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	02/10/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide informed consent and communicate preferences for Cardiopulmonary Resuscitation (CPR) to the resident and/or representative for 1 of 3 residents (Resident 1) reviewed. This failure placed residents and/or residents' representatives at risk for not being fully informed of health care decisions and residents' health care advocates not available to assist them in decision making.Findings included.Review of the facility's policy, Advanced Directives, revised 12/2024, showed the definition of Advance Directive may include Portable Order for Life-Sustaining Treatment (POLST) (a medical order form designed to document patient preferences for end-of-life care-such as CPR, and medical interventions). The policy showed the facility staff would determine upon admission whether the resident had an Advance Directive and identify the primary decision-maker and place a copy of such Advance Directive in the permanent medical record. The policy showed it may include Durable power of attorney for health care (DPOA-HC) and POLST.Resident 1 was admitted on [DATE] with diagnoses including Alzheimer's dementia, paraplegia/functional quadriplegia (partial loss of sensation and control of body), and cancer. The Minimum Data Set, an assessment tool, dated [DATE], showed Resident 1 had severe cognitive impairment, was dependent on activities of daily living, transfers and bed mobility.Resident 1's POLST, dated [DATE], and uploaded to Resident 1's electronic medical record on [DATE], showed Resident 1 had chosen Do Not Resuscitate (DNR) and selective medical treatment.Resident 1's hospital care management assessment, dated [DATE], showed Resident 1 had a verified medical DPOA on file and had a POLST on file.Resident 1's Skilled Nursing Facility Transfer Orders, dated [DATE], showed Resident 1 had a DNR order and the resident had a POLST and an Advance Directive. On [DATE] at 3:46 PM, Collateral Contact (CC) said Resident 1 had a POLST and DPOA-HC, that designated CC as the designated decision maker, that was provided to the facility. CC said the POLST outlined Resident 1's wishes for DNR and selective medical treatment. CC said the facility had completed a new POLST on [DATE] with Resident 1 that indicated Resident 1 wanted to be resuscitated and had Resident 1's signature on the document. CC said Resident 1 could not sign a document legibly due to their quadriplegia. CC said they were not informed of the change in resuscitation orders until Resident 1 was readmitted to the hospital on [DATE] and the doctor inquired why the POLST had been changed and gave CC a copy of a POLST signed at the facility on [DATE].Resident 1's POLST, dated [DATE], showed Resident 1 had chosen to attempt resuscitation/CPR and full treatment. The POLST showed Resident 1's legible name on the signature line of the form.On [DATE] at 1:17 PM, Staff A, Resident Care Manager and Licensed Practical Nurse, reviewed the POLST dated [DATE]. Staff A acknowledged they had signed and dated the POLST form as the reviewer. When asked why a new POLST was completed with Resident 1, Staff A said facility staff reviewed new admissions in their morning meeting and gave them a list of documents they needed. Staff A said they were probably given a note that Resident 1 needed a POLST. Staff A said they usually go and talk with the residents and if they seemed with (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it they complete the POLST with them. Staff A said they were not aware Resident 1 had a POLST in the medical record uploaded on [DATE].Resident 1's Impaired Cognition Care Plan, dated [DATE], showed impaired cognitive function/dementia or impaired thought processes r/t [related to] Alzheimer's, BIMS score is 7 (cognitive test indicating severe cognitive impairment).Resident 1's speech therapy notes, dated [DATE], showed Resident 1 lacked insight into condition and risk factors and had reduced health literacy (understanding).Resident 1's Care Conference Evaluation, dated [DATE], showed a care conference was held with Resident 1 and their significant other. The evaluation showed under POLST/Advance Directives -CPR full code-husband states he is POA.On [DATE] at 4:04 PM, CC said they had attended the care conference at the facility with Resident 1. CC said the facility did not disclose they had completed a new POLST of attempt resuscitation/CPR and Full treatment with Resident 1 on [DATE]. CC said Resident 1 had always been firm in their preference of DNR.Resident 1's POLST, dated [DATE], showed Resident 1's CPR preference as DNR and selective medical intervention. The form indicated it was discussed with POA [power of attorney], CC, on phone. The form showed no documentation the POLST was discussed with Resident 1.On [DATE] at 12:26 PM, Staff H, Resident Care Manager, said they were filling in for another Resident Care Manager and had completed Resident 1's POLST on [DATE] with CC. Staff H said they had initiated a new POLST because the medical provider had told them Resident 1 did not have a POLST on file. Staff H said they called CC and CC said DNR and selective medical intervention so that is what they put on the POLST. Staff H said they were unaware Resident 1 had a POLST on file.On [DATE] at 3:45 PM, Staff G, DNS, said facility staff were expected to review hospital records when a resident was admitted and if the resident had a POLST they should review it with the resident to ensure it was still their preferences. Staff G said staff should review the records to determine if there was an active DPOA-HC and complete an assessment with the residents for cognitive status. Staff G said if there was an active DPOA-HC and/or a cognitive issue they expected the staff to reach out to the resident representative during decision making. Staff G reviewed Resident 1's medical record and said they believed the staff did not see and/or were not aware of the POLST form from the hospital records. Staff G said education needed to happen with staff to ensure they reviewed the records sent from the hospital on admission.Reference WAC 388-97-0260

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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 interview and record review, the facility failed to implement care plan interventions for low meal intake and diet modifications for 1 of 3 residents (Resident 1) reviewed. This failure placed residents at risk of malnutrition, clinical complications and a decreased quality of life.Findings included.Resident 1 was admitted on [DATE] with diagnoses including paraplegia/functional quadriplegia (partial loss of sensation and control of body), dementia and cancer. The Minimum Data Set, an assessment tool, dated 12/17/2025, showed Resident 1 had severe cognitive impairment, was dependent on staff for eating, transfers and bed mobility.Resident 1's nutrition care plan, dated 12/16/2025, showed Resident was at risk or potential nutrition risk r/t [related to] new environment, altered diet, poor appetite, and varied intake. Care plan interventions included monitor/document circumstances surrounding mealtimes/refusals to eat., attempt to determine pattern or cause, where possible alter or remove cause, monitor/record eating habits and patterns to assist in determining cause of limited intake, monitor /record/report to provider PRN [as needed] situations leading to decreased food consumption.Resident 1's progress note, dated 12/23/2025, showed resident was on alert for low meal intake and resident was triggering for skin conditions, low intake, low fluid intake. The note showed resident consuming 25-50% of meals with variable fluid intake along with episode of coughing with meal, weight was noted at 195 pounds down from 201 pounds in hospital, provider was aware and nutrition eval was pending. The note showed staff would continue to encourage oral intake, provide assistance with meals and monitor weights.Resident 1's meal intake record, dated December 15th through December 30th, showed Resident 1 consumed 0-25 % for the following meals:12-17-2025- Breakfast and lunch12-19-2025- Lunch and Dinner12-20-2025- Breakfast and Lunch12-21-2025- Breakfast Lunch and dinner12-22-2025- Breakfast and Lunch12-23-2025- Dinner12-25-2025- Lunch and Dinner12-26-2025- Breakfast, Lunch and Dinner12-27-2025- Dinner12-28-2025- Breakfast and Dinner12-29-2025- Breakfast and DinnerReview of Resident 1's medical record showed no documentation the facility attempted to determine circumstances around meals, patterns and/or causes of limited meal intake, or situations leading to decreased food intake.Resident 1's speech therapy treatment note, dated 12/23/2025, showed Resident 1 tolerated MT2 (mildly thick liquids a fluid consistency designed for safer swallowing with the viscosity similar to tomato juice and/or runny honey), in 100% of the opportunities compared to TN0 (thin liquids). The note showed nursing staff were instructed on the diet change and need to ensure no TN0 is accessible for patient during meals. The note showed the current drinks/liquid were mildly thick drinks MT2.Resident 1's physician order, dated 12/23/2026, showed Resident 1's diet was mildly thick consistency (level 2-MT2), no straws and upright for PO [oral intake] w/ [with] 1:1 assist.Resident 1's nutrition care plan intervention, dated 12/23/2025, showed Resident 1's diet was downgraded to minced and moist [food] and mildly thick [liquids].Resident 1's activity of daily living care plan intervention, dated 12/23/2026, showed Resident 1 required total assistance to eat, ensure patient was as upright as possible, ensure patient had swallowed bite before initiating the next one and no straws.Resident 1's medical provider notes, dated 12/24/2025, showed there was a concern with Resident 1's swallow ability. The note showed that speech therapy evaluated and moved the resident to thickened liquids. The note showed that unfortunately all the thin liquids had not been removed from Resident 1's tray.On 02/04/2026 at 4:04 PM, Collateral Contact, said they had brought Ensure (a liquid meal replacement) from home because that is what Resident 1 drank throughout the day at home. On 02/06/2026 at 4:10 PM, Staff I, Registered Dietician, said they completed an evaluation of Resident 1. Staff I said the resident had a lot of comorbidities and was on an appetite stimulant. Staff I (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said they did not know why Resident 1 had low intake. Staff I said they did not know how Resident 1 was feeling, if they were giving up or was the appetite stimulate helping, they did not ask. Staff I said they knew Resident 1 had snacks and Ensure that was brought from home in their room. Staff I said Resident 1 had a sippy cup and they were able to use it on their own. Staff I said they were unaware of what was in the cup. Staff I said they were not requesting the staff document or track what Resident 1 was consuming from their home snacks only what the facility was providing.On 02/10/2026 at 12:02 PM, Staff B, Certified Nursing Assistant, said they had cared for Resident 1 often during their stay at the facility. Staff B said Resident 1 was dependent for all activities of daily living and eating. Staff B said Resident 1 had a sippy cup that had a straw in it some days. Staff B said Resident 1 used the sippy cup to drink out of and could sometimes hold the cup but needed assistance at times. Staff B said there was Ensure in the room and they would pour it in the sippy cup. Staff B said they did not have to add anything to the ensure, they would just open the bottle and pour it in the cup. Staff B said Resident 1 refused to go to the dining room for meals and when there were limited aides on the floor it was hard to provide Resident 1 with the assistance they needed.On 02/10/2026 at 1:32 PM, Staff C, Licensed Practical Nurse, said they cared for Resident 1 during their stay at the facility multiple days per week. Staff C said there was a supplement the family brought in. Staff C did not recall the brand of the supplement but said they would put the supplement in Resident 1's sippy cup. Staff C said the cup was a two-handed cup with a lid that had an opening for a straw and they would put a straw in the cup and Resident 1 would drink out of the cup using the straw.On 02/10/2026 at 3:45 PM, Staff G, Director of Nursing, said they expected staff to follow the care plan interventions when caring for residents. Staff G said they did not know if the staff had determined the causes, patterns and/or circumstances of Resident 1's low intake. Staff G said Ensure straight from the container is not considered mildly thick and Resident 1 should not have been drinking it without thickening added to it. Staff G said Resident 1 required 1:1 assistance per the plan of care and no straws and staff should have followed the care plan.Reference WAC 388-97-1020 (1)(2)(a)(b)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately and/or timely assess and monitor a pressure ulcer for 1 of 3 residents (Resident 1) reviewed for wounds. This failure placed residents at risk of worsening pressure ulcers, lack of treatment evaluation and decreased quality of life.Findings included.Review of the facility policy, Wound Prevention and Treatment, revised 02/03/2023, showed the facility monitored wounds weekly and documentation of size, color, odor, healing progression, notifications and other pertinent information will be documented in the electronic medical record. Physician notification and resident/resident representative notification will be completed as needed.Resident 1 was admitted on [DATE] with diagnoses including paraplegia/functional quadriplegia (partial loss of sensation and control of body), dementia and cancer. The Minimum Data Set, an assessment tool, dated 12/17/2025, showed Resident 1 had severe cognitive impairment, was dependent on activities of daily living (ADLs), transfers and bed mobility.Resident 1's admission Evaluation, dated 12/15/2025, showed a stage 2 pressure ulcer (a partial thickness skin loss presenting as a shallow, open ulcer from prolonged unrelieved pressure) 2.5-inch x 0.1 inch surrounded by blanchable redness on the coccyx (tailbone).Resident 1's Skin Assessment, dated 12/15/2025, showed a horizontal open area 2.5-inch x 0.10-inch x 0.1- inch to the coccyx.Resident 1's provider notes, dated 12/16/2025, showed SNF [skilled nursing facility] recommendations to reposition every two hours, monitor skin integrity, especially the sacral area (bony structure at base of the spine).Review of Resident 1's medical record showed no wound care orders for the stage 2 pressure ulcer from admission on [DATE] through 12/27/2025.Resident 1's progress notes, dated 12/27/2025, showed the nurse was notified by the CNA [certified nursing assistant] while providing ADL care to assess a sacral wound. The note showed the assessment revealed a sacral wound present.Resident 1's Skin Grid Weekly Skin Evaluation, dated 12/28/2025, showed a Stage 2 pressure ulcer on the sacrum 1CM (centimeter) x .20 CM x .15 CM.Resident 1's progress notes, dated 12/29/2025, showed the resident had a new stage 2 pressure area and the resident continued to be at risk for pressure areas r/t [related to] dx [diagnosis] of quadriplegia (the partial or total loss of sensory and motor function in all four limbs) along with a healed stage 4 (pressure ulcer that extends to muscle, tendon or bone) pressure area in same area.Resident 1's wound consultant initial assessment, dated 12/30/2025, showed Resident 1 had a wound to the left buttock with etiology listed as MASD [moisture associated skin damage], the severity was partial thickness (non-pressure).On 02/10/2026 at 10:57 AM, Staff A, Resident Care Manager and Licensed Practical Nurse, said licensed nurses were expected to complete skin assessments weekly and document their wound assessment. Staff A said they reviewed the medical record and said Resident 1 had no documentation of a skin assessment between 12/15/2025 and 12/28/2025. When asked if the documentation of a stage 2 pressure ulcer on the sacrum documented in the Skin Grid Weekly Skin evaluation on 12/28/2025 was the same wound as the MASD on the left buttock, assessed by the wound consultant on 12/30/2025, Staff A said they did not know, the record was not clear, the left buttock is not the same as the coccyx and/or sacrum.On 02/10/2025 at 12:02 PM, Staff B, Certified Nursing Assistant, said Resident 1 wanted to sit up in bed all the time. Staff B said Resident 1 did not want to transfer to their wheelchair and or reposition. Staff B said Resident 1 had an open wound on their bottom since admit and it was present throughout the stay.On 02/10/2026 at 1:32 PM, Staff C, Licensed Practical Nurse, said they did not complete wound care for Resident 1. Staff C said the Resident 1 often refused to allow staff to reposition them.On 02/10/2026 at 3:24 PM, Staff D, Wound Consultant/Physician Assistant, said they had not evaluated Resident 1 prior to the 12/30/2025 consultation. Staff D said they diagnosed Resident 1's wound on the buttock as (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MASD and not pressure related. Staff D said this was due to the appearance of the wound and the wound was not over a bony prominence. Staff D said the wound they evaluated was on the fleshy part of the buttock and extended from the left to the right buttock. When asked if they had evaluated a wound on the coccyx and/or sacrum, Staff D said they were unaware of a wound on the coccyx and/or sacrum. Staff D said they were unaware Resident 1 had a healed stage 4 pressure ulcer on their sacrum.On 02/10/2026 at 3:45 PM, Staff G, Director of Nursing, said their expectation was the licensed nurse would complete a weekly skin assessment. Staff G said Resident 1 should have had a skin assessment completed in the week after admission.Reference WAC 388-97-1060 (3)(b)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately document the clinical condition for 1 of 3 residents (Resident 1) reviewed. This failure placed residents at risk of inaccurate medical records, inaccurate assessments and lack of continuity of care.Findings included.Resident 1 was admitted on [DATE] with diagnoses including paraplegia/functional quadriplegia (partial loss of sensation and control of body), dementia and cancer. The Minimum Data Set, an assessment tool, dated 12/17/2025, showed Resident 1 had severe cognitive impairment, was dependent on activities of daily living (ADLs), transfers and bed mobility.Suprapubic CatheterResident 1's physician orders, dated 12/16/2025, showed Resident 1 had a suprapubic catheter (a tube inserted through an abdominal incision directly into the bladder to drain urine).Resident 1's Documentation Survey Report (nursing assistant documentation), dated December 2025, showed the nursing assistants had documented Resident 1 was incontinent of urine on December 15th, 16th, 17th, 19th, 20th, 21st, 22nd, 23rd, 26th, 27th, 28th and 30th.On 02/10/2026 at 3:45 PM, Staff G, Director of Nursing, said the documentation in the documentation survey report was incorrect, Resident 1 was not incontinent of urine.Resident 1's Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 1 was always incontinent of urine.On 02/10/2026 at 1:51 PM, Staff E, Minimum Data Set Coordinator, said the MDS was coded incorrectly because Resident 1 had a suprapubic catheter and the resident was not incontinent of urine.Resident 1's wound consultant notes, dated 12/30/2025, showed Resident 1 had urinary incontinence.On 02/10/2026 at 3:24 PM, Staff D, Wound Consultant/Physician Assistant, said they had assumed Resident 1 was incontinent of urine because they were incontinent of bowel movement. Staff D said they were unaware Resident 1 had a suprapubic catheter.Peg TubeResident 1's medical provider notes, dated 12/16/2025, 12/22/2025, 12/23/2025, 12/24/2025, 12/26/2025 and 12/29/2025 showed the SNF [skilled nursing facility] recommendations included PEG tube feeds (a tube inserted into the stomach to instill liquid nutrition through) as ordered, assist with oral intake as needed; prefers eating in room.On 02/10/2026 at 2:17 PM, Staff F, Physician Assistant Certified, said Resident 1 did not have PEG tube feeds. Staff F said the SNF recommendations were pulled using Artificial Intelligence from the hospital records and they must have missed it when proof reading, it was an error.WoundsReview of the facility policy, Wound Prevention and Treatment, revised 02/03/2023, showed the facility monitored wounds weekly and documentation of size, color, odor, healing progression, notifications and other pertinent information will be documented in the electronic medical record. Physician notification and resident/resident representative notification will be completed as needed.Resident 1's admission Evaluation, dated 12/15/2025, showed a stage 2 pressure ulcer (a partial thickness skin loss presenting as a shallow, open ulcer from prolonged unrelieved pressure) 2.5-inch x 0.1 inch surrounded by blanchable redness on the coccyx (tailbone).Resident 1's Skin Grid Weekly Skin Evaluation, dated 12/28/2025, showed a Stage 2 pressure ulcer on the sacrum 1CM (centimeter) x .20 CM x .15 CMResident 1's wound consultant initial assessment, dated 12/30/2025, showed Resident 1 had a wound to the left buttock with etiology listed as MASD [moisture associated skin damage], the severity was partial thickness (non-pressure).On 02/10/2026 at 10:57 AM, Staff A, Resident Care Manager and Licensed Practical Nurse, when asked if the documentation of a stage 2 pressure ulcer on the sacrum documented in the Skin Grid Weekly Skin evaluation on 12/28/2025 was the same wound as the MASD on the left buttock, assessed by the wound consultant on 12/30/2025, Staff A said they did not know, the record was not clear, the left buttock is not the same as the coccyx and/or sacrum.On 02/10/2026 at 3:24 PM, Staff D, Wound Consultant/Physician Assistant, said the wound they evaluated was on the fleshy part of (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the buttock and extended from the left to the right buttock. When asked if they had evaluated a wound on the coccyx and/or sacrum, Staff D said they were unaware of a wound on the coccyx and/or sacrum. Staff D said they were unaware Resident 1 had a healed stage 4 pressure ulcer on their sacrum.Reference WAC 388-97-1720 (1)(a)(i)(ii)