

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER Bridges to Home		STREET ADDRESS, CITY, STATE, ZIP CODE 18904 Burke Ave N Shoreline, WA 98133	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform a resident and/or their representative of their health status in a timely manner for 1 of 3 residents (Resident 2), reviewed for resident rights. This failure placed the resident and/or their representative at risk of not being fully informed of changes in condition, making informed decisions, and ensuring that treatment aligns with the resident's goals and preferences. Findings included .Review of the admission record showed that Resident 2 was admitted to the facility on [DATE] with a diagnosis that included chronic respiratory failure (a long term condition where the lungs cannot get enough oxygen into the blood or cannot remove enough carbon dioxide [made of one [NAME] and two oxygen elements]).Review of the progress note dated 01/21/2026 showed that Resident 2 was decannulated (removal of a tracheostomy tube [a breathing tube inserted through a small opening in the neck into the trachea/ windpipe to help a person breathe, receive oxygen, or clear secretions]), and [an unknown] staff later found the resident with one trach [tracheostomy] tie off and noted that the tracheostomy flange (outer part of a tracheostomy tube) had broken. The note further showed that during the decannulation event, Resident 2's oxygen saturation (percentage of oxygen carried in the blood) dropped to 84% (percent) before it returned to their baseline level of 94%-96%.Review of the hospital note dated 03/02/2026 showed that Resident 2's representatives shared to their hospital doctor that the facility forgotten to inform them of an event that happened on 01/21/2026 and they were informed on 02/13/2026 where Resident 2 became disconnected from the ventilator (a machine that moves air in and out of the lungs) and needed support and they felt unheard and dismissed.In an interview on 03/27/2026 at 12:57 PM, Staff F, Social Worker, stated that the facility's process was for nurses to notify the social worker when an incident requires contacting the resident's representatives. Staff F stated that it was the facility's policy to notify them within 24 hours. Staff F stated that any change in a resident's medical condition, whether significant or not, the resident representatives should be notified. Staff F stated they received an email about Resident 2's decannulation event on 01/21/2026, after hours [after 5:00 PM]. Staff F stated that Resident 2's representatives were not notified of the decannulation incident until 02/13/2026. Staff F stated that it was a mistake and further stated that the resident's representatives should have been notified within 24 hours.In an interview on 03/27/2026 at 1:27 PM, Staff A, Program Administrator, stated that it was their policy to notify the family and/or resident representatives when there was an incident within 24 hours. Staff A stated that Resident 2's representatives were notified of the decannulation incident late [02/13/2026] and that they should have been notified timely within 24 hours.Reference: (WAC) 388-97-0260.</p>		

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review, the facility failed to ensure an allegation of abuse and/or neglect was reported to the State Agency within the required timeframe for 1 of 3 residents (Resident 1), reviewed for abuse reporting. This failure placed a resident at risk for potential unidentified abuse and/or neglect and lack of protection from abuse and/or neglect. Findings included .Review of the Nursing Home Guidelines, The Purple Book, dated October 2015 (sixth edition) showed, Neglect means: a) a pattern of conduct or inaction by a person or entity with a duty of care to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that avoids or prevents physical or mental harm or pain to a vulnerable adult; or b) an act or omission that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety. Review of the guideline showed, Abuse - Mental as a willful verbal or nonverbal action that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult. Mental abuse may include ridiculing, yelling, or swearing. Further review of the guideline showed, Verbal Abuse: Any use of oral, written or gestured language that willfully includes threats and/or disparaging & derogatory terms to or about residents or their families, within hearing distance of any resident regardless of their age, ability to comprehend, or disability; threats of harm; saying things to frighten a resident. Review of the facility's policy titled Abuse and Neglect Prevention and Reporting, revised in February 2026, showed, it is the policy of the [facility name] that all patients [residents] be free from abuse and neglect. The policy further showed, It is the policy of [facility name] to that all suspected, alleged, or actual cases of patient abuse or neglect, including injuries of unknown origin, shall be thoroughly and completely investigated and reported according to State and Federal regulations. Review of Resident 1's physician order dated 02/11/2026 showed an order for droplet precautions (an infection control measure used to prevent the spread of germs [tiny organisms]) due to runny nose and increased secretions. The order further showed that Resident 1 was to remain in their room and may leave room for bathing. Review of the February 2026 incident log showed an incident that occurred on 02/16/2026, documented as a staff to staff verbal interaction. Review of the incident investigation report dated 02/25/2026 showed that on 02/16/2026 Resident 1 had been out of their room and remained in the facility's common area and later in the shared playroom. The investigation report showed, On February 16, 2026, at approximately 10:00 AM, Staff D, Associate Executive Director for Clinical Operations at (facility name) had a verbal interacting with Staff C, Activity Director. During the interaction, Staff D speaking in an elevated and agitated tone of voice instructed Staff C to disregard physician orders and the facility's infection policy concerning resident [Resident 1's] physician ordered droplet precaution. The investigation report showed, It had been discovered through interviews that Staff D had also directed Staff E, RN [Registered Nurse] to bring Resident 1 out of her room. Staff C and Staff E at different times, both informed Staff D of Resident 1's active droplet precautions and physician orders. Despite these concerns, Staff D insisted that the Resident 1 be brought out of isolation. This action placed the staff and all the residents in danger of becoming infected and will be monitored of signs and symptoms of infection. Staff E ultimately complied with instructions. As a result, the resident was present during the interaction between Staff D and Staff C. When Staff C objected to this action and offered to don [to put on] PPD [PPE- Personal Protective Equipment] and be in the room with the resident instead of the resident [Resident 1] being in the community. In response Staff D stated, I would rather have sick babies than dead babies. This statement implied that the resident would be at risk of death if she remained in her room, which is totally unfounded. Since the resident can understand language and this statement implies hard to the resident, abuse that was not ruled out. Further review of the investigation showed, Since a physician's order was made known and there was not a reason not to follow it, it placed others at (continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>risk, and they believed that the neglect allegation was not ruled out. In an interview on 03/25/2026 at 11:26 AM, Staff C stated that they met Resident 1 in the facility's common area and moved them to the playroom. Staff C stated they were instructed by Staff D to take Resident 1 to a shared playroom. Staff C stated that they knew Resident 1 was on droplet precaution and taking them to the facility's common area was against the physician's order. Staff C stated that Resident 1 was not wearing a mask because she did not tolerate masks. Staff C further stated that there were no other residents both in the facility's common area and in a shared playroom during Resident 1's presence. When asked whether they reported the incident, Staff C stated they did not because everybody knew about it. In an interview on 03/25/2026 at 1:15 PM, Staff B, Director of Nursing, stated they follow the Purple Book guidelines and that allegations of neglect must be reported to the State Agency within the required timeframe. Staff B stated they were in the facility when the incident occurred. Staff B stated that Staff A, Program Administrator, was on leave at the time, and they did not report the incident until Staff A returned to the facility. Staff B stated that the allegation occurred on 02/16/2025 and that the facility reported the allegation on 02/23/2026. Staff B stated that the allegation of neglecting Resident 1's physician-ordered droplet precautions should have been reported to the State Agency in a timely manner as required. Staff B further stated that the facility's policy required reporting within 24 hours and that the facility should have followed its abuse and/or neglect reporting policy. In an interview on 03/25/2026 at 1:27 PM, Staff A stated they were on leave when the incident occurred on 02/16/2026. Staff A stated that the allegation of neglecting Resident 1's physician-ordered droplet precautions occurred on 02/16/2026 and was reported to the State Agency on 02/23/2026. Staff A stated that the allegation was not reported within the required timeframe and it should have been. Staff A further stated the facility should have followed its abuse and/or neglect reporting policy. Reference: (WAC) 388-97-0640 (5)(a).</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interview and record review, the facility failed to ensure allegation of abuse and/or neglect was investigated timely and thoroughly for 1 of 3 residents (Resident 1), reviewed for abuse investigation. This failure placed the resident at risk for repeated incidents, unidentified abuse, and a diminished quality of life. Findings included .Review of the Nursing Home Guidelines, The Purple Book, revised in 2015 (sixth edition), showed that all alleged incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown source, personal and/or financial exploitation, or misappropriation of resident property must be thoroughly investigated. Review of the facility's policy titled Abuse and Neglect Prevention and Reporting, revised in February 2026, showed, it is the policy of the [facility name] that all patients be free from abuse and neglect. Review of the policy showed, It is the policy of [facility name] to that all suspected, alleged, or actual cases of patient abuse or neglect, including injuries of unknown origin, shall be thoroughly and completely investigated and reported according to State and Federal regulations. Review of the policy showed, As soon as a report of alleged or suspected abuse or neglect is received, the investigation shall begin in order to rule out or identify abuse or neglect. Further review of the policy showed, The initial investigation will be completed within 24 hours, the full investigation will be completed within five days of the date of the incident. Review of Resident 1's physician order dated 02/11/2026 showed an order for droplet precautions (an infection control measure used to prevent the spread of germs [tiny organisms]) due to runny nose and increased secretions. The order further showed that Resident 1 was to remain in their room and may leave room for bathing. Review of the February 2026 incident log showed an incident that occurred on 02/16/2026, documented as a staff to staff verbal interaction. Review of the incident investigation report dated 02/25/2026 showed that on 02/16/2026 Resident 1 had been out of their room and remained in the facility's common area and later in the shared playroom. The investigation report showed, On February 16, 2026, at approximately 10:00 AM, Staff D, Associate Executive Director for Clinical Operations at (facility name) had a verbal interacting with Staff C, Activity Director. During the interaction, Staff D speaking in an elevated and agitated tone of voice instructed Staff C to disregard physician orders and the facility's infection policy concerning resident [Resident 1's] physician ordered droplet precaution. The investigation report showed, It had been discovered through interviews that Staff D had also directed Staff E, RN [Registered Nurse] to bring Resident 1 out of her room. Staff C and Staff E at different times, both informed Staff D of Resident 1's active droplet precautions and physician orders. Despite these concerns, Staff D insisted that the Resident 1 be brought out of isolation. This action placed the staff and all the residents in danger of becoming infected and will be monitored of signs and symptoms of infection. Staff E ultimately complied with instructions. As a result, the resident was present during the interaction between Staff D and Staff C. When Staff C objected to this action and offered to don [to put on] PPD [PPE- Personal Protective Equipment] and be in the room with the resident instead of the resident [Resident 1] being in the community. In response Staff D stated, I would rather have sick babies than dead babies. This statement implied that the resident would be at risk of death if she remained in her room, which is totally unfounded. Since the resident can understand language and this statement implies hard to the resident, abuse that was not ruled out. Further review of the investigation showed, Since a physician's order was made known and there was not a reason not to follow it, it placed others at risk, and they believed that the neglect allegation was not ruled out. In an interview on 03/25/2026 at 11:26 AM, Staff C stated that they met Resident 1 in the facility's common area and moved them to playroom. Staff C stated they were instructed by Staff D to take Resident 1 to a shared playroom. Staff stated that they knew Resident 1 was on droplet precaution and taking them to the facility's common area was against the physician's order. Staff C stated that Resident 1 was not wearing a mask because she did not tolerate masks. Staff C further stated that there were no other residents both in the facility's common area and in a shared playroom during Resident 1's (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>presence. In an interview on 03/25/2026 at 1:15 PM, Staff B, Director of Nursing, stated they follow the Purple Book guidelines and that allegations of neglect must be investigated within the required timeframe. Staff B stated they were in the facility when the incident occurred. Staff B stated that Staff A, Program Administrator, was on leave at the time, and they did not investigate the incident until Staff A returned to the facility. Staff B stated that the allegation occurred on 02/16/2025 and that the facility completed the investigation on 02/25/2026. Staff B stated that the allegation of neglecting Resident 1's physician ordered droplet precautions should have been investigated in a timely manner as required. Staff B further stated that the facility's policy requires investigation within 24 hours and that the facility should have followed its abuse and/or neglect investigation policy. In an interview on 03/25/2026 at 1:27 PM, Staff A, Program Administrator, stated that they were on leave when the incident occurred on 02/16/2026. Staff A stated that the allegation of neglecting Resident 1's physician ordered droplet precautions occurred on 02/16/2026 and the investigation was completed on 02/25/2026. Staff A stated they were responsible for completing this investigation. Staff A stated that they were not able to rule out the findings of abuse and neglect during their investigation. Staff A stated that they did not interview Resident 1 or their representatives to assess any potential harm related to the allegation. Staff A stated, I don't know why she was not asked. I heard that when staff ask her [Resident 1] to do something, they report that she repeats what they say. Staff A stated they did not interview other residents or their representatives either to determine whether the allegation had affected them. Staff A stated that the investigation should have been completed within the required timeframe and that the facility should have followed its abuse and/or neglect investigation policy. Reference: (WAC) 388-97-0640 (6)(a)(b).</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on interview and record review, the facility failed to implement care plan for 1 of 3 residents (Resident 1), reviewed for comprehensive care plan. The failure to implement care plan for droplet precaution (an infection control measure used to prevent the spread of germs [tiny organisms]) placed the resident at risk for unmet care needs and a diminished quality of life. Findings included .Review of the facility's policy titled, Comprehensive Care Plan, dated July 2022, showed that, IDT [Interdisciplinary Team] will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights. Review of Resident 1's physician order dated 02/11/2026 showed an order for droplet precautions due to runny nose and increased secretions. The order further showed that Resident 1 was to remain in their room and may leave room for bathing. Review of Resident 1's care plan, printed on 03/25/2026, showed that the resident was recovering from respiratory symptoms that included a runny nose and increased secretions. The care plan further showed that Resident 1 was on droplet precaution and was to remain in their room except when leaving for bathing. Review of the incident investigation report dated 02/25/2026 showed that on 02/16/2026, Resident 1 was outside their room in the facility's common area and later in a shared playroom. The investigation report further showed that the physician order for droplet precaution and to maintain Resident 1 in their room was not followed. In an interview on 03/25/2026 at 11:26 PM, Staff C, Activity Director, stated that on 02/16/2026, they observed Resident 1 in the facility's common area. Staff C stated that they were instructed to take Resident 1 from the facility's common area to the shared playroom and supervised them in shared playroom. Staff C further stated that no other residents were present in either the facility's common area or in the shared playroom during the time Resident 1 was there. In an interview on 04/01/2026 at 2:11 PM, Staff B, Director of Nursing, stated they expected staff to follow the care plan for residents. Staff B further stated that they expected staff to follow the droplet precaution care plan and that Resident 1 should not have left their room. Reference: (WAC) 388-97-1020(1)(2)(a)(b).</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>Based on observation, interview and record review, the facility failed to ensure sufficient dietary support personnel were available for 2 of 8 residents (Residents 1 & 3), reviewed for food and nutrition services. This failure to provide the kitchen with adequate dietary staff left residents at risk for less than palatable meals, improperly prepared meals, foodborne illness, late food service, and other negative health outcomes. Findings included .Review of the facility provided document titled, Facility Assessment [a document developed and maintained by nursing homes that assessed the resident population and their care needs, the condition of the building, risks and threats to the building such as unique environmental risks etc., and the resources the facility would require to manage resident needs and safety including staff and equipment], revised on 01/13/2026, showed that the facility did not plan for the number of cooks needed to meet food and nutrition services requirements. RESIDENT 1 Review of the physician's order dated 03/23/2026 showed that Resident 1 had an order to take meals orally four times daily. RESIDENT 3 Review of physician's order dated 12/16/2025 showed that Resident 3 had an order for restricted diet to 60 calories (unit of energy) per day. Observation and interview on 03/05/2026 at 1:44 PM with Staff G, Nutrition Services Manager, showed they were working in the kitchen. Staff G stated the kitchen was short staffed with only them working in the kitchen. Staff G stated that they were responsible for the duties of the Dietary Manager, cook, and kitchen housekeeping at the same time. Staff G stated I'm [I am] responsible for carrying out all of the tasks required in the kitchen. Staff G stated they prepared the meals for 03/06/2026 since they work at the facility every other day and would not be onsite the following day [03/06/2026]. Staff G stated that the facility had two residents [Residents 1 and 3] who take food orally, and that they were responsible for preparing and cooking meals for these residents. Staff G stated that Resident 1 was receiving both tube feeding (delivering food and liquids directly into the stomach through a tube) and oral intake, with a plan to gradually discontinue the tube feeding over time. Staff G stated that Resident 3 was dependent on tube feeding but received oral food for pleasure feeding [small amounts of food or drink given for enjoyment]. In a follow-up interview on 03/27/2026 at 10:28 AM, Staff G stated that the facility needed a cook and that they have requested the facility to hire one but have not heard back from facility management. Staff G stated, Initially, the facility's plan was to admit only tube~feeding residents, but now we have two oral~eating residents, and I have to cook three meals a day for each of them. I only come to the facility every other day, so the residents were not receiving freshly prepared meals. Staff G stated, The cooked meal is being heated by the aide when I'm not here but that is not freshly prepared meal. Staff G further stated, The kids [Residents 1 and 3] need to eat fresh meals but since I am coming every other day, they have not been getting fresh meals. In an interview on 03/27/2026 at 1:27 PM, Staff A, Program Administrator, stated that they have one staff for kitchen and that was Staff G. Staff A stated that Staff G had expressed concerns about staff shortage in the kitchen and that they needed a cook. Staff A stated they had requested facility higher management to hire a cook but did not receive a timely response. Staff A further stated that they were recently instructed to hire a cook and have been looking for a contractor who could provide a trained cook. Staff A stated they would expect the two residents [Residents 1 and 3] to receive freshly prepared food every day. Staff A further stated that they would expect the facility to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition services. Reference: (WAC) 388-97-1160.</p>		