STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505534	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitional Care of Seattle	2611 S Dearborn Street Seattle, WA 98144

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure services provided met professional standards of practice for 1 of 3 residents (Resident 1) reviewed for professional standards. The failure to follow, timely implement or implement and/or clarify physician orders and the failure to determine the reason for refusals, notify the provider of the refusals, and address the reasons for refusals placed all residents at risk for negative health outcomes, unmet care needs, and decreased quality of life. Findings included. <Resident 1>Review of the 01/04/2026 admission Minimum Data Set (MDS, an assessment tool) showed Resident 1 had medically complex conditions including a history of blood clots, dementia, and vision problems. The MDS showed Resident 1 had significant loss in mental abilities, had verbal and physical behaviors directed towards others that did not interfere with the resident's care, and behaviors of rejecting care. The MDS showed Resident 1 was dependent on staff for eating, hygiene, toileting, bathing, bed mobility, and dressing.Review of an Activities of Daily Living (ADL) care plan, dated 12/29/2025, showed Resident 1 had self-care deficits related to dementia and weakness. The care plan showed interventions that directed staff to use two staff members for bed mobility (turning/repositioning in bed), was dependent on staff for dressing, and required two staff members to transfer using a mechanical lift into a wheelchair.<Failure to follow/implement and/or clarify Physician Orders>Review of a hospital Discharge summary, dated [DATE], showed Resident 1 admitted with two Pressure Injuries (PI, damage to the skin and underlying tissue caused by prolonged pressure, friction or shear), one on the right heel and one on the right buttocks. The discharge summary showed wound treatments orders for Resident 1's right heel PI to be completed every three days. A second wound treatment showed for Resident 1's right buttocks PI to be changed daily. The discharge summary showed physicians' orders that directed staff for Resident 1 to be out of bed three times daily and turned every two hours when in bed. Additional diet orders directed staff to provide Ensure (high quality protein shake) three times daily, and Juven (a specialized drink mix designed to support wound healing) twice daily. The discharge summary directed staff to transfer Resident 1 with a sit to stand mechanical lift to a manual tilt in space wheelchair (improves alignment and reduces pressure). Review of Resident 1's physicians' orders, dated 12/29/2026-02/02/2026, showed no indication staff implemented physician orders for Resident 1 to be out of bed three times daily. Review of physician's orders showed on 01/03/2026, six days after Resident 1 admitted staff implemented the Juven order, and on 01/18/2026 staff implemented the Ensure order three times daily, twenty days after Resident 1 admitted to the facility.Review of Resident 1's January Medication Administration Record (MAR) showed on 01/09/2026 evening shift through 01/12/2026 evening shift, Resident 1 did not receive the Juven. Staff documented the medication was on order and not available. Review of Resident 1's December 2025 and January 2026 Treatment Administration Record (TAR) showed staff entered Resident 1's wound treatment orders as the right heel to completed daily. The TAR showed the right buttocks treatment order (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505534	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Transitional Care of Seattle		STREET ADDRESS, CITY, STATE, ZIP CODE 2611 S Dearborn Street Seattle, WA 98144	

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was put in to be changed every three days.Review of Resident 1's medical chart and progress notes showed no documentation that facility staff clarified Resident 1's physician order to be out of bed three times daily. Review of 12/30/2025, 12/31/2025, 01/03/2026, 01/29/2026 provider notes showed the provider reviewed all of Resident 1's diagnoses and under PU's documented Resident 1 out of bed three times daily, turn in bed every two hours, and wound care per the wound provider. Review of Point of Care (POC, certified nursing assistance documentation) documentation for transfers out of bed, dated 12/29/2025-02/05/2026, showed no documentation that staff transferred Resident 1 out of bed. Review of POC documentation for bed mobility showed multiple days (01/02/2026 day and night shift, 01/04/2026 night or evening shift, 01/11/2026 night shift, 01/13/2026 night shift, and 01/17/2026 night shift) with no documentation from facility staff. The POC bed mobility documentation showed on multiple days (01/03/2026 night shift, 01/06/2026 day shift, 01/14/2026 day shift, 01/22/2026 night and day shift, 01/27/2026 day shift, 01/30/2026 evening shift, 02/05/2026 night shift) staff documented staff gave no assistance or activity did not occur.During an interview on 01/16/2026 at 9:25 AM, Resident 1's Collateral Contact (CC) stated they have visited Resident 1 four times and stay for an average of three hours. The CC stated during their visits Resident 1 was always in bed and staff did not come in and reposition or turn Resident 1. The CC stated Resident 1 should have Ensure, they received it in the hospital, and was told it would be ordered at the facility. The CC stated Resident 1 was a slow eater, had difficulty seeing, needed staff to cut up their food and assistance with eating.In an observation and interview on 01/16/2026 at 1:15 PM, Resident 1 stated their behind hurt and they just finished lunch. Resident 1 was observed in bed on their back with the head of the bed slightly elevated. In an interview on 01/30/2026 at 1:03 PM, Staff C (Registered Nurse, RN) stated they had not seen Resident 1 out of bed. In an observation and interview on 01/30/2026 at 1:10 PM, Resident 1 stated their bed was uncomfortable and they wanted to move around like anyone else.During an interview on 02/11/2026 at 12:05 PM, Staff B (Director of Nursing) stated the facility did not put in orders for Resident 1 to be out of bed because it was a standard of care. When asked why the provider documented in their progress notes for the resident to be out of bed three times a day, Staff B stated they would have to clarify with the provider and all residents should be out of bed. Staff B stated Resident 1 refused to get out of bed. Staff B stated Resident 1 admitted to the facility with two pressure ulcers and facility staff did not implement the transfer orders for Ensure and Juven because when the resident admits they are seen by the dietician first to look at the resident's needs. Staff B stated Resident 1 was totally dependent and required two person assistance with bed mobility and that Certified Nurses Assistants (CNA) and nurses perform turning and repositioning. Staff B stated they would need to talk to staff about documenting activity did not occur, staff gave no assistance, that it could be refusals or staff were confused by terminology, and they would expect staff to complete documentation. <Failure to assess Refusals>Review of the comprehensive care plan showed a 12/29/2025 behavior care plan developed for behaviors that required intervention and psychotropic medication, and no specific behaviors or interventions were identified on the care plan.Review of Resident 1's medical record from 12/29/2025-02/05/2025 showed under meal intake documentation Resident 1 refused seventeen meals, under bathing documentation Resident 1 refused one bath, under behavior monitoring documentation Resident 1 had one episode of refusing care, refused weekly weights five times and refused medications at times. Review of Resident 1's progress notes dated 12/29/2025- 02/05/2026, showed on 01/08/2026, staff documented Resident 1 refused to swallow their medications. The note did not indicate what the staff did or who they notified. Review of a 01/16/2026 and a 01/18/2026 progress notes showed Resident 1 was cooperative with repositioning attempts but refused at (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times. Staff documented they provided education regarding the risks and benefits of turning and the resident verbalized understanding. Review of two progress notes, dated 01/19/2026 showed Resident 1 refused to have a bladder scan performed and staff documented they re-educated the resident but did not indicate if the provider or resident representative was notified. Review of a progress notes dated 0/19/2026 showed Resident 1 refused and spit out their antibiotic medication and their ensure. The note did not indicate what staff did in response to Resident 1's refusals or if the provider was notified of Resident 1's refusals. Review of progress notes dated 12/29/2025-02/05/2026 showed no indication the provider was informed of Resident 1's multiple refusals. In an interview on 02/11/2026 at 12:12 PM when asked if Resident 1 had the cognitive ability to understand the risks and benefits of not turning when staff re-educated them for refusing, Staff B stated no Resident 1 did not have the cognitive ability to understand. Staff B stated the provider should be notified, staff should document refusals in the record, and the behavior care plan should have current behaviors and interventions listed to direct staff how to manage refusals. Refer to F686REFERENCE: WAC 388-97-1060(1)(ii)(3)(b).

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure 1 of 3 residents (Resident 1) reviewed for Pressure Injuries (PI, damage to the skin and underlying tissue caused by prolonged pressure, friction or shear) received the necessary care and services, consistent with professional standards of practice to promote healing, and prevent new PI's from developing. Failure to ensure PI's were consistently assessed to include wound characteristics and measurements, to evaluate the resident's compliance with the plan of care, and prevent new PI's from developing. This failure placed resident's at risk for prolonged wound healing, increased discomfort, diminished quality of life, and development of avoidable PI's.Findings included .According to the facility Skin Integrity policy, revised January 2026, a Licensed Nurse (LN) would document skin impairments that included the measurements of size, color, presence of odor, exudates, and presence of pain associated with the skin impairment on the weekly wound evaluation. The LN would notify the medical provider and the resident representative of the skin condition and the treatment plan, and the Registered Dietician would be notified. The policy showed when a wound failed to improve after two weeks of treatment or the wound deteriorated, the medical provider and the resident representative would be notified. <Resident 1>Review of the 01/04/2026 admission Minimum Data Set (MDS, an assessment tool) showed Resident 1 admitted to the facility on [DATE]. The MDS showed Resident 1 had medically complex conditions including a history of blood clots, dementia, and impaired vision. The MDS showed Resident 1 had significant loss in mental abilities, had verbal and physical behaviors directed towards others that did not interfere with the resident's care, and behaviors of rejecting care. The MDS showed Resident 1 was at risk for PI's, had two unhealed PI's that were unstageable and presented as Deep Tissue Injuries (DTI, purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure or shearing (skin is pulled in opposite directions injuring the skin layers). The MDS showed Resident 1 was dependent on staff for eating, hygiene, toileting, bed mobility, transfers, bathing, and dressing.Review of 12/29/2025, Braden Scale (an assessment tool used to predict PI risk) showed Resident 1 was assessed at moderate risk for PI's due to being bedfast (unable to leave bed), had very limited mobility and sensory perception. The assessment showed Resident 1 had adequate nutrition and ate over half their meals.Review of Resident 1's care plan, initiated 12/29/2025, showed the resident had actual impairments to their skin integrity to include a DTI to their right buttocks and right heel. An intervention, initiated on 01/18/2026, twenty days after Resident 1's admission, directed staff to frequently reposition the resident when resting. Review of an admission skin/wound evaluation showed it was created by staff on 01/05/2026 and dated for 12/29/2025. The evaluation showed Resident 1 was identified with two PI's on admission that were suspected DTI to the right heel and right buttocks. The evaluation did not include measurements, wound assessment, or pain associated with the wounds. Review of skin/wound evaluations showed no skin/wound evaluation completed on 01/05/2026 for both PI's and only the right heel PI was assessed on 01/12/2026. Review of a skin/wound evaluation dated 01/19/2026 showed a new unstageable PI was found to Resident 1's right upper back. The skin/wound evaluation showed the PI was identified on 01/14/2026, sixteen days after Resident 1 admitted to the facility. The skin/wound evaluation showed under registered dietician notification was left blank and no date was entered.During an interview and observation on 01/30/2026 at 1:20 PM Resident 1's upper back wound was observed as an oblong shaped open area. Observations of their right buttocks showed a large wound extending from the right buttocks to the tailbone. During the observation of the PI's, Resident 1 stated their buttocks hurt. Review of a facility investigation for the facility (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acquired PI to Resident 1's upper back, dated 01/14/2026, showed Resident 1 was at extreme risk for impaired skin integrity. The investigation showed the root cause analysis was due to the resident's profound immobility, deconditioning from sepsis, malnutrition and inadequate hydration. The investigation showed facility staff put interventions of documentation of frequent turns and a new order of Ensure three times daily. During an interview on 01/30/2026 at 1:41 PM Staff B stated Resident 1 refused to get out of bed and refusing most intakes by mouth. When asked why Resident 1 refused, Staff B stated it was resident driven and the staff were having difficulties getting care done. Review of Resident 1's medical record from 12/29/2025-02/05/2025 showed under meal intake documentation Resident 1 refused seventeen meals, under bathing documentation Resident 1 refused one bath, under behavior monitoring documentation Resident 1 had one episode of refusing care, refused weekly weights five times and refused medications at times.Review of progress notes, dated 12/29/2025-02/05/2026 showed no indication staff informed the provider of Resident 1's refusals or determined the reason for refusals.In an interview on 02/11/2026 at 12:20 PM, Staff B stated there should be weekly documentation of wounds including measurements and wound characteristics. When asked why the new PI to the back was not assessed until 01/19/2026, five days after it was found on 01/14/2026, Staff B stated they would have to ask the wound nurse and was not able to answer the question. Staff B stated that Resident 1 was at extreme risk for wounds, when asked why the Braden assessment showed moderate risk and which one was accurate, Staff B replied Resident 1 was at extreme risk. Staff B stated Resident 1 was dependent on staff for turning/repositioning in bed and for all transfers out of bed. Refer to F658Reference WAC: 388-97-1060