

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/24/2024
NAME OF PROVIDER OR SUPPLIER Fir Lane Health and Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 2430 North 13th Street Shelton, WA 98584	

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)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40914</p> <p>Based on interview and record review, the facility failed to provide a written notice to the resident, the resident representatives, and representative of the Office of the State Long-Term Care Ombudsman of an emergency transfer for 1 of 3 residents (1) reviewed for hospitalization s. This failure placed residents and/or their representatives at risk of not being able to make informed decisions about transfers and prohibited access to an advocate who could inform the resident/representative of their options and rights.</p> <p>Findings included .</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses including chronic inflammatory demyelinating polyneuritis (a condition resulting in loss of sensation in the arms and legs). The quarterly Minimum Data Set (MDS) assessment, dated 11/25/2023, documented Resident 1 had no cognitive impairment and required moderate to total dependence on staff for assistance with activities of daily living. The MDS documented Resident 1 had an active plan to return to the community. No referrals had been made for discharge planning.</p> <p>On 05/23/2024 at 5:18 PM, Resident 1 said the facility did not provide a notice of transfer when they were transferred to the hospital from a scheduled appointment.</p> <p>Progress notes, dated 02/16/2024, documented Resident 1 was transferred to the hospital on 02/14/2024 directly from an appointment. The resident was admitted to the intensive care unit.</p> <p>Review of the Resident 1's electronic record showed no documentation the required written notification of transfer was provided to the resident, their representative or Office of the State Long-Term Care Ombudsman.</p> <p>On 05/24/2024 at 4:18 PM, Staff B, Registered Nurse and Director of Nursing Services, said Resident 1 was transferred to the hospital from a clinic appointment. The facility did not complete the notification of transfer because the resident did not transfer from the facility. Staff B said the facility did not notify the Office of the State Long-Term Care Ombudsman of Resident 1's transfer to the hospital.</p> <p>Reference WAC 388-97-0120 (2)(a-d), -0140(1)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40914</p> <p>Based on interview and record review, the facility failed to consider re-admission of a resident after an unplanned hospitalization for 1 of 1 sample residents (1) reviewed for permitting residents to return to the facility. This failure placed residents at risk for increased anxiety related to being placed in an unfamiliar environment, and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses including chronic inflammatory demyelinating polyneuritis (a condition resulting in loss of sensation in the arms and legs). The quarterly Minimum Data Set (MDS), an assessment tool, dated 11/25/2023, documented Resident 1 had no cognitive impairment and required moderate to total dependence on staff for assistance with activities of daily living. The MDS documented Resident 1 had an active plan to return to the community. No community referrals had been made for discharge planning.</p> <p>The care plan, dated 12/30/2022, documented Resident 1 wished to return home upon discharge. Resident 1 required home health services and written instruction on medications, nutrition, and home exercises.</p> <p>Progress notes, dated 02/16/2024, documented Resident 1 was transferred to the hospital on 02/14/2024 directly from an appointment. The resident was admitted to the intensive care unit.</p> <p>Review of the Resident 1's electronic record showed no documentation related to the inability to provide care for the resident, a notice to the resident regarding need for discharge, discussions with the hospital related to Resident 1's discharge, updated and ongoing discharge planning, or discussion with Resident 1 regarding refusal to allow the resident to return to the facility.</p> <p>On 05/23/2024 at 5:18 PM, Resident 1 said while at the facility, she received infusions for chronic inflammatory demyelinating polyneuritis. The infusions improved her quality of life and managed the loss of sensation in her legs. The infusion clinic required an escort be present because Resident 1 required assistance with her mobility. The day the facility discharged her, the resident went to the infusion appointment and their staff explained her vital signs were unstable. The clinic transferred the resident to the hospital. Resident 1 expected to hear from the facility during the hospitalization but no one reached out to see how she was doing or to discuss plans to return to the facility. Resident 1 contacted the facility towards the end of the hospitalization and spoke with Staff D, Business Office Manager. Staff D told Resident 1 the facility could not provide the level of care Resident 1 needed. Resident 1 said the facility did not provide her any notice indicating they could not provide care for the resident. Resident 1 said she felt the infusion clinic requiring an escort attend prompted the facility to say they could not provide the care the resident needed. The resident felt this was the reason the facility would not accept her back. Resident 1 said staffing was the facility's responsibility and she should not have to suffer as a result. Resident 1 said eventually, the hospital was able to assist her in transferring home. While Resident 1 was happy to be home, the resident felt the facility did not make the efforts required for a safe discharge.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/24/2024 at 3:55 PM, Staff D said she spoke with Resident 1 and told the resident they could not accept her back because they could not provide care for her. Staff D said Staff A, Administrator or Staff B, Registered Nurse and Director of Nursing Services, told her to inform Resident 1 of this discussion.</p> <p>On 05/24/2024 at 4:18 PM, Staff B said the facility could not provide the care Resident 1 needed because the infusion clinic required an escort. The infusions lasted 8 hours each visit and they could not provide staff for the amount of time required. Staff B said they attempted to get family to attend infusion appointments but they were not receptive. Staff B said they discussed this concern during care conference and were actively looking for a suitable location for Resident 1. Staff B said there were no current discharge planning notes showing the facility's efforts to find placement for Resident 1 in a setting that could meet the resident's needs. Staff A said she spoke with Resident 1 regarding the facility's inability to meet the needs of the resident. Staff A said they did not provide a formal notice or other documentation to notify the resident of the facility's intent. Staff A said there were no notes documented in the medical record regarding these conversations. Staff A said she should of documented the conversations.</p> <p>Reference WAC 388-97-0120 (4)(b)</p>		