

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 03/11/2025
NAME OF PROVIDER OR SUPPLIER Fir Lane Health & Rehabilitation Center		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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were free of physical restraints for 3 of 3 residents (Resident 1, 2 and 3) when medical devices prevented the residents from freedom of movement. This failure placed the residents at risk for injury, frustration, and a decreased quality of life.</p> <p>Findings included .</p> <p><RESIDENT 1></p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses including dementia and other progressive neurological conditions. The Minimum Data Set (MDS), an assessment tool, dated 02/18/2025, showed Resident 1 had severe cognitive impairment, had a fall since the last assessment and required substantial assistance for transfers.</p> <p>Resident 1's care plan, revised 12/29/2023, showed resident was at risk for falls and had poor safety awareness.</p> <p>On 03/10/2025 at 10:25 AM, Resident 1 was observed sitting in their wheelchair. The resident's right wrist was off the wheelchair armrest with the remainder of the forearm positioned on the armrest. A Velcro strap was around the resident's forearm, securing the arm to the armrest. When asked if the resident could remove the Velcro strap, Resident 1 did not respond and/or appear to understand the directions.</p> <p>On 03/10/2025 at 12:15 PM, Staff A, Certified Nursing Assistant (CNA), said Resident 1's right arm was contracted (limbs that are permanently and/or temporarily shortened and stiff) and they secured it to the armrest with a Velcro strap to stretch the resident's arm to prevent the arm from contracting further. Staff A said the arm was to be secured to the armrest with Velcro anytime the resident was in their wheelchair.</p> <p>On 03/10/2025 at 12:30 PM, Staff B, Licensed Practical Nurse (LPN), said Resident 1's right arm was secured to the wheelchair armrest because the resident's arm was contracted, and it was to be used at all times when the resident was in their wheelchair.</p> <p>(continued on next page)</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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 1's medical record on 03/10/2025, showed no assessment, care plan, consent and/or physician order for a Velcro strap to secure the resident's arm to the wheelchair armrest.</p> <p>On 03/10/2025 at 2:08 PM, Staff C, LPN, Resident Unit Manager, said they were not aware Resident 1 had their right arm secured to the armrest of the wheelchair with a Velcro strap. Staff C reviewed Resident 1's medical record and said there was no documentation regarding the Velcro strap.</p> <p><RESIDENT 2></p> <p>Resident 2 was admitted to the facility 12/20/2024 with diagnoses including dementia. The MDS, dated [DATE], showed the resident had severe cognitive impairment.</p> <p>Resident 2's safety device care plan, revised 12/30/2024, showed the tilt in space wheelchair (the chair's frame and wheels remain stationary, while the seat and backrest tilt as one unit) was related to WC [wheelchair] positioning and to reduce falls. The care plan did not show how far the wheelchair should be tilted back, when it should be tilted back and/or what to do if the resident was attempting to get out of the wheelchair.</p> <p>Resident 2's physician order, dated 12/30/2024, showed the tilt n space WC [wheelchair] was for positioning.</p> <p>Resident 2's Safety Device Evaluation, dated 12/30/2024, showed the tilt and space wheelchair was to treat the medical symptom of weakness and did not restrict freedom of movement.</p> <p>On 03/10/2025 at 12:15 PM, Staff A, CNA, said when Resident 2 was out of bed, they placed the resident in a tilt in space wheelchair because the resident was a fall risk. Staff A said they tilted the resident back as far back as the wheelchair tilted so the resident could not get out of the wheelchair and fall. Staff A said the day before they had placed the resident in the wheelchair tilted back and when they returned the resident had climbed out of the chair and was found sitting on the couch.</p> <p>On 03/10/2025 at 12:30 PM, Staff B, LPN, said Resident 2 walked unsteady and attempted to get out of their tilt in space wheelchair and walk frequently. Staff B said the Resident was to be placed in their wheelchair and tilted back at all times unless the resident was eating to prevent the resident from getting up from the chair.</p> <p>On 03/10/2025 at 2:00 PM, Staff D, CNA, said when Resident 2 was in their tilt in space wheelchair they were to be tilted back. Staff D said when Resident 2 attempted to crawl out of the wheelchair they tried to calm them down but if they tilted the wheelchair back further the resident could not climb out of the chair.</p> <p>On 03/11/2025 at 11:01 AM, Resident 2 was observed sitting in a tilt in space wheelchair. The wheelchair was tilted back at approximately 45 degrees with the resident staring at the ceiling. The head rest was positioned at the level of the resident's neck and Resident 2 had their hands behind their head to support their head.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/11/2025 at 11:08 AM, Staff A, CNA, said they had tilted Resident 2 back in their wheelchair and placed the resident in the day room. Staff A said if they did not tilt the resident back in the wheelchair the resident would get up and try to walk.</p> <p><RESIDENT 3></p> <p>Resident 3 was admitted on [DATE] with diagnosis of dementia. The MDS, dated [DATE], showed the resident had severe cognitive impairment.</p> <p>Resident 3's physician order, dated 08/15/2022, showed a tilt n space w/c [wheelchair] to maintain proper body alignment.</p> <p>Resident 3's risk of fall care plan, revised 04/25/2023, showed resident 3 was in a tilt wheelchair. The care plan did not show how far the wheelchair should be tilted back, when it should be tilted back and/or what to do if the resident was attempting to get out of the wheelchair.</p> <p>Resident 3's Safety Device Evaluation, dated 10/30/2024, showed the tilt and space wheelchair was to treat the medical symptom of weakness and did not restrict freedom of movement.</p> <p>On 03/10/2025 at 10:26 AM, Resident 3 was observed in the facility day room in a tilt in space wheelchair. The resident's wheelchair was tilted at approximately a 45-degree angle with the resident staring at the ceiling. Resident 3 had their arm behind their head to support their head from falling back. Resident 3 was observed using their arm to attempt to grab a puzzle off the table. The resident was unable to see the puzzle due to the tilt of the wheelchair. Resident 3's legs were dangling in the air; no footrests were observed on the wheelchair. At 10:48 AM, Staff E, Activity Assistant, entered the day room and lead a seated exercise class. Staff E made no attempt to tilt Resident 3 up in their wheelchair. At 11:07 AM, Resident 3 remained in the same position tilted back in their wheelchair.</p> <p>On 03/10/2025 at 12:15 PM, Staff A, CNA, said Resident 3 sometimes tried to climb out of their wheelchair and they thought that was why the resident was placed in a tilt in space wheelchair. Staff A said they tilted the wheelchair back enough so the resident could not get out of the wheelchair and the Resident was to be tilted back anytime they were placed in the wheelchair unless the resident was eating and/or engaged in an activity. When asked how far they tilted the wheelchair back, Staff A said, as far as it will go.</p> <p>On 03/10/2025 at 12:30 PM, Staff B, LPN, said Resident 3 was placed in a tilt in space wheelchair so they wouldn't fall, because the resident was confused and would try to get up. Staff B said even with the wheelchair tilted back the resident tried to get out of the chair.</p> <p>On 03/10/2025 at 2:00 PM, Staff D, CNA, said Resident was in a tilt in space wheelchair because they crawled out of the chair, and they tilted it back to prevent this.</p> <p><FINAL INTERVIEW></p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/11/2025 at 12:46 PM, Staff F, Director of Nursing, Registered Nurse, said they were unaware of the Velcro strap on Resident 1's right arm. Staff F said they expected a physician order, care plan, assessment and consent for use of a strap that restricted the resident from freely moving their arm. Staff F said the tilt in space wheelchairs for Resident 2 and Resident 3 were used for positioning to assist with the resident's trunk control and should be tilted back no further than 20 degrees. Staff F said facility staff were restricting Resident 2 and Resident 3's freedom of movement when they tilted the wheelchairs back to 45 degrees to prevent the residents from getting out of their chairs.</p> <p>WAC Reference 388-97-0620 (1)</p>		