STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505230	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fir Lane Health & Rehabilitation Center	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068 Based on observation, interview and record review, the facility failed to provide assistance with bathing, dressing and personal hygiene for 2 of 4 residents (Resident 1 and 2) reviewed for quality of care. This failure placed residents at risk for poor hygiene, loss of dignity and a diminished quality of life. Findings included . <Resident 1> Resident 1 was admitted on [DATE]. The Minimum Data Set Assessment (MDS), an assessment tool, dated 03/07/2025, showed the resident was cognitively intact and required substantial assistance from staff for bathing, dressing and supervision/touching assistance for personal hygiene. On 03/27/2025 at 11:06 AM, Resident 1 was observed lying in bed. The resident said they had their first shower on 03/11/2025 (11 days after admission) after repeatedly asking for a shower. The resident said no one had offered to assist them with getting ready for the day. The resident said the staff did not routinely offer to get them out of bed, assist them to the bathroom, clean up for the day, brush their teeth and/or get ready for bed at night, they don't do that here. Resident 1's care plan, revised 03/17/2025, showed the resident required one person level of assistance with bathing/showering two times per week and as necessary. The care plan showed the resident required total assistance with personal hygiene care and ext [extensive] assist of 1 staff for dressing. Review of Resident 1's bathing task documentation, dated 03/26/2025, showed the resident had received one shower since admission on 02/28/2025. <Resident 2> Resident 2 was admitted on [DATE]. The MDS, dated [DATE], showed the resident was cognitively intact. (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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/27/2025 at 11:35 AM, Resident 2 was observed lying in bed, wearing sweatpants and a shirt. The head of resident 2's bed was elevated, and the resident was eating their lunch from a tray on a table parallel to the bed. Resident 2 said the staff did not offer showers, provide assistance to get out of bed and/or to wash up for the day, that is not going to happen here. The resident said they were lucky to get a staff member to come to their room everyday and they were at the facility for several days before they were able to obtain a toothbrush and toothpaste. The resident said they were in the bed 24 hours per day and maybe every three days the staff would change their clothes. Resident 2's care plan, revised 03/19/2025, showed the resident required one person level of assistance with bathing/showering two times per week and as necessary. The care plan showed the resident required set up assistance with personal hygiene care and set up assist upper [upper body] and mod [moderate] assist for dressing. Review of Resident 2's bathing task documentation on 03/26/2025, showed since admission on 02/26/2025 the resident received one shower and had one shower that was offered and refused. <Final interviews> On 03/27/2025 at 12:02 PM, Staff E, Certified Nursing Assistant, said they were assigned to care for Resident 1 and 2. Staff E said they had not provided assistance to Resident 1 and Resident 2 that morning for getting out of bed, dressing and/or personal hygiene, I was too busy. On 03/27/2025 at 4:00 PM, Staff A, Acting Director of Nursing, said they expected the nursing staff to provide care and assistance per the resident's plan of care. Staff A said they expected the nursing staff to provide at a minimum for morning and evening care; personal hygiene, mouth care, dressing/undressing and assistance with getting in and/out of their bed. WAC Reference 388-97-1060 (2)(c)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068 Based on interview and record review, the facility failed to ensure medications to prevent seizures were administered per physician orders for 1 of 3 residents (Resident 6) reviewed for quality care. Resident 6 experienced harm when they were found unresponsive, required Cardio-Pulmonary Resuscitation (CPR/an emergency procedure consisting of chest compressions combined with giving breaths of air) and was hospitalized when their medication for seizures were not administered for multiple doses due to the unavailability of the medications, resident refusals, and failure to notify the physician of the omissions. This failure placed all residents at risk for medical complications and a diminished quality of life. Findings included . Review of the facility policy titled, Medication Administration, revised ,d+[DATE], showed staff were to document if a resident refused and or a dose was omitted in the EMR [electronic medical record]. The policy showed that it was not acceptable to omit a dose by indicating NA for medication not available from pharmacy, staff were to remove a dose from emergency kit or contact the pharmacy, if the medication was not available, contact the physician for further orders. Review of the facility policy titled, Refusal of Medication, Treatment and/or Dietary restrictions, revised , d+[DATE], showed the facility would review and offer alternative interventions as appropriate if medication was refused and notify physician and resident representative of resident's wishes. Resident 6 was admitted on [DATE] with diagnoses of dementia and seizure disorder. The Minimum Data Set Assessment, an assessment tool, dated [DATE] showed the resident had severe cognitive impairment. On [DATE] at 3:09 PM, Collateral Contact 1 (CC1) said in the evening of [DATE], they were called by a facility licensed nurse and were told Resident 6's eyes rolled back, and they attempted to arouse the resident with a sternal rub and were unsuccessful. CC 1 said the nurse indicated they initiated CPR, called 911 and the resident was taken to the emergency room . CC 1 said they contacted the emergency room nurse and were told they believed the resident had a seizure due to not receiving their medications for seizures. CC 1 contacted the facility, and the licensed nurse confirmed the resident hadn't received their seizure medications for a few days. CC1 said they had not been notified prior to this episode by the facility that there were problems with administering the resident's medications and were upset about what the resident was put through. Resident 6's care plan, alteration in neurological status with potential for seizure activity r/t [related to] epilepsy, revised [DATE], showed an intervention of; medications as ordered for seizure activity. Resident 6's behavior care plan, revised [DATE], showed the resident had a behavior problem r/t resisted care and refused to take medication. The target behavior care plan, dated [DATE], showed one of the interventions for refusals of care/medications was to refer to MD [medical doctor] as needed for additional treatment and eval [evaluation]. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident 6's physician orders, dated [DATE], showed an order for Valproic Acid 250 milligrams (mg) per 5 milliliters (ml) give 5ml four times per day for epilepsy (seizure disorder). An order, dated [DATE], for Dilantin 200mg two times per day for epilepsy. An order, dated [DATE], for Levetiracetam 10ml two times per day for epilepsy. Resident 6's laboratory results, dated [DATE], showed the Valproic acid level low at 43 microgram (ug)/ml, normal reference range ,d+[DATE]. Keppra (Levetiracetam) level was within normal range at 37.5 ug/ml, (reference range 10XXX,d+[DATE].0 ug/ml). Laboratory results, dated [DATE], showed phenytoin levels elevated at 2.7 ug/ml (normal reference range 1XXX,d+[DATE].0). Resident 6's Medication Administration Record (MAR), dated February 2025, showed the resident refused their Valproic Acid medication, Dilantin medication and their Levetiracetam medication on [DATE] and [DATE] at bedtime. The resident's MAR, dated [DATE], showed the resident did not receive their Valproic acid medication on [DATE] at 12:00 PM, 4:00 PM and 8:00 PM and refused it on [DATE] at 8:00 PM. The MAR further showed the resident refused their Dilantin and Levetiracetam medication on [DATE] at bedtime. Resident 6's progress notes, dated [DATE], showed the following medication administration notes: at 14:26 (2:26 PM) the Valproic acid was not available in the cart at 18:37 (6:37 PM) re-check with pharmacy and will be coming in tonight at 23:45 (11:45 PM) follow up with pharmacy and will deliver tonight. Review of Resident 6's EMR on [DATE], showed no documentation the physician and/or resident representative was notified of the resident's refusal of medications on [DATE], [DATE], [DATE] and/or the unavailability of the valproic acid on [DATE]. Resident 6's progress notes, dated [DATE], showed the LN [licensed nurse] reported the resident had become unresponsive and pulseless (no heartbeat) they started CPR, and medics took the resident to the hospital. Resident 6's hospital emergency room records, dated [DATE] at 18:56 (6:56 PM), showed the chief complaint as, resident was brought to the emergency from the facility by EMS [emergency medical services] for a seizure, the facility staff started CPR for unknown amount of time, felt pulse, patient had pulse for medics. The record showed per EMS the patient had not taken seizure meds for 2 days. The record showed hospital laboratory results, collected on [DATE] at 18:58 PST (6:58 PM), showed Phenytoin (Dilantin) level low at 5.5 micrograms (mcg)/ml (normal reference range is 10.0 -20.0 mcg/ml) and Valproic Acid level low at 36 mcg/ml (normal reference range is 50XXX,d+[DATE].0 mcg/ml). The record showed the resident was given intravenous (medication administered into the resident's veins) Dilantin and Valproic acid. The record showed the subtherapeutic (a dose or concentration of a drug that is below what is used for treating disease or producing an optimal therapeutic effect) levels most likely led to seizure. The record showed the assessment/plan for the resident was acute UTI [urinary tract infection] and seizure secondary to subtherapeutic anticonvulsant (medication used to prevent or control seizures) medication. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE], Staff A, Acting Director of Nursing, said they reviewed Resident 6's medical record and found no notification to the resident's physician and/or representative of the medication refusals or the unavailability of the medication. Staff A said the staff should have notified the physician of the refusals and the unavailability of medications, especially seizure medications. WAC Reference [DATE] (3)(k)(iii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 46068 Based on observation, interview and record review, the facility failed to ensure 3 of 6 staff members (Staff B, C and D) used personal protective equipment (PPE) in accordance with the Centers for Disease Control (CDC) guidelines when caring for residents with known COVID 19 (an infectious virus causing respiratory illness that may cause difficulty breathing and could lead to severe impairment or death) infections. This failure placed residents and staff at risk for contracting and spreading COVID 19. Findings included . A 06/24/2024 CDC update titled, Infection Control Guidance: SARS-CoV-2 (the virus that causes COVID 19), showed residents should be placed on transmission based precautions and when health care personnel enter the room of a patient with suspected or confirmed COVID 19, they should use a N95 respirator (a mask that filters 95% of airborne particles), gown, gloves, and eye protection. A 04/12/2024 CDC guidance titled, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, showed staff were to remove and discard PPE, other than respirators, upon completing a task before leaving the patient's room. If a respirator was used, it should be removed and discarded after leaving the patient room and closing the door. A 08/09/2023 Washington State Department of Health aerosol precaution sign, showed the PPE required for caring for residents with COVID 19, including gown, gloves, N95 respirator and eye protection. <Staff B> On 03/25/2025 at 10:46 AM, Resident 3's room was observed with an aerosol precaution sign on the door. Staff B, Licensed Practical Nurse, entered the resident room wearing a gown, gloves, N95 respirator and eye protection. At 10:52 AM, prior to exiting the room, Staff B doffed (took off) the gown and gloves. Staff B exited the room with the N95 respirator and eye protection on. Staff B removed the eye protection and cleaned it with disinfecting wipes. Staff B did not remove the N95 respirator. Staff B continued down the hallway wearing the same N95 respirator and engaged with residents and staff in the hallway. At 1:50 PM, Staff B said they usually changed their N95 respirators after caring for a resident with COVID 19 but had forgotten. <Staff C> On 03/25/2025 at 10:57 AM, Resident 3's room was observed with an aerosol precaution sign on the door. Staff C, Certified Nursing Assistant (CNA), entered the resident's room wearing a gown, gloves, N95 respirator and eye protection. Upon exiting the room Staff C doffed the gown, gloves and performed hand hygiene. Staff C exited the room and without changing the N95 respirator and/or the eye protection, proceeded down the hallway engaged with other residents and assisted them with refreshments. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:02 PM, Resident 4's room was observed with an aerosol precaution sign on the door. Staff C entered the room wearing a gown, gloves, N95 respirator and eye protection. Staff C removed the gown and gloves prior to exiting the room. Staff C exited the room without changing the N95 respirator and/or eye protection and proceeded down the hallway into another resident unit. <Staff D> On 03/25/2025 at 1:26 PM, Resident 5's room was observed with an aerosol precaution sign on the door. Staff D, CNA, entered the room wearing a gown, gloves, N95 respirator and eye protection. Staff D removed the gown and gloves prior to exiting the room. Staff D exited the room without changing the N95 respirator and/or eye protection and proceeded down the hallway with the eye protection flipped up onto their head. At 1:42 PM, Staff D said when they exit a resident's room that was positive with COVID 19, they remove their gown and gloves but not their N95 respirator and/or eye protection. Staff D said they felt like they should, but additional N95 respirators and/or eye protection were not always available. <Final interview> On 03/27/2025 at 4:00PM, Staff A, Acting Director of Nursing, said residents with COVID 19 were placed on aerosol precautions. Staff A said they expected when staff entered rooms of residents on aerosol precautions, they would wear a N95 respirator, eye protection, gown and gloves and remove all the PPE upon exiting the room. Staff D said the staff did not follow their infection control procedures when caring for the residents with COVID 19. Reference WAC 388-97-1320 (1)(a)(2)(b)