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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fir Lane Care	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observations, interviews and record review, the facility failed to implement the plan of care for 1 of 3 (Resident 1) residents reviewed for quality of care. This failure placed residents at risk for clinical complications, discomfort, lack of nutrition and a diminished quality of life. Findings included . Resident 1 was admitted to the facility on [DATE] with diagnoses including diabetes and multiple sclerosis (a disease affecting your brain and spinal cord). The Minimum Data Set, an assessment tool, dated 04/11/2025, showed the resident had a pressure ulcer, required substantial/maximal assistance with bed mobility, was dependent on staff for transfers and had severe cognitive impairment. Resident 1's current care plan showed the following: -Focus Area-the resident has a stage III (pressure ulcer with full thickness loss of skin exposing subcutaneous tissue) pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure) present on the sacrum (tailbone), revised 04/29/2025. Interventions showed the importance of frequent repositioning. - Focus Area-ADL [activities of daily living] self-care deficit, revised 04/30/2025. Interventions showed for dressing resident required total assistance, for personal hygiene required extensive assistance, for bed mobility the resident was a max assist of two staff, resident was incontinent and was on scheduled check/change, required 1:1 assistance with meals in dining room as tolerated, resident was extensive assist with eating and was highly encouraged and assisted to w/c [wheelchair] and dining. On 05/08/2025 at 11:22 AM, Resident 1 was observed lying in bed. The head of the bed was straight up at 90 degrees. The resident was slumped in the bed, lying on their right side with their head bent forward at an angle. When asked if they were comfortable the resident said, no. On 05/08/2025 at 1:35 PM, Resident 1 was observed in the same position, lying on their right side in bed. The head of the bed had been lowered to approximately 45 degrees. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/08/2025 at 1:37 PM, when asked if the Resident 1 was going to get up for the day, Staff A, Certified Nursing Assistant (CNA), said Resident 1 usually got up into the wheelchair but the resident had an incident the other day and slid out of the wheelchair and landed on the floor, so they were trying to get him a new chair. Staff A said they thought the resident and his wife preferred him to be up and said the resident would sit up and go to the dining room for meals. Resident 1's progress notes, dated 05/05/2025, showed a nursing communication to therapy for a possible change in condition in the following areas: falls and W/C [wheelchair] positioning, the resident had slid out of wheelchair today after lunch. Resident 1's progress notes, dated 05/07/2025, showed a therapy to nursing communication. The note showed the therapist recommended repositioning when needed and placing resident back to bed after meals and when fatigued. On 05/15/2025 at 9:58 AM, 11:16 AM and 12:00 PM, Resident 1 was observed lying in bed. The head of the bed was upright at 90 degrees. The resident was lying on their right side with a pillow wedged under their left hip. The resident's legs were pulled up to their abdomen and their head rested against the wall at a downward angle. The resident had a hospital gown on that exposed their bare chest. The resident's hair was not combed. On 05/15/2025 at 12:25 PM, Staff B, CNA, was observed delivering a meal tray to Resident 1's room. On 05/15/2025 at 12:26 PM, Resident 1 was observed lying in bed with the head of the bed upright at 90 degrees. The resident was lying on their right side with a pillow wedged under their left hip. The resident's legs were pulled up to their abdomen and their head rested against the wall at a downward angle. The resident had a hospital gown on that exposed their bare chest. The resident's hair was not combed. A bedside table with a meal tray on it was in front of the resident. The items on the tray were uncovered. No staff were observed in the room. The resident was turned on their side and unable to maneuver to use the utensils to eat. On 05/15/2025 at 12:33 PM, Staff A, CNA, said they were assigned to care for Resident 1. When asked if they were going to get the resident out of bed, Staff A said they were going to but the aide that had the resident the day before told them not to. On 05/15/2025 at 12:46 PM, Resident 1 was observed in the same position they had been observed at 9:58 AM, 11:16 AM, 12:00 PM, 12:26 PM; observed lying in bed, the head of the bed was upright at 90 degrees. The resident was lying on their right side with a pillow wedged under their left hip. The resident's legs were pulled up and their head rested against the wall at a downward angle. The resident had a hospital gown on that exposed their bare chest. The resident's hair was not combed. The meal on the overbed table was observed to be untouched. Staff C, Administrator, was brought into Resident 1's room. Staff C said the resident was unable to eat due to the position of the resident in the bed. On 05/15/2025 at 4:31 PM, Staff D, Director of Nursing, said Resident 1 should have been assisted out of bed and into their wheelchair. Staff D said if the resident refused, they should have been assisted with their meal in the room, and repositioned in the bed. Staff D said they expected the staff to follow the resident's plan of care. (continued on next page)

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