facility policy titled, Medication Storage - Storage of Medications, dated 01/25, documented insulin products should be stored in the refrigerator until they were opened. The date is noted on the label of the insulin vials and pens (a device to inject insulin) when first used. Opened insulin vials may be stored in the refrigerator or at room temperature. Open insulin pens should be stored at room temperature. The policy directed the staff member to refer to the specific product labeling for additional details. Review of Lispro (a rapid-acting insulin) and Glargine (a long-acting insulin) insulin vial and pen manufactures recommendations, documented the insulin was good for 28 days once opened and stored at room temperature. On 12/09/2025 at 9:07 AM, Medication Cart 4 was observed with Staff F, Licensed Practical Nurse. The following was observed:-Resident 60's glargine insulin pen was observed with no date indicating when it was first used.-Resident 16's lispro insulin was opened and dated 11/06/2025, 34 days prior. In an interview on 12/09/2025 at 9:07 AM, Staff F stated that insulin was good for 28 days after it was removed from the refrigerator, opened and store at room temperature. Staff F stated Resident's 60 and 16 still were receiving these insulins. In an interview on 12/09/2025 at 1:03 PM, Staff B, RN/Director of Nursing Services, stated that the facility followed the manufacturers recommendations regarding how long insulins were good after they were opened and removed from the refrigerator. Staff B stated most insulins were good for 28 days after they were opened. Reference WAC 388-97-1300(2) |