STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505195	A. Building B. Wing	12/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Auburn Rehab & Health Center	2830 I Street Northeast Auburn, WA 98002

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents received timely care and treatment prescribed by the Medical Provider (Physician, Nurse Practitioner or Physician Assistant) for a change in condition for 1 of 3 residents (Resident 1) reviewed for accidents and injury. This failure placed residents at risk for harm, worsening medical conditions, and diminished quality of life.Findings included.<Resident 1>Review of Resident 1's quarterly Minimum Data Set (MDS - an assessment tool) dated 11/08/2025, showed Resident 1 had diagnoses including kidney failure requiring dialysis, and a chronic neurological-muscle disease with impairment of their arms and legs. Resident 1 was assessed to require a mechanical lift for transfers, a manual wheelchair for mobility, and was dependent on staff for care. According to a 12/11/2025 day shift nurse progress note, Staff F (Licensed Practical Nurse-LPN) received a call from the dialysis clinic stating Resident 1 reported they were in pain because their left leg was hurt during transport to the dialysis clinic. The note showed the Nurse Practitioner (NP) assessed Resident 1 upon return to the facility. The note showed the NP ordered an x-ray and pain medication. The progress note was entered into the record at 5:54 PM. Review of the NP progress notes from 12/11/2025 visit showed an assessment was completed on Resident 1 upon return from their dialysis appointment. The assessment showed Resident 1 had acute left hip and upper thigh pain after returning from dialysis, Resident 1 told the NP their left leg was bent during transport from the facility to their dialysis appointment. The NP note showed Resident 1's pain was more than a strain to the muscle. The note showed the NP discussed the assessment with the facility nurse, directed the nurse to give pain medication, and ordered a left hip x-ray STAT (as soon as possible). Review of the 12/11/2025 11:19 AM order entered into the medical record by the NP showed a STAT left hip x-ray. The order summary showed Staff E (LPN) confirmed the order at 3:55 PM, four and a half hours later. Review of a 12/11/2025 evening shift progress note written by Staff E, showed a new order for x-ray of left hip STAT was received and the order was initiated. The progress note was entered into the record at 11:33 PM. Review of Resident 1's 12/12/2025 x-ray report showed the left hip x-ray was completed at 8:35 PM, 33 hours after the NP ordered the STAT x-ray. The report showed Resident 1 had an acute hip fracture. The report showed a reported date and timestamp of 12/12/2025 at 9:11 PM. Review of a 12/12/2025 evening shift nurse progress note, entered late on 12/13/2025 at 2:43 PM, showed Staff C (LPN) received a phone call from the x-ray company reporting Resident 1's hip fracture. Staff C wrote information was passed to the night shift for follow up because it was the end of the evening shift. Review of a 12/13/2025 9:29 AM nurse progress note showed the nurse received a report Resident 1 had a hip fracture. The note showed directions to send Resident 1 to the hospital, notify the family, and notify nurse management. In an interview on 12/30/2025 at 9:25 AM, Staff B (Assistant Director of Nursing) stated that when x-ray results were received showing an acute fracture, the Medical Provider should be notified immediately. Staff B stated if results were received after hours there was an on-call provider number staff should call to report. Staff B stated when the on-call provider was called a progress note was automatically generated into the medical record. Staff B stated there was no progress note in Resident 1's record showing the on-call provider was notified of the hip fracture. Staff B stated the NP notified them on 12/13/2025 at about 7:30 AM that Resident 1 had a hip fracture. Staff B stated the NP gave directions to send Resident 1 to the hospital. Staff B stated they called the facility nurse assigned to Resident 1. Staff B stated the nurse was not aware of Resident 1's x-ray results and told Staff B Resident 1 was at their dialysis appointment. Staff B said they directed the nurse to call the dialysis clinic to send Resident 1 to the hospital.In an interview on 12/30/2025 at 9:58 AM, the NP stated they expected the nursing staff to review the x-ray results and report a fracture immediately to the provider, including calling the on-call provider if the report was after hours. The NP stated the facility did not notify the provider of the fracture. The NP stated they looked up the x-ray report in Resident 1's medical record on 12/13/2025 at 7:30 AM and tried calling the facility. The NP stated when they could not reach the facility staff, they called Staff B to instruct the facility to send Resident 1 to the hospital immediately for the hip fracture from the 12/11/2025 incident. The NP stated a hip fracture was a severe injury requiring ambulance transportation to the hospital for immediate intervention. In an interview on 12/30/2025 at 10:16 AM, Staff C stated they were the evening shift nurse on 12/12/2025 and received a phone call and report from the x-ray company about 10:00 PM, which was shift change. Staff C stated they did not report the fracture to the Medical Provider. In an interview on 12/30/2025 at 10:21 AM, Staff D (LPN)