STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505059	A. Building B. Wing	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Panorama City Conv & Rehab Ctr	1600 Sleater Kinney Road SE Lacey, WA 98503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40914 Based on observation, interviews and record review, the facility failed to provide the two staff person assistance and use of a gait belt for transfers as required according to the plan of care for 1 of 3 sampled residents (Resident 1) reviewed for falls. Resident 1 experienced harm when they fell and sustained a head laceration when staff transferred them without a second staff person to assist and properly support resident with a gait belt. This failure placed residents at risk for falls with injury, pain and a diminished quality of life. Findings included . Resident 1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease and kidney disease. The quarterly minimum data set (MDS) an assessment tool, dated 02/26/2025, documented Resident 1 has moderately impaired cognition and was dependent on staff for all activities of daily living (ADLs). The Care Directive, dated 08/13/2024, documented Resident 1 required a sit-to-stand (a device which mechanically assists a resident to stand) for morning cares. Resident 1 required two staff, using a gait belt, for transfers throughout the day. The facility investigation, dated 03/23/2025, documented Resident 1 was on the floor in their bathroom. Staff responding noted there was no wheelchair, walker, gait belt or sit-to-stand near the bathroom. The resident was observed on the floor in the bathroom, laying on her back on the right side. Blood was coming out of the resident's head. 911 was called and the resident was transported to the hospital. Resident 1 required eight staples to a laceration on the head, measuring 2 x (by) 5 centimeters (cm). The resident had bruising to the right shin measuring 4 x 3.5 cm, to the left shin measuring 4 x 3.5 cm, and right forehead measuring 6 x 7 cm. The root cause of the fall was related to Staff E, nursing assistant (NA), not following the care plan, not using a gait belt, and use of only one staff to transfer Resident 1. On 05/12/2025 at 1:53 PM, Staff D, NA, said Resident 1 required the sit-to-stand in the morning due to difficulty with weakness. Staff D said two staff were always required when using the sit-to-stand. Staff D said if Resident 1 did walk, staff always needed to use a gait belt with two staff persons. Staff D said sometimes, Resident 1 would get stubborn and this was why it was important to have two staff persons. Staff D said Resident 1's care plan explained the resident's mobility needs. Staff D said Resident 1 did not have a history of falls except for the incident on 03/23/2025. (continued on next page)

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	On 05/12/2025 at 2:03 PM, Resident 1 was observed to be assisted with walking from a chair to a recliner. Two staff assisted the resident, using a gait belt. The resident was observed to be resistive to staff. The staff were observed to reposition the gait belt to gain a better grip on the resident. Resident 1 continued to be resistive towards staff. On 05/12/2025 at 2:09 PM, Staff C, Licensed Practical Nurse and Unit Manager, said Resident 1 had pain and just generally struggled to get moving in the morning. Staff C said they decided it would be best to use the sit-to-stand in the morning. The resident should otherwise have two staff and a gait belt for transfers. Staff C said Resident 1 had not had any recent falls accept for the incident on 03/23/2025. Staff C said the resident fell because Staff E did not follow the care plan. Staff C said this resulted in bruising and a laceration to Resident 1's head for which the resident required staples to close. There were no prior incidents with Staff E aside from tardiness/lateness. Staff C said they though Staff E's ongoing lateness made it difficult to keep up with the work and daily schedule. On 05/12/2025 at 3:02 PM, Staff A, Administrator, said he would expect staff to follow the care plan. Staff A said Staff E was terminated from the facility due to the incident. On 05/14/2025 at 1:46 PM, Staff B, Director of Nursing and Registered Nurse, said the care plan was in place and Staff E had what he needed for the job. Staff E was terminated from the facility. Reference WAC 388-97-1060 (3)(g)