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	08/21/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the Resident Representative of multiple falls for 1 of 3 (Resident 3) residents reviewed. This failure placed residents and their representatives at risk of not being able to participate in resident care decisions, providing support, delayed medical treatment, and a diminished quality of life.Findings included.Resident 3 was admitted on [DATE] with a diagnosis of a stroke with hemiplegia (paralysis affecting one side of the body). The Minimum Data Set, an assessment tool, dated 06/27/2025, showed Resident 3 required substantial assistance for bed mobility, transfers and had severe cognitive impairment.On 08/14/2025 at 3:32 PM, Resident 3's representative said when they met with facility staff about discharge, a staff member told them Resident 3 had five falls since admission. Resident 3's representative said they had been notified of one fall since Resident 3 had been admitted to the facility but had not been made aware of multiple falls, I did not know he had been falling; I was here every day, I don't know why they didn't tell me?Review of the facility incident report, dated 06/24/2025 at 2300 (11:00 PM), showed Resident 3 fell and was found on the floor next to their bed. The report showed Resident 3 sustained a scratch on their arm. Facility staff initiated neurological checks and obtained vital signs. The report showed the physician and Director of Nursing were notified on 06/25/2025. The report had a conclusion note, dated 06/26/2025, that showed the family and physician were notified.Review of the facility incident report, dated 06/26/2025 at 23:05 (11:05 PM), showed Resident 3 was found prone (face down) parallel to the bed. The report showed no notifications completed. In the notes section of the report, dated 06/27/2025, showed the family and physician were notified.Review of the facility incident report, dated 06/27/2025 at 04:45 (4:45 AM), showed Resident 3 was found prone on floor parallel to the bed. The report showed the family member was notified on 06/27/2025 at 12:47 PM.Resident 3's progress note, dated 06/27/2025, showed the resident discharged home with family member.On 08/20/2025 at 2:49 PM, Staff E, Regional Clinical Nurse, said they had reviewed the incident reports and completed the conclusion/note section of the report. Staff E said they had not contacted the family member to notify them of the falls. Staff E said they did not remember the details of the incident reports but assumed they asked the staff if the family had been notified. Staff E acknowledged they would not have interviewed the licensed nurses that were assigned at the time of the falls due to the falls occurring on night shift. Staff E said the expectation was that the staff notify the resident's representative at the time of the fall unless they had requested to not be notified.Reference WAC 388-97-0320

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to accurately document and reconcile controlled substances for 2 of 3 (Resident 1 and 2) residents reviewed. This failure placed residents at risk for misappropriation of medications, missed medications and possible diversion of controlled substances. Findings included.<Policy>Review of the facility's undated policy titled, Med Administration, showed that staff were to prepare medication for administration and log out the drug on the controlled drug declining inventory page in the bound Controlled Substance Record Book and include the date, time, number/amount of drug and signature. The policy showed that staff were to document all controlled drugs had been counted at each change of shift.<Resident 1>Resident 1 was admitted to the facility on [DATE] with a diagnosis of malnutrition.Resident 1's physician orders, dated 08/06/2025, showed an order to administer dronabinol (controlled substance used to stimulate appetite) 5 milligrams two times a day for malnutrition. On 08/13/2025 at 10:20 AM, Staff A, Registered Nurse, was observed preparing Resident 1's dronabinol medication for administration. Staff A documented the medication on the declining inventory page in the Controlled Substance Record Book, including the date, time, and amount. The inventory page was observed to have an entry dated 08/10/2025 at 2022 (10:22 PM) immediately before Staff A's entry of 08/13/2025 at 10:20. When asked why there was no documentation for 08/11/2025 and 08/12/2025, Staff A said, oh I guess I forgot to document those days, but I did administer the medication. Staff A proceeded to enter documentation for 08/11/2025 and 08/12/2025. Staff A said they had not counted the dronabinol at the change of shifts on 08/10/2025, 08/11/2025 and 08/12/2025, because they only had counted the medications that were in the medication cart and the dronabinol was stored in a medication refrigerator.Resident 1's Medication Administration Record, dated 08/01/2025 through 08/31/2025, showed Resident 1's dronabinol was administered two times a day from 08/01/2025 through 08/12/2025 and one time on 08/13/2025.Review of Resident 1's inventory page for their dronabinol in the Controlled Substance Record Book, showed one administration time on 08/04/2025 and 08/06/2025, three entries on 08/10/2025 and one entry date on 08/11/2025 and 08/12/2025.<Resident 2>Resident 2 was admitted to the facility on [DATE].Resident 2's physician orders showed an order for oxycodone (controlled substance for pain) every six hours as needed for moderate to severe pain.Review of the facility incident report, dated 07/11/2025, showed the staff discovered documentation on Resident 2's inventory page for their oxycodone in the Controlled Substance Record book that did not have the time documented. The report further showed Resident 2 was not in the facility on multiple days the medication was documented to have been administered. The report showed the facility concluded there were irregularities identified in the Controlled Substance Record Book and concerns for potential controlled substance diversion activity and/or misappropriation of the resident's medication. On 08/21/2025 at 12:23 PM, Staff B, Director of Nursing, said they expected staff to document the date and time they administer the medication in the electronic medical record and in the Controlled Substance Record Book at the time of administration. Staff B said the staff should be reviewing all the pages of the Controlled Substance Record Book and ensuring the medication count is correct during each shift change and not just counting the medications located in the medication cart. Staff B said there were multiple documentation errors, and the licensed nurses had not followed the procedure for documenting and reconciling controlled substances.Reference WAC 388-97-1300 (1)(b)(i-ii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on interviews, observations and record review, facility staff failed to perform hand hygiene during medication administration for 2 of 3 (Staff C and D) staff reviewed for infection control. This failure placed residents at risk for the spread of infection and a diminished quality of life. Findings included.Review of the facility's undated policy, Handwashing/Hand Hygiene, showed hand hygiene was indicated: immediately before touching a patient, after touching a resident, after touching the resident's environment and immediately after glove removal.On 08/14/2025 at 3:32 PM, Collateral Contact 1 (CC1) said they visited their family member daily and when the nurses came in the room to give the resident their medications, they did not wash their hands coming and/or going. CC1 said they didn't wear gloves when administering eye drops and/or wash their hands when they finished.On 08/20/2025 at 10:43 AM, Staff C, Registered Nurse (RN), was observed entering Resident 4's room without performing hand hygiene. Staff C took Resident 4's blood pressure, and temperature using a thermometer on the forehead. Staff C exited the room without performing hand hygiene, took their pen out of their pocket and documented on their paper. Staff C proceeded to perform hand hygiene and then pulled their keys out of their pocket, opened the medication cart, took the medications out of the cart, used the computer mouse to document in the electronic medical record and entered Resident 4's room without performing hand hygiene. Staff C administered the medications to the resident, collected their used drinking cup and paper pill container and exited the room without performing hand hygiene. Staff C proceeded to the medication cart and used the computer mouse to document in the electronic medical record.08/20/2025 at 11:18 AM, Staff C, RN, entered Resident 5's room without performing hand hygiene, placed their hands around the resident's head to speak into their ear, held their arm to place the blood pressure cuff on the resident's arm and proceeded to take their blood pressure and temperature with the thermometer on the forehead. Staff C exited the room without performing hand hygiene, obtained the pen from their pocket and documented on their paper. Staff C gathered Resident 5's medications from the medication cart and entered the resident's room without performing hand hygiene. Staff C adjusted the resident's linens, moved their pillows, and their bedside table. Staff C put on gloves and administered the resident's eye drops, removed the gloves and without performing hand hygiene proceeded to apply a medication patch to the resident's back. Staff C exited the room without performing hand hygiene, took the keys out of their pocket and opened the medication cart and placed the keys back in their pocket.On 08/20/2025 at 12:42 PM, Staff D, Licensed Practical Nurse, was observed entering Resident 6's room after performing hand hygiene and donning a gown and gloves. A sign on Resident 6's door showed enhanced barrier precautions (infection control measure to prevent spread of infection) were in place. Staff D was observed preparing to administer intravenous (medications administered in the veins) medication. Staff D used a syringe to flush the resident's intravenous access site in their arm and attempted to prepare the intravenous solution for administration before discovering it would not mix adequately. Staff D proceeded to remove their gown and gloves and exited the room without performing hand hygiene. Staff D removed keys from their pocket, opened the medication cart, assessed the contents of the cart, closed the cart and proceeded down the hallway.On 08/21/2025 at 12:23 PM, Staff B, Director of Nursing, said staff were expected to perform hand hygiene when entering and exiting resident rooms, after removing gloves and before and after touching residents and/or their environment.Reference WAC 388-97-1320 (1)(c)