STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505535	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridges to Home	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 2 residents (Resident 4) was free from a significant medication error. Resident 4 experienced harm when they were hospitalized for a benzodiazepine (medication to treat seizures [a temporary, uncontrolled burst of electrical activity in the brain that can cause temporary changes in behavior, movements, sensations, or awareness]) overdose (excessive/dangerous dose of a drug). This failure placed the residents at risk for serious medication errors, complications, and adverse health outcomes.Findings included.Review of the facility's policy titled, Medications -Medication Pass Procedure, revised on 12/27/2023, showed, medications will be administered per the eight rights of medication administration: right patient, right medication (check the medication label), right dose (check the medication label against the order and apply appropriate calculations), right route, right time, right documentation, right reason, and right response.Review of the facility's policy titled, Medication Error Reporting and Adverse Drug Reaction Prevention and Detection, dated January 2023, showed medication errors and adverse drug reactions are considered significant if they require hospitalization, require treatment with a prescription medication, or are life threatening.Review of the facility's document titled, Medication Event Log, showed an entry dated 04/17/2025 for a medication error of Wrong Dose for Resident 4.Review of Resident 4's face sheet printed on 07/30/2025, showed they admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure with hypercapnia (occurs when the respiratory system fails to eliminate carbon dioxide [a natural waste product/gas of breathing and burning], leading to its buildup causing confusion, rapid breathing, and lethargy [drowsiness or unusual lack of energy or mental awareness], other disorders of the lung and seizures.Review of Resident 4's physician orders printed on 07/30/2025, showed an order for Midazolam (a benzodiazepine) 5 mg/mL [milligrams per milliliter (a unit of measurement)] injection solution (0.28 mL) VIAL (ML) Intranasal [via nose] - Both Nostrils [nose]. The order further showed to use 0.28 mL (1.4 mg) intranasally one time as needed (PRN) for seizures and to give half dose in each nostril for a seizure lasting longer than four minutes and may repeat in 10 minutes for ongoing seizure.Review of Resident 4's clinical note dated 04/17/2025, showed Resident 4's Heart Rate (HR) was at 220 beats per minute (bpm) at 7:00 AM, staff provided oral suctioning (process of removing secretions or fluids by means of a tube and a device) and repositioning. Resident 4's oxygen dropped to the 40s at the lowest, was put on four liters of oxygen and had seizure like activity at 7:04 AM. Resident 4's oxygen went up to 100 percent, their Respiratory Rate (RR) was very high, and their HR was in the 200 to 220s bpm. Resident 4's seizure activity continued for over four minutes and was moved to rescue medication. The note showed, Nurse pulled up rescue Midazolam, and administered to patient [Resident 4] intranasally. Patient started to calm down, and seizure activity subsiding by 0715 [7:15 AM], though RR elevated in the 100s. Nurses and CNAs [certified nursing assistant] by her side for duration of incident. Attempted to wean patient off of O2 [oxygen], but desaturated [when oxygen levels in the blood drop to a low level] every time, so kept her on 2L [two liters of oxygen]. Discovered at this time that nurse had administered 2 ml of Midazolam instead of 0.28 ml, and DNS [Director of Nursing Services] notified immediately, after which 911 called for transport to hospital. MD [Medical Doctor] also (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505535	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridges to Home	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	notified. Medics arrived by around 0730 [7:30 AM], and patient left for hospital with nurse by 0745 [7:45 AM]. Patient stable on 2 L [two liters of] O2, still with elevated RR and HR when she left the facility. An addendum note showed Resident 4's RR was 130, HR was 183, and oxygen was 100 percent on 2 L of oxygen when they went to the hospital.Review of Resident 4's Emergency Department Provider note, dated 04/17/2025, showed a diagnoses or chief complaint of Seizure/Overdose. The note showed Resident 4 was an eight-month-old with Aicardi syndrome (a rare and severe neurodevelopmental disorder [with infantile spasms]), large overcirculating Atrial Septal Defect (significant opening in the heart that causes extra blood volume to increase workload in the heart and lungs). The note showed Resident 4 presented with acute on chronic hypercarbic [hypercapnia] respiratory failure in the setting of drug overdose after receiving the incorrect seizure rescue dose (10 mg of Midazolam vs [versus] 1.6 mg). The note's physical exam for Resident 4 showed they were sleeping, unresponsive, tachycardic [fast HR], tachypneic [rapid RR] with decreased effort, had mottled skin, and was minimally responsive to nail bed pressure and sternal rub [technique used in a medical setting to assess responsiveness]. The note showed, Upon arrival to the ED [emergency department], [Resident 4] was found to be febrile [fever] to 101.2 [Fahrenheit- a scale for measuring temperature], heart rate was 174 up to 202. She was tachypneic in the 50s and 60s, and she was satting [oxygen level] in the high 80s to 90s, with minimal wincing to sternal rub and nail bed pressure. Resident 4 was escalated to [put on] BiPAP [Bilevel Positive Airway Pressure- a device that helps you breathe by delivering air through a mask]. The note further showed Resident 4 was signed out to the PICU (Pediatric Intensive Care Unit) for further workup for infection and continued management of her acute on chronic respiratory failure secondary to medical error of a Midazolam overdose at [facility], as patient was requiring significant more oxygen and respiratory support than her baseline 6 L [six liters] of High-Flow Nasal Cannula (HFNC- a device that gives additional oxygen through your nose) at home despite becoming more awake.Review of Resident 4's PICU admission note, dated 04/17/2025, showed Resident 4 was initially quite somnolent [sleepy or drowsy] and was placed on HFNC. However, even with increased arousal, she remained tachypneic. She then spiked a fever raising the concern for an additional infectious etiology to her respiratory failure. The note further showed an assessment that Resident 4 was admitted to the PICU critically ill with acute on chronic hypercarbic respiratory failure of unclear etiology- initially thought from over sedation but now with potential infectious etiology.Review of Resident 4's Inpatient Discharge summary, dated [DATE], showed Resident 4 was admitted to the hospital on [DATE] with a primary diagnosis of Benzodiazepine overdose, and a secondary diagnosis of Urinary tract infection [UTI-an infection in the urinary system], Infantile spasms. The hospital course section showed Resident 4 was admitted for acute on chronic hypercarbic respiratory failure in the setting of klebsiella (a type of bacteria) UTI and sedation effects from a reported overdose of Midazolam.In an interview on 07/30/2025 at 2:05 PM, Collateral Contact 1 (CC1), stated that Resident 4 was hospitalized on [DATE] due to a seizure, respiratory failure, and an overdose of Midazolam. CC1 stated that Resident 4 was not doing well on high flow oxygen at the hospital and was put on BiPAP and was transferred to the PICU where Resident 4 was found to have a UTI.In an interview and joint record review on 07/30/2025 at 4:50 PM, Staff F, Registered Nurse (RN), stated when administering medication, they should check to see that they have the right patient, medication, dose, time, route, documentation, and reason and to double check the Medication Administration Record as they go. A joint record review of Resident 4's physician orders showed an order for PRN Midazolam to give 0.28 ml (or 1.4 mg, half dose in each nostril) for seizures. Staff F stated that on 04/17/2025, Resident 4 was seizing aggressively, had a HR over 200 bpm and a RR over 100. Staff F stated that they stepped out of Resident 4's room and saw the PRN order for Midazolam at the nurse's station then went to the medication cart to obtain the medication and prepared it at Resident 4's bedside. Staff F stated that somewhere in between the medication cart and bringing the medication into the room they thought the order was for 2.8 ml of Midazolam instead of the ordered 0.28 ml. Staff F stated that they did not (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505535	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridges to Home	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	check the order at the medication cart when they took out the medication and that they should have. Staff F stated that they should have stopped and thought this was wrong when I pulled the entire contents of the bottle [2 ml or 10 mg], but she was seizing. Staff F stated that they pushed through it and it was not the right thing to do. Staff F stated that they gave Resident 4, almost 10 times the ordered amount [of Midazolam].In a follow up interview on 07/30/2025 at 5:39 PM, when asked if Staff F received any training/in-service they stated they talked through it [medication error], and what should have happened in that situation and had a lot of conversations.On 07/31/2025 at 11:42 AM, Staff I, RN, stated when administering medication, they should check to ensure they have the right patient, dose, medication, time, and route. Staff I stated they were not aware of any medication error incident for Resident 4. Staff I stated that they were trained upon hire on medications. When asked if they had received any education/in-service related to medication errors, Staff I stated, nothing additional, not that I've attended.In an interview on 07/31/2025 at 12:14 PM, Staff G, RN, stated that they were not aware of any medication error incidents. Staff G further stated that they did not receive any education/in-service regarding medication errors that happened in the facility.In an interview on 07/31/2025 at 1:01 PM, Staff H, Pharmacist, stated that receiving 2 ml of Midazolam for Resident 4, would be too much, and an overdose based on Resident 4's weight. Staff H stated that an overdose of Midazolam could cause sedation, difficulty breathing, and can cause tachycardia in less than 1% of the adverse reactions. Staff H further stated that Resident 4 had cardiac problems and could have more of an effect.On 07/31/2025 at 3:08 PM, Staff D, Nurse Manager, stated that they were Resident 4's primary nurse on 04/17/2025. Staff D stated Staff F prepared the medication (Midazolam) in Resident 4's room and administered the wrong dose. Staff D stated that Resident 4 was hospitalized on [DATE] for getting the incorrect dose of Midazolam. When asked how the medication error happened, Staff D stated that they thought it was drawn up in the room and not at the computer. When asked what the facility did about it, Staff D stated they did not remember. When asked if they received any education or in-service regarding the incident, Staff D stated no and that it was just discussed.On 08/01/2025 at 9:05 AM, Staff C, Nurse Manager, stated that when administering medication staff should check for right patient, medication, route, dose, and time. Staff C stated this would be important so the resident would not receive the wrong medication/dose and would not be overmedicated. Staff C stated that Staff F did not follow the five (medication administration) rights when administering PRN Midazolam to Resident 4 on 04/17/2025.In a phone interview and joint record review on 08/01/2025 at 12:02 PM, Staff N, Medical Director, stated that Resident 4 was hospitalized on [DATE] for seizure and an overdose of Midazolam. A joint record review of Resident 4's hospital notes showed they had acute on chronic hypercarbic respiratory failure. Staff N stated that Resident 4 presented with respiratory failure, needed an escalation of respiratory support for BiPAP, and that multiple things could have caused it.On 08/04/2025 at 12:35 PM, Staff B, Director of Nursing Services, stated they would expect their staff to follow the eight medication administration rights. Staff B stated that Resident 4 had chronic respiratory failure at their baseline and that based on their hospitalization notes from 04/17/2025 they had an acute episode. Staff B further stated that on 04/17/2025, Staff F should have drawn Midazolam at the medication cart while looking at the medication order instead of taking it to Resident 4's bedside and drawing it up there and not having anything to refer or look back to.Reference: (WAC) 388-97-1060 (3)(k)(iii).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505535	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridges to Home	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement care plans for 4 of 7 residents (Residents 7, 1, 6 & 4), reviewed for comprehensive care plans. The failure to implement care plans for use of benzodiazepine (a medication for seizures/epilepsy [a temporary, uncontrolled burst of electrical activity in the brain that can cause temporary changes in behavior, movements, sensations, or awareness]), diuretic (medications that help move extra fluid out of the body), and antibiotic (medications to treat infections) placed the residents at risk for unmet care needs and a diminished quality of life.Findings included. Review of the facility's policy, titled Comprehensive Assessment and Care Planning, dated July 2022, showed its purpose it to ensure that all patients are comprehensively assessed using the patient assessment protocols. The policy further showed a chart review that included a review of the most recent physician orders and a review of medication and treatment records. RESIDENT 7Review of Resident 7's face sheet, printed on 07/29/2025, showed they were admitted to the facility on [DATE]. Review of Resident 7's physician orders included the following medications:-Midazolam (a benzodiazepine)- used for anxiety (emotion involving fear and worry) during tracheostomy (an opening surgically created through the neck into the windpipe to allow air to fill the lungs) care-Clonazepam (a benzodiazepine)-for epilepsy-Furosemide (a diuretic)- for atrial septal defect (a heart condition where there is a hole in the heart's upper chambers)-Spironolactone (a diuretic)- for dilated heart (a form of heart disease).-Cephalexin (an antibiotic)- to prevent respiratory infections.-Azithromycin (an antibiotic)- to prevent respiratory infections. During a joint record review and interview on 08/04/2025 at 11:58 AM with Staff E, Nurse Assessment Coordinator, showed Resident 7's care plan did not show benzodiazepine, diuretic and antibiotic use were included. Staff E stated that they did not think that they should be included in the care plan. Staff E further stated, I don't [do not] know if it's [it is] a requirement. In an interview on 08/04/2025 at 12:59 PM, Staff B, Director of Nursing Services, stated that they expected benzodiazepine, diuretic, and antibiotic use to be included in the care plan. RESIDENT 1Review of the face sheet printed on 07/29/2025 showed Resident 1 admitted to the facility on [DATE] with diagnoses that included epilepsy and personal history of Urinary Tract Infections (UTI – an infection in the urinary system). Review of Resident 1's July 2025 Medication Administration Record (MAR) showed the following orders:-Clonazepam for epilepsy-Cephalexin for history of UTI-Nitrofurantoin microcrystal (an antibiotic) for history of UTI-Erythromycin Ethylsuccinate (an antibiotic) for neurogenic bowel (loss of normal bowel function due to nerve damage)-Tobramycin 0.3 percent (%)-dexamethasone 0.1% (an antibiotic) for acute and chronic respiratory failure (a serious condition where the body does not get enough oxygen)-Ciprofloxacin 0.3%-dexamethasone 0.1% (an antibiotic) for earwax buildup Review of Resident 1's comprehensive care plan printed on 07/29/2025, did not show a care plan for benzodiazepine and antibiotic use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505535	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridges to Home	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/01/2025 at 8:29 AM, Staff K, Registered Nurse (RN), stated that for residents taking antibiotics they would monitor for adverse side effects and potential yeast infections (fungus normally found on the skin and digestive system). Staff K stated that they monitored respiratory function and black box warnings (most serious type of warning) for residents taking benzodiazepine. Staff K stated that they followed the residents' care plans and expected antibiotics and benzodiazepine to be in the care plan. When asked why that would be important, Staff K stated that the medications have side effects that could have implications on the residents' health and that they would need to monitor side effects and assess if the medication was working per their indication. RESIDENT 6Review of a face sheet printed on 07/29/2025 showed Resident 6 admitted to the facility on [DATE] with diagnoses that included hypoplastic left heart syndrome (congenital heart defect where the left side of the heart is severely underdeveloped, affecting normal blood flow). Review of Resident 6's July 2025 MAR showed an order for spironolactone and hydrochlorothiazide (a diuretic) for hypoplastic left heart syndrome with a start date of 03/20/2025. Review of Resident 6's comprehensive care plan printed on 07/29/2025 did not show a care plan for diuretic use. In an interview on 08/01/2025 at 10:19 AM, Staff I, RN, stated that they monitored hydration (the body's ability to absorb water), signs/symptoms of dehydration (a condition in which the body loses so much fluid that it cannot function normally) and electrolytes due to fluid imbalance for residents taking diuretics. Staff I stated that they would expect diuretic use to be part of the residents' care plan. In an interview and joint record review on 08/01/2025 at 2:51 PM, Staff C, Nurse Manager, stated that when monitoring high-risks medications like diuretics, antibiotics and benzodiazepine, they were looking at their side effects. When asked if they expected these medications to be part of the resident's care plan, Staff C stated, it should be. A joint record review of Resident 1's comprehensive care plan did not show a care plan for benzodiazepine or antibiotic use. Staff C stated that they did not see a care plan and that there should have been. A joint record review of Resident 6's comprehensive care plan printed on 07/29/2025 showed that they did not have a care plan for diuretic use. Staff C stated that there should be a care plan for it. In an interview on 08/04/2025 at 10:27 AM, Staff B stated that they expected benzodiazepine, antibiotic, and diuretic medications to be part of the resident's care plan. Staff B further stated that it should have been in their care plan, and that we just missed it. RESIDENT 4Review of Resident 4's face sheet printed on 07/30/2025, showed they admitted to the facility on [DATE] with diagnoses that included seizures, UTI, and other disorders of electrolyte and fluid balance. Review of Resident 4's physician orders printed on 07/30/2025, showed the following orders:-Midazolam as needed for seizures.-Clonazepam for dystonic crises (multiple hours of spasms or movements)-Hydrochlorothiazide for other disorders of electrolyte and fluid balance.-Furosemide for Atrial Septal Defect.-Nitrofurantoin for UTI. Review of Resident 4's comprehensive care plan printed on 07/30/2025, did not show a care plan for benzodiazepine, diuretic, or antibiotic use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505535	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridges to Home	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/01/2025 at 10:15 AM, Staff I stated that if a resident was on a diuretic, antibiotic, or a benzodiazepine for their medical conditions, they would expect to see that in their care plan. A joint record review and interview on 08/01/2025 at 11:14 AM with Staff C showed Resident 4's physician orders and care plan had orders for midazolam, clonazepam, hydrochlorothiazide, furosemide, and nitrofurantoin were not in the care plan. Staff C stated that these medications should have been in the care plan. In an interview on 08/04/2025 at 12:37 PM, Staff B stated they would expect diuretics, antibiotics, and benzodiazepines to be included in the care plan. Reference: (WAC) 388-97-1020 (1) .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505535	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridges to Home	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the nurse staffing information postings were posted at the beginning of each shift for 3 of 4 days and failed to ensure the nurse staffing information posting was in a prominent location readily accessible to residents/representatives and visitors, reviewed for Nurse Staffing Information. These failures placed the residents/representatives and visitors at risk for not being fully informed of current nurse staffing levels and resident census information.Findings included .Review of the facility's undated policy titled, Staff Postings, showed, Staffing will be posted daily in a readable format in a prominent location in the facility. It further showed, the Director of nursing or designee will post the following information daily at the beginning of each shift. Observations on 07/30/2025 at 9:28 AM, showed that the nurse staff posting form labeled, Staffing Standard was dated 07/29/2025 and posted on the wall at the nurse's station behind the counter.Observations on 07/31/2025 at 8:14 AM, showed that the nurse staff posting form labeled, Staffing Standard was dated 07/30/2025 and posted on the wall at the nurse's station behind the counter.Observations on 08/01/2025 at 7:57 AM, showed that the nurse staff posting form labeled, Staffing Standard was dated 07/31/2025 and posted on the wall at the nurse's station behind the counter.In an interview and joint observation on 08/01/2025 at 8:05 AM, Collateral Contact 2 (CC2), stated that they did not know about the nurse staffing information posting. A joint observation showed that the nurse staff posting was dated 07/31/2025 and posted on the wall at the nurse's station behind the counter. CC2 stated that the nurse staff posting was new to them and that it's [it is] not that visible. In an interview and joint record review on 08/01/2025 at 8:38 AM, Staff Q, Office Administrator, stated that they would post the nurse staff posting when they came to work at 8:30 AM. A joint record review of the Staffing Standard form showed that it was dated 07/31/2025 and posted on the wall at the nurse's station behind the counter. Staff Q stated that they just came to work and would be posting the current Staffing Standard form. In a follow up interview at 9:45 AM, Staff Q stated that they oversaw the nurse staff posting and would change it in the morning when they came to work. When asked if they would post it at the beginning of the nursing shift, Staff Q stated that they did not come in at 5:45 AM and that it was posted at the start of their shift at the nurse's station.In an interview on 08/01/2025 at 2:32 PM, Staff A, Administrator, stated that they expected the nurse staffing information to be posted daily projecting the staffing today and the actual hours worked and that it would be posted at the beginning of the shift. When asked if they would expect it to be in a prominent place that was visible to residents, family and visitors, Staff A stated, yes, and that they always had it at the nurse's station. Staff A further stated that Staff Q would post it at the beginning of their shift, and not at the beginning of the nursing shift.No Associated WAC.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505535	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridges to Home	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure Medication Regimen Review (MRR- a comprehensive assessment of resident's medications, performed by a pharmacist [a qualified professional to provide expert advice on medication management, safety, and regulatory compliance] to identify and address potential problems) was completed for 1 of 5 residents (Resident 6), reviewed for unnecessary medications. This failure placed the resident at risk of receiving unnecessary medications and a diminished quality of life. Findings included . Review of the facility's policy titled, Medication Regimen Review and Reporting, dated January 2023, showed, The nursing center follows up on the recommendations to verify that appropriate action has been taken. Recommendations shall be acted upon within 30 calendar days. It further showed, For those issues that require physician intervention, the attending physician either accepts and acts upon the report and recommendations or rejects all or some of the report and should document his or her rationale of why the recommendation is rejected in the resident's medical record. Review of Resident 6's May 2025 MRR dated 05/30/2025 and June 2025 MRR dated 06/27/2025 showed the same recommendation to check BMP [Basic Metabolic Panel - a blood test that measures eight different substances in the blood, providing important information about the body's chemical balance and metabolism (the process in which the body break down nutrients to create energy)]. Further review showed, Physician/Prescriber Response was not completed for the May 2025 MRR dated on 05/30/2025. In an interview and joint record review on 07/31/2025 at 2:25 PM, Staff E, Nursing Assessment Coordinator, stated that the pharmacist would email the MRR recommendations to them, Staff A, Administrator, Staff B, Director of Nursing Services, and Staff N, Medical Director. Staff E stated that Staff N would complete the MRR recommendation and email it back to them. Staff E stated that Staff N did not send the completed recommendations for April 2025 and May 2025 until June 2025. Staff E stated that Staff N did not respond timely. A joint record review of Resident 6's May 2025 MRR dated 05/30/2025 showed to check BMP and that the Physician/Prescriber Response was not completed. Further joint record review of Resident 6's June 2025 MRR dated 06/27/2025 showed the same recommendation to check BMP and that it was completed on 06/30/2025. Staff E stated the MRR dated 05/30/2025 and 06/27/2025 were the same recommendation and because Staff N had completed the MRR recommendations late, Staff N had completed the most recent recommendation dated 06/27/2025. In a follow up interview on 08/01/2025 at 10:25 AM, Staff E was asked if anyone had followed up on the MRR with Staff N in April 2025 or May 2025, Staff E stated, No, I don't [do not] think we did. In an interview on 08/01/2025 at 11:32 AM, Staff B stated that their expectation was for the Pharmacist to give them the MRR recommendations and that Staff N would give their responses and recommendations. Staff B further stated that they expected the MRRs to be completed timely and that they were aware that Resident 6's May 2025 MRR recommendation was completed late. Reference: (WAC) 388-98-1300 (4)(c) .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505535	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridges to Home	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on interview and record review, the facility failed to maintain proper temperature for 1 of 1 refrigerator (Medication Room Refrigerator), reviewed for medication storage. This failure placed the residents at risk of receiving compromised and ineffective medications.Findings included.Review of the facility's policy titled, Storage of Medication, dated January 2023, showed, Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. The policy showed that medications requiring refrigeration would be kept between 36 to 46 degrees Fahrenheit (F - a scale for measuring temperature). The policy further showed that a temperature log or tracking mechanism would be maintained to verify that temperature has remained within accepted limits.Review of the facility document titled, Refrigerator and Freezer temperature logs, showed temperatures taken from the Med [Medication] room Fridge as follows:-On 12/02/2024, entry was blank/no documentation.-On 03/19/2025, entry was 50 F.-On 04/01/2025, entry was blank/no documentation.-On 05/03/2025, entry was 50 F.-On 05/18/2025, entry was blank/no documentation.-On 05/22/2025, entry was blank/no documentation. -On 07/01/2025, entry was 50 F.-On 07/06/2025, entry was blank/no documentation.-On 07/10/2025, entry was 49 F.-On 07/13/2025, entry was blank/no documentation.-On 07/26/2025, entry was blank/no documentation.-On 07/27/2025, entry was blank/no documentation.On 07/31/2025 at 8:39 AM, Staff C, Nurse Manager, stated there was a running log for the medication room refrigerator that certified nursing assistants filled out with nurse supervision in the medication room. Staff C stated that the medication room refrigerator temperature should be checked daily.A joint record review and interview on 07/31/2025 at 8:56 AM, with Staff C showed the following temperature entries for the medication room refrigerator: -On 12/02/2024, entry was blank/no documentation.-On 03/19/2025, entry was 50 F.-On 04/01/2025, entry was blank/no documentation.-On 05/03/2025, entry was 50 F.-On 05/18/2025, entry was blank/no documentation.-On 05/22/2025, entry was blank/no documentation. -On 07/01/2025, entry was 50 F.-On 07/06/2025, entry was blank/no documentation.-On 07/10/2025, entry was 49 F.-On 07/13/2025, entry was blank/no documentation.-On 07/26/2025, entry was blank/no documentation.-On 07/27/2025, entry was blank/no documentation.Staff C stated some entries were missing, and that the temperature should have been checked, and that a temperature of 50 F was too high. Staff C stated it was important to check the temperature of the medication room refrigerator because bacteria could grow if it was too hot and could be a danger and a risk to our kids [residents]. Staff C stated if the temperature was out of range, they would expect staff to notify the nurse and there would be documentation on what the facility did about it.In a follow-up interview on 08/01/2025 at 8:55 AM, Staff C stated that the medication refrigerator temperature range should be from 36 F to 46 F. Staff C stated they spoke with the pharmacist about the medications in the refrigerator and were told the formula would have been a concern for the temperatures outside of the range. Staff C stated six of seven residents were on formula and that if a temperature entry was not checked, they would not know what the temperature was. When asked if there was any documentation to show if anything was done when the temperature was 50 F, Staff C stated, not that I was aware of unfortunately.On 08/01/2025 at 9:47 AM, Staff B, Director of Nursing Services, stated that they expected staff to check the medication refrigerator temperature daily. Staff B stated the expected temperature range was between 36 F to 46 F and would expect staff to report it to the Administrator if the temperature was out of range. Staff B stated that some entries were missing, and that they did not have a way to go back. Staff B further stated it was important to monitor the medication room refrigerator temperatures to maintain the integrity of the medications that are stored in there.Reference: (WAC) 388-97-1300 (2).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505535	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridges to Home	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure Enhanced Barrier Precautions (EBP-precaution to protect residents from multidrug-resistant organism [a germ that is resistant to medications that treat infections]) practices were followed for 1 of 7 residents (Resident 2), reviewed for infection control. In addition, the facility failed to ensure hand hygiene practices and/or proper use of gloves were followed during garbage disposal and resident care for 4 of 8 staff (Staff M, Staff G, Staff R & Staff C). These failures placed the residents, visitors, and staff at an increased risk for infection and related complications.Findings included . Review of the facility's undated policy titled, Infection Prevention and Control Program, showed, For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities .device care or use. feeding tube [flexible plastic tube inserted into the stomach to deliver liquid nutrition], tracheostomy [procedure to help air and oxygen reach the lungs by creating an opening into the windpipe from outside the neck]/ventilator [medical device that supports or recreates the process of breathing by pumping air into the lungs] . Review of the facility's undated policy titled, Handwashing/Hand Hygiene, showed, Use an alcohol-based hand rub containing at least 62% [percent] alcohol; or alternatively, soap.and water for the following situations.before donning [applying] sterile gloves . It further showed, Applying and Removing gloves 1. Perform hand hygiene before applying non-sterile gloves 4. Hold the removed gloved in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove. 5. Perform hand hygiene. EBPReview of Resident 2's risk for infection care plan printed on 07/30/2025 showed an intervention to Maintain Enhanced Barrier Precautions. Observation on 07/29/2025 at 12:45 PM, showed Resident 2 in the dining/activity room in their wheelchair. Resident 2 had mucous/secretion coming out of their tracheostomy and secretions coming down from the left side of their mouth down to their cheek. When Resident 2 coughed, foam-like secretions were coming out of their tracheostomy. At 12:52 PM, Staff L, Licensed Practical Nurse, entered the dining/activity room, performed hand hygiene and applied gloves. Staff L suctioned (process of removing secretions or fluids by means of a tube and a device) Resident 2 and when they were done, they removed their gloves and performed hand hygiene. Staff L did not wear a gown while suctioning Resident 2. In an interview on 07/29/2025 at 2:52 PM, Staff L stated that when caring for residents on EBP their process was to perform hand hygiene before entering the room, to use gown and gloves when providing any care like transfers, personal care and when they would need to access any devices like their tracheostomy and gastrostomy (G-tube – a surgical device used to provide direct access to the stomach for feeding, hydration and medication). Staff L stated that Resident 2 was on EBP due to a G-tube and a tracheostomy. Staff L stated that it was their understanding that if it was a common space, they did not need to wear a gown because of dignity issues. In an interview on 08/01/2025 at 3:16 PM, Staff C, Nurse Manager, stated that staff were to use Personal Protective Equipment (PPE-gown and gloves) anytime they provided direct patient care for residents on EBP. Staff C stated that they expected staff to wear a gown when suctioning a resident and that they expected Staff L to have worn a gown when they suctioned Resident 2 in the dining/activity room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505535	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridges to Home	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	HAND HYGIENE/GLOVE USESTAFF MObservation on 07/31/2025 at 8:15 AM, showed Staff M, Certified Nursing Assistant, walked down the hallway wearing gloves on both hands and holding a garbage bag on their right-hand walking towards the dining/activity room. Staff M entered the dining/activity room and exited the door to the basement. In an interview on 07/31/2025 at 8:23 AM, Staff M stated that they performed hand hygiene before/after care and wore gloves anytime they provided care so that they did not pass germs to the resident or themselves. Staff M stated that they would change gloves in between tasks. When asked about glove use in the hallway, Staff L stated, typically, no when they were not providing care and that if they were providing care or interacting with residents, they would wear PPE. Staff M further stated when they took the garbage out, they wore gloves and that they did not want to touch dirty garbage. Staff M stated that they had just come out of Resident 2's room and that they had changed their soiled brief. Staff M stated that they applied new gloves before taking the garbage bag out of the resident's room and that they went through the dining/activity room to take the stairs to the basement where they threw the garbage out. Staff M further stated that it was their preference to wear gloves when taking out the garbage. STAFF GObservation on 07/31/2025 at 10:40 AM, showed Staff G, Registered Nurse (RN), performed hand hygiene, wore their gown and a mask prior to entering Resident 2's room. Resident 2 coughed and Staff G suctioned Resident 2's mouth. When Staff G was done, they removed their gloves and applied new gloves without performing hand hygiene. Staff G took supplies that were at the bedside and adjusted Resident 2's clothing. Staff G then removed their gloves, applied new gloves and removed Resident 2's G-tube dressing. Staff G removed their gloves, applied new gloves, cleansed and dried the skin around Resident 2's G-tube with a gauze (thin, loosely woven cloth used for dressings). Staff G removed their gloves, applied new gloves and applied zinc oxide ointment (skin protectant) on a cotton tipped applicator (disposable stick with pieces of soft cotton at the end) and applied the ointment on the skin around Resident 2's G-tube. When Staff G was done, they removed their gloves, applied new gloves, and applied Aquaphor (brand name- used to protect and moisturize skin) on Resident 2's skin around their G-tube. Staff G then wiped the surrounding skin of Resident 2's G-tube with a no sting barrier (liquid film-forming skin protectant) wipe and removed their gloves. Staff G then applied new gloves and applied foam dressing around Resident 2's G-tube. Staff G removed their gloves, applied new gloves and applied more Aquaphor to the right side of Resident 2's abdomen. Staff G removed their gloves, applied new gloves, cleaned up Resident 2's bedside table, and placed the trash can and bedside table by the wall. Resident 2 started to cough and Staff G suctioned Resident 2. When Staff G was done, they removed their gloves and applied new gloves. Staff G suctioned Resident 2 again and removed their gloves. Staff G applied new gloves and transferred Resident 2 into their wheelchair with the help of Staff K, RN. Staff G applied Resident 2's brace, placed pillows under their legs and a blanket on their lap. When they were done, Staff G removed their PPE and performed hand hygiene. Staff G did not perform hand hygiene between glove use and between tasks (suctioning, dressing change and transfers). In an interview on 07/31/2025 at 11:05 AM, Staff G stated that they changed gloves between caring for a tracheostomy and G-tube, between dirty to clean task and if they thought their gloves could have gotten dirty. When asked if they performed hand hygiene between glove use, Staff G stated, I probably should have and that they did not usually perform hand hygiene if they were doing care like tracheostomy care. When Staff G was informed of observations made of them changing gloves between suctioning, G-tube dressing change, and transferring without performing hand hygiene, Staff G stated they performed hand hygiene before they entered and exited Resident 2's room. When asked if they should have performed hand hygiene between glove use, Staff G stated, probably and that they (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505535	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridges to Home	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	did not know exactly what their policy was. In an interview on 08/01/2025 at 3:06 PM, Staff C stated that staff were to perform hand hygiene between glove use and between tasks. Staff C further stated that Staff G should have performed hand hygiene between tasks when they provided care to Resident 2. In an interview on 08/04/2025 at 10:28 AM, Staff B, Director of Nursing Services, stated that they expected staff to perform hand hygiene before/after glove use, when going in/out of resident rooms, and between different tasks. When asked about glove use in the hallway, Staff B stated that they were not 100 percent sure if they had a policy on glove use in the hallway. Staff B stated that the door in the dining/activity room was the only access to the stairs to the basement. Staff B stated that Staff M could have used the soiled utility room or the elevator to dispose of the garbage bag. Staff B stated that they expected staff to follow EBP and the signage that was posted on the residents' door. Staff B stated that staff were to apply and remove PPE at the door. Staff B further stated that they expected Staff L to have worn a gown in the dining/activity room when they suctioned Resident 2. STAFF RObservation on 07/29/2025 at 2:02 PM, showed Staff R, RN, wore PPE and suctioned Resident 3. Staff R then turned on Resident 3's ventilator and readjusted Resident 3's feet. Staff R removed their gloves and applied a new pair of gloves and continued to suction Resident 3. Staff R did not do hand hygiene between glove use. On 07/29/2025 at 4:13 PM, Staff R stated hand hygiene should be performed before applying gloves and after removing them. Staff R stated they should have done hand hygiene between glove use during Resident 3's care. STAFF CObservation on 07/29/2025 at 2:11 PM, showed Staff C wore PPE while doing care for Resident 3. Staff C disconnected Resident 3's G-tube, unhooked the wheelchair seatbelt, and removed Resident 3's headphones. Staff C assisted Staff R transfer Resident 3 from their wheelchair into their bed using a Hoyer lift (mechanical device used to safely transfer individuals who has limited mobility from one place to another). Staff C touched the Hoyer lift, Resident 3's backpack, Hoyer lift sling, and G-tube. Staff C then connected Resident 3's G-tube to their feeding tube. Staff C did not change gloves or do hand hygiene between tasks. On 07/29/2025 at 3:54 PM, Staff C stated that hand hygiene should be performed when entering and exiting a resident room and after removal of soiled gloves. Staff C stated that they should have removed their gloves and done hand hygiene after assisting with Resident 3's transfer as it was a whole different task, and then apply new gloves and continue to the next task. On 08/01/2025 at 9:52 AM, Staff B stated their expectation was for staff to perform hand hygiene when entering and exiting a resident room. Staff B stated Staff C should have done hand hygiene between tasks. Staff B further stated that when staff performed hand hygiene between glove use, they would need to carry hand sanitizer with them or go to the door to sanitize. Reference: (WAC) 388-97-1320 (1)(a)(c) .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505535	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridges to Home	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff followed and implemented abuse and neglect policies and procedures for the protection of residents during a medication error investigation for 1 of 2 residents (Resident 4), reviewed for allegations of potential neglect. This failure placed the residents at risk for abuse and/or neglect.Findings included .Review of the facility's undated policy titled, Freedom from Abuse, Neglect, and Exploitation Abuse Definition, showed, Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff member.Review of the facility's undated policy titled, Freedom from Abuse, Neglect, and Exploitation Abuse Policies II, showed:-The facility will maintain and implement policies to prohibit and prevent abuse, neglect, exploitation of residents and misappropriation of resident property.-Each allegation of abuse will be thoroughly investigated in an effort to determine if abuse, neglect, exploitation and/or mistreatment occurred.-The investigation will include interviews with the alleged victim, alleged perpetrator, witnesses, and others who may have knowledge of the allegations, to the extent possible.- Staff will immediately report allegations or suspicions of abuse to the Administrator, state agency, adult protective services and other required agencies.-Staff will be trained regarding any changes that are being implemented.Review of the facility's undated policy titled, Abuse Prevention and Reporting, showed, It is the policy of this facility that all suspected, alleged, or actual cases of resident abuse, including injuries of unknown origin, shall be thoroughly and completely investigated and reported according to State and Federal regulations. The policy showed, All reports will be made following the purple books guidelines within the time frame set in the purple book. The policy further showed, It is not necessary for the reporter to categorize the event as abuse for the facility to consider the potential for abuse and act accordingly.Review of the Nursing Home Guidelines The Purple Book, dated October 2015, showed an Appendix C Medication Error Decision Tree, and medication errors that may be abuse or neglect must be reported to the Department and to law enforcement.Review of Resident 4's clinical note dated 04/17/2025, showed Resident 4 was sent out to the hospital after having a seizure (a temporary, uncontrolled burst of electrical activity in the brain that can cause temporary changes in behavior, movements, sensations, or awareness) and getting an overdose (an excessive/dangerous dose of a drug) of Midazolam (a benzodiazepine-medication to treat seizures).Review of Resident 4's physician orders printed on 07/30/2025, showed an order for Midazolam to use 0.28 milliliters (ml-a unit of measurement or 1.4 mg [milligrams]) as needed (PRN) for seizures.Review of Resident 4's investigation document titled, Incident Report, dated 04/17/2025, showed Resident 4 was having seizure activity and staff (Staff F, Registered Nurse) administered 2 ml of Midazolam instead of 0.28 ml as ordered and was transferred to the hospital. The investigation showed under section, Clinical Manager Review, that Staff F misread the order and bottle label, and that after the incident another staff checked the label on the bottle against the order in EMR [Electronic Medical Record] and they match and are correct. Pt. [Resident 4] did not exhibit any of the expected side effects: depressed HR [heartrate] and depressed RR [respiratory rate]. Pt had HR in 200's [beats per minute (bpm) and RR in high 80s. The investigation showed four witnesses or employees involved listed on the report. The investigation showed, Appendix C Medication Error Decision Tree [from the purple book] with a pathway that the facility used. The facility determined that the route they used for Appendix C, showed they determined no negative effect was done on the resident, that there was a significant risk of harm, that there was no serious disregard of consequences, and that they would follow up in their Quality Assurance Program. Further review of the facility's investigation did not show any witness statements, any intervention to show how the incident would be prevented from occurring again and/or if any changes were implemented and staff were trained. The investigation did not show that the State Agency was notified and whether abuse or neglect was ruled out.Review of Resident 4's Emergency Department (ED) Provider note, dated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505535	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridges to Home	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/17/2025, showed Resident 4 presented with acute on chronic hypercarbic respiratory failure (occurs when the respiratory system fails to eliminate carbon dioxide [a natural waste product/gas of breathing and burning], leading to its buildup causing confusion, rapid breathing, and lethargy [drowsiness or unusual lack of energy or mental awareness]) in the setting of drug overdose after receiving the incorrect seizure rescue dose (10 mg of Midazolam vs [versus] 1.6 mg). Resident 4 was escalated to [put on] BiPAP [Bilevel Positive Airway Pressure- a device that helps you breathe by delivering air through a mask]. The note further showed Resident 4 was signed out to the PICU (Pediatric Intensive Care Unit) for further workup for infection and continued management of her acute on chronic respiratory failure secondary to medical error of a Midazolam overdose at [facility], as patient was requiring significant more oxygen and respiratory support than her baseline 6 L [six liters] of High-Flow Nasal Cannula (HFNC- a device that gives additional oxygen through your nose) at home despite becoming more awake.Review of Resident 4's Inpatient Discharge summary, dated [DATE], showed Resident 4 was admitted to the hospital on [DATE] with a primary diagnosis of Benzodiazepine overdose, and a secondary diagnosis of Urinary tract infection [UTI-an infection in the urinary system], Infantile spasms. The hospital course section showed Resident 4 was admitted for acute on chronic hypercarbic respiratory failure in the setting of klebsiella (a type of bacteria) UTI and sedation effects from a reported overdose of Midazolam.On 07/30/2025 at 4:33 PM, Staff R, RN, stated that when a medication error happened, they would need to do an incident report. Staff R stated they would have to explain what happened, notify the doctor, family, social worker, and include witness statements. Staff R further stated the report would be reviewed by management staff and there would be a plan on how to prevent the mistake from happening again.In a joint record review and interview on 07/30/2025 at 4:50 PM, with Staff F showed Resident 4's physician orders had an order for PRN Midazolam to give 0.28 mL (or 1.4 mg, half dose in each nostril) for seizures. Staff F stated that on 04/17/2025, Resident 4 was seizing aggressively. Staff F stated that they gave Resident 4, almost 10 times the ordered amount [of Midazolam]. Staff F stated that they sat down with Staff B, Director of Nursing Services, and Staff E, Nurse Assessment Coordinator, and talked about the purple book. Staff F stated that they had to determine if harm was done in this scenario (medication error to Resident 4).In a follow up interview on 07/30/2025 at 5:39 PM, when asked if Staff F received any training/in-service they stated they talked through it [medication error], and what should have happened in that situation and had a lot of conversations.In an interview on 07/31/2025 at 1:01 PM, Staff H, Pharmacist, stated that receiving 2 ml of Midazolam for Resident 4, would be too much, and an overdose based on Resident 4's weight. Staff H stated that an overdose of Midazolam could cause sedation, difficulty breathing, and can cause tachycardia (HR over 100 bpm) in less than 1% of the adverse reactions. Staff H further stated that Resident 4 had cardiac problems and could have more of an effect.On 07/31/2025 at 3:08 PM, Staff D, Nurse Manager, stated that they were Resident 4's primary nurse on 04/17/2025. Staff D stated that Resident 4 was hospitalized on [DATE] for getting the incorrect dose of Midazolam from Staff F. When asked how the medication error happened, Staff D stated that they thought it was drawn up in the room and not at the computer. When asked what the facility did about it, Staff D stated they did not remember. When asked if they received any education or in-service regarding the incident, Staff D stated no and that it was just discussed.On 08/04/2025 at 10:28 AM, Staff J, RN, stated that everyone was a mandatory reporter. Staff J stated that it was important to conduct a thorough investigation to make sure that an incident did not happen again, and to find holes in protocols and procedures. Staff J further stated they would expect to see witness statements in the investigation to have, extra evidence about what happened, different point of view.On 08/04/2025 at 11:16 AM, Staff E stated everyone was a mandatory reporter. Staff E stated the purpose of investigating was to determine if abuse, neglect, or misappropriation may have occurred and to find ways to improve or prevent the incident from happening again. Staff E stated a medication error could be a potential for abuse or neglect and would use the guidance given in the purple book. Staff E stated that it would be important to rule out abuse and neglect when (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505535	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridges to Home	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigating and that staff were expected to follow the abuse and neglect policies.A joint record review and interview on 08/04/2025 at 12:35 PM, with Staff B showed Resident 4's hospital notes revealed they were admitted for a seizure/overdose and was signed out to the PICU for further workup for infection and continued management of her acute on chronic respiratory failure secondary to medical error of a Midazolam overdose at [facility], as patient was requiring significant more oxygen and respiratory support than her baseline 6 L of High-Flow Nasal Cannula at home despite becoming more awake. Staff B stated that Resident 4 had chronic respiratory failure at their baseline and that based on their hospitalization notes from 04/17/2025 they had an acute episode. Staff B stated that everyone was a mandatory reporter, and that the purpose of investigating was to find out if neglect or abuse was suspected, correct policies/procedures that were not done correctly, and to keep staff and residents safe. Staff B stated that a medication error could be potential for abuse and neglect and that they expected staff to follow their abuse and neglect policies. Additional joint record review of Resident 4's investigation dated 04/17/2025 showed no witness statements were included in their investigation. Staff B stated the investigation was not very thorough, when rereading what was written, and that they did not include any witness statements and would have expected to include them to find out all aspects of what happened. Staff B stated they verbally counseled staff. Staff B further stated that they did the investigation prior to the hospital notes being uploaded into EPIC (hospital EMR) and that based on the hospital notes they would have redone the Medication Error Decision Tree which would have led the facility to report and log the incident.Reference: (WAC) 388-97-0640 (2).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505535	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridges to Home	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the Office of the State Long-Term Care Ombudsman (an advocate for residents of nursing homes who protect and promote resident rights under federal and state law and regulations) of discharges and/or transfers, as required for 1 of 1 resident (Resident 11), reviewed for discharge process. This failure placed the residents at risk for lack of advocacy and possible unidentified or unmet care needs. Findings included . Review of the facility's policy titled, Transfer and Discharge, dated July 2022, showed, Prior to facility initiated transfer, the patient [resident] will be notified in writing by Social Services or Designee, the reasons for transfer in a language and manner they can understand. It further showed, The State Ombudsman Office will be sent a copy of the notice. Review of a face sheet printed on 08/04/2025, showed Resident 11 was admitted to the facility on [DATE] and discharged on 05/28/2025. Review of the discharge Minimum Data Set (an assessment tool) dated 05/28/2025 showed that Resident 11 discharged to the community. Review of Resident 11's electronic health records did not show that the Ombudsman was notified of their discharge. In an interview on 07/31/2025 at 5:15 PM, Staff O, Social Worker, was asked if they notified the Ombudsman when a resident transferred/discharged from the facility, Staff O stated they were not sure as they were covering for Staff P, Social Worker, and to ask Staff E, Nurse Assessment Coordinator. Staff O further stated that they notified the State (department responsible to provide support, care and resources for people with developmental disabilities and their families) about the residents' discharge. In an interview on 08/01/2025 at 10:25 AM, Staff E was asked if they would send a notification to the Ombudsman of residents' discharge from the facility or transfers to the hospital, Staff E stated, Not that I know of. In an interview on 08/01/2025 at 11:06 AM, Staff B, Director of Nursing Services, was asked if they sent notifications of residents' transfer/discharge to the Ombudsman, Staff B stated not that they knew of. Staff B further stated that Staff P would know and that they notified the entities that needed to be notified. In a phone interview on 08/04/2025 at 10:48 AM, Staff P stated that they did not notify the Ombudsman of discharges or transfers and that they would notify the residents' insurance and the State. Reference WAC 388-97-0120 (5)(a).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505535	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridges to Home	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.

(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 staff document medications and/or enter physician orders before administration of medication in accordance with professional standards for 2 of 4 residents (Residents 5 & 6), reviewed for medication administration. These failures placed the residents at risk for medication errors and negative outcomes.Findings included.Review of the facility's policy, titled Receiving and Documenting Physician's orders, dated August 2024, showed telephone/verbal orders would be entered into the Electronic Medical Record (EMR), and it would be double checked and received by a Registered Nurse (RN) or Licensed Practical Nurse (LPN), and then sent to the on-call physician to be double checked and signed.Review of the facility's policy, titled MEDICATIONS - Medication Pass Procedure, dated 12/17/2023, showed that all medications would be administered under physician orders as part of the physician's plan of treatment. The policy guidelines included that medications would be documented in the electronic Medication Administration Record (MAR) immediately after they have been administered to the resident.RESIDENT 5Review of Resident 5's face sheet printed on 07/29/2025, showed they admitted to the facility on [DATE].Review of Resident 5's July 2025 MAR showed an order for cholecalciferol (Vitamin D3-supplement) 10 micrograms (mcg - unit of measurement) per milliliter (ml-a unit of measurement) and to give 2.5 ml one time daily.Observation on 07/30/2025 at 9:54 AM, Staff R, RN, drew 1.2 ml of the cholecalciferol medication in a syringe. Staff R stated that there was not any medication left in the bottle and that they had not received the refill. Staff R further stated that they would have to call the physician regarding this medication. Staff L, LPN, informed Staff R that they would contact the physician for them.Observation on 07/30/2025 at 9:57 AM, showed Staff L informed Staff R that they received a one-time order to administer the 1.2 ml of the cholecalciferol for Resident 5. Staff R was not shown a written order and did not check the EMR.Observation on 07/30/2025 at 10:12 AM, showed Staff R administering 1.2 ml of cholecalciferol to Resident 5.On 07/30/2025 at 11:35 AM, Staff R stated that they wrote a note in the MAR that they had given 1.2 ml of cholecalciferol.A joint record review and interview on 08/01/2025 at 9:09 AM with Staff B, Director of Nursing Services, showed Resident 5's EMR had no physician order for cholecalciferol 1.2 ml. A joint record review of the July 2025 MAR showed an entry note dated 07/30/2025, that 1.2 ml of cholecalciferol was administered per a verbal order due to medication unavailability [under the cholecalciferol 2.5 ml physician order]. Staff B stated that they expected the nurse that communicated with the physician to enter the order in the EMR and to be the one to administer the medication.RESIDENT 6Review of Resident 6's face sheet printed on 08/01/2025, showed they admitted to the facility on [DATE].During an observation on 07/31/2025 at 8:20 AM, Staff G, RN, prepared the following medications for Resident 6's medication administration:-Sildenafil (a medication that helps reduce the blood pressure in the lungs)10 mg/ml suspension, give 2 ml.-Fluticasone propionate (used to prevent or control wheezing) 44 mcg, give two puffs twice daily.-Albuterol (used to prevent shortness of breath and wheezing) 90 mcg inhaler, give four puffs four times daily.-Sodium chloride (treatment used to help loosen up respiratory secretions) 0.9 percent for nebulizer (a device that turns liquid medicine into a fine mist to be inhaled), 3 ml every six hours.-Hydrochlorothiazide (helps reduce the amount of fluid in the body) 5 mg per ml, give 2 ml twice a day.-Sacubitril-valsartan (used to treat heart failure) 4 mg per ml, give 5.6 ml daily.-Spironolactone (used to treat heart failure) 25 mg per 5 ml, give 1 ml every 12 hours.-Cholecalciferol (used for vitamin D supplement) 25 mcg, give one time daily.-Aspirin 81mg (used to prevent blood clot formation), give one tab daily.-Levothyroxine (treats hypothyroidism [when your thyroid (produces hormones that regulate metabolism) gland does not make and release enough hormone into your bloodstream]) 25 mcg, give one tab daily.-Lansoprazole (helps decrease the amount of stomach acid) 3 mg per ml, give one time daily.Staff G drew 3.9 ml of the sacubitril-valsartan into a syringe then stated that they did (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505535	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridges to Home	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.

(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	not have enough for a full dose (5.6 ml). Staff G further stated they had a messenger application where they could contact the physician and get an order regarding this medication. Staff G later stated that they heard back from the physician and were given an order to give the 3.9 ml. After the medications were administered to Resident 6, Staff G stated that they had already signed off on the medications prior to administration.In an interview on 07/31/2025 at 4:10 PM, Staff G stated, once I draw it [medication] and double check it, I click it [in the MAR]. It's another way to show that I have drawn it up. Staff G further stated that if the resident refused the medication, they would have to go back and edit the administration. Staff G stated that when you sign off on medications in the MAR, it should mean that the medication was given.A joint record review and interview on 08/01/2025 at 9:09 AM with Staff B, showed Resident 6's EMR did not show a physician order to give 3.9 ml of sacubitril-valsartan. Staff B stated that they did not find this order and that it should have been entered in. Staff B further stated that they expected medications to be signed off in the MAR after the medications have been administered.Reference WAC 388-97-1620(2)(b)(ii).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505535	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridges to Home	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's representative was provided information about COVID-19 (an infectious disease-causing respiratory illness) vaccinations, including risks, benefits, potential side effects, documented if the vaccine was accepted and/or refused in the medical record for 1 of 5 residents (Resident 5), reviewed for COVID-19 immunizations. This failure placed the resident at risk for COVID-19 infection and denied their representative of the right to make informed decisions.Findings included .Review of the Centers for Disease Control and Prevention online document titled, Staying Up to Date with COVID-19 Vaccines, dated 01/07/2025, showed that parents of children ages 6 months to 17 years should discuss the benefits of vaccination with a healthcare provider.Review of the facility's undated policy, titled, Influenza [flu-contagious respiratory illness], pneumococcal [protection against infections that can cause pneumonia (a lung infection)], and COVID-19 immunizations, showed the COVID-19 vaccine would be offered to each resident. The resident and the resident representative received education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine. The policy further showed the resident's medical record would include that the resident or the resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine and if the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal.Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's hospital immunization record, dated 07/03/2025, did not show Resident 5 received the COVID-19 vaccine or if it had been declined.Review of Resident 5's Electronic Health Record (EHR) did not show documentation that the COVID-19 vaccine was offered or that their representative was educated on the risks and benefits of the vaccine.In an interview on 08/04/2025 at 1:56 PM, Staff E, Nurse Assessment Coordinator, stated that they did not know if Resident 5's representative was offered the COVID-19 vaccine and that there was no documentation. Staff E further stated there should be documentation in the EHR when a vaccine was declined or not medically appropriate.In an interview on 08/04/2025 at 12:59 PM, Staff B, Director of Nursing, stated that COVID-19 vaccines were offered to residents per doctor's recommendations.No reference WAC.