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	02/24/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to communicate, develop and implement an effective discharge plan and provide sufficient time and orientation prior to discharge for 1 of 3 residents (Resident 1) reviewed for discharge. This failure placed residents at risk of displacement, adequate housing and a decreased quality of life.Resident 1 was admitted to the facility on [DATE] with diagnoses including ankle infection, mood disorder and substance abuse. Resident 1 was discharged from the facility on 02/19/2026. Resident 1's Minimum Data Set Assessment, dated 01/04/2026, showed Resident 1 was cognitively intact.Resident 1's Mobility Care Plan, dated 12/29/2025, showed Resident 1 had limited mobility r/t [related to] weight bearing restrictions NWB [non weight bearing RLE [right lower extremity] for 6 weeks.Resident 1's Discharge Care Plan, dated 12/30/2025, showed Resident 1 wished to return/discharge to placement options and there was potential for complications r/t discharge planning to include health literacy, prior living environment may not be possible due to resident not having a home.Resident 1's admission Discharge Evaluation, dated 12/30/2025, showed Resident 1's discharge plan was unknown.Resident 1's Managed Care Resident Discharge Plan, dated 01/13/2026, showed Resident 1's projected discharge date was 02/27/2026 and the location was home with mother versus placement. The plan showed the barriers to discharge were placement and the foot injury and the plan to remove barriers was to work with resident to establish a discharge plan. The plan showed the alternate or back up plan if preferred discharge location was not attainable was LTC [long term care].Resident 1's Managed Care Resident Discharge Plan, dated 02/03/2026, showed Resident 1's projected discharge date was 02/27/2026 and the location was home with mother versus placement. The plan showed the barriers to discharge were non-weight bearing and placement. The plan to remove barriers was to work with DSHS [Department of Social and Health Services] for placement options and finalize dc [discharge plan]. The plan showed the alternate or back up plan if preferred discharge location was not attainable was LTC.Resident 1's orthopedic (bone doctor) consult, dated 02/03/2026, showed Resident 1 was NWB [non-weight bearing] for two weeks in boot and then begin WBAT [weight bearing as tolerated] in two weeks (02/17/2026).Resident 1's Managed Care Resident Discharge Plan, dated 02/11/2026, showed Resident 1's projected discharge date was 03/27/2026. The plan showed the discharge location was home with mother versus placement, barriers to discharge non-weight bearing on one foot and the plan to remove the barriers was f/u [follow up] appointment and monitor. The plan showed the alternate or back up plan if preferred discharge location was not attainable was LTC.On 02/23/2026 at 3:09 PM, Resident 1 said Staff C, Social Service Director (SSD), told them they had to leave the facility after they had a verbal altercation with a nurse. Resident 1 said they did not want to discharge from the facility but did not believe it was optional. Resident 1 said they asked Staff C what to do because they did not know where to go and Staff C said they would work on a location. Resident 1 said Staff C notified them they were being discharged to a shelter at the last (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	second. Resident 1 said they thought they were going to another facility and/or senior housing, but Staff C gave them a pamphlet of where they were being discharged to, and they thought it was like transitional housing for the homeless. Resident 1 said they thought they would have a bed at the facility and be able to stay at the place for a while until they could find something else. Resident 1 said they were surprised when the facility van dropped them off in the streets of Olympia at a homeless shelter. Resident 1 said the doors to the shelter were locked but there were a lot of people outside waiting to go in. Resident 1 said the shelter opened and allowed them to go in for a meal but there were no beds available for the night. Resident 1 said that although they could bear weight on their leg it was painful and they could only take a few steps. Resident 1 said they were still utilizing a knee scooter to get around. Resident 1 said they were scared and had to wheel a long distance to find a restaurant open and contact family to come and pick them up.Resident 1's progress notes, dated 02/17/2026, showed Staff A, Administrator, overheard Resident 1 threatening to physically harm a nurse and making derogatory comments. The note showed the police were notified and spoke with Resident 1. The note showed Resident 1 denied making threats to staff but said it would not happen again.Resident 1's progress notes, dated 02/17/2026, showed Staff C, SSD, followed up with Resident 1 regarding how the Resident was doing, recent concerning behaviors and discharge planning. The note showed Staff C discussed discharge planning with Resident 1 and contacted the resident's mother. The note showed Resident 1's mother did not want the resident to return home. The note showed during the conversation the resident was making verbally aggressive comments to Staff C and overheard making statements about wanting to physically harm staff. The note showed Staff C addressed it immediately and informed the resident that such behavior and statements were inappropriate and would not be tolerated. The note showed Staff C reiterated that the goal was to support Resident 1 and ensure their care needs were met. The note showed Resident 1 was not receptive to further discussion. The note showed Staff C asked Resident 1 if they preferred a specific county for shelter placement, Resident 1 said it did not matter and requested they leave their room.Resident 1's Transfer and Discharge notice, dated 02/18/2026, showed Resident 1 was discharged because the safety of other individuals in the facility was endangered due to the clinical or behavioral status of the resident. The notice showed it was given to Resident 1 on 02/17/2026 and the date of the transfer/discharge was 02/19/2026. The notice showed the discharge location was the Olympia Union Gospel.Resident 1's Recapitulation of Stay, dated 02/19/2026, showed Resident 1's dc [discharge] was happening r/t Resident 1 was very aggressive and verbally abusive to staff on and off along with smelling ethoh [alcohol] on the resident. The Recapitulation showed Resident 1 was being discharged to a shelter.Resident 1's progress note, dated 02/19/2026, showed Resident 1 was anxious about d/c [discharge] and creating scenarios to delay the process. The note showed the resident was concerned they could not take all their belongings with them.On 02/24/2026 at 12:26 PM, Staff C, SSD, said Resident 1 was discharged for endangering the lives of others in the facility, specifically Staff D, LPN. Staff C said Resident 1 had made threats to physically harm Staff D. Staff C denied Resident 1 physically touched or harmed Staff D. Staff C said Resident 1's behavior had been escalating over the past two weeks prior to discharge. Staff C said Resident 1 would be derogatory towards other residents and had a verbal altercation with their roommate that resulted in the roommate moving out of the room. Staff C said they did not update the plan of care related to the escalating behaviors until 02/17/2026 when Resident 1 threatened to harm Staff D and the police were called. Staff C said they instructed staff to redirect Resident 1 to Staff C when they were having behaviors and staff adjusted Resident 1's medication times per the resident's request. Staff C said they would tell Resident 1 their behavior was unacceptable and the (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident would reply they did not like Staff D. Staff C said Resident 1 would smell of alcohol. Staff C said they did not suggest Staff D no longer care for Resident 1 or explore substance abuse counseling. Staff C said they asked Resident 1 if they were okay with going to a homeless shelter. Staff C said Resident 1 didn't say no.On 02/24/2026 at 1:28 PM, Staff B, Resident Care Manager, said Resident 1 was discharged because they were verbally aggressive with a licensed nurse and had threatened to hurt them. Staff B said Resident 1's behavior had appeared to escalate in the past few weeks, and it was when the resident smelled of alcohol. Staff B said Resident 1 would make fun of the other residents, was short with staff and verbally attacked a particular nurse. Staff B said they did notify the medical provider about the suspected alcohol use. Staff B said they did not make changes to the care plan regarding the behavior. Staff B said they were not aware of any referrals to behavior health consultant and/or substance abuse programs. Staff B said the social work department made those referrals. Staff B said on 02/17/2026, Resident 1 threatened to harm Staff D, Licensed Practical Nurse (LPN), and the police were called. Staff B said a decision was made by the administration that Resident 1 was to be discharged . Staff B said Resident 1 was told on 02/18/2026 to get packed up and the facility van would be taking them to a shelter on 02/19/2026. Staff B said on 02/19/2026 when they went into Resident 1's room to review the medications and discharge paperwork with the resident, Staff B said it appeared Resident 1 was trying to delay the discharge. Staff B said they believed Resident 1 thought if they delayed the discharge process, they would be able to stay at the facility. Staff B said they did not know if Resident 1 had a choice to stay at the facility. Staff B said they did not know what would have happened if the Resident refused to leave the facility. Staff B said they did not offer Resident 1 to stay when they thought Resident 1 was attempting to delay their discharge because Staff B said they were told the resident was leaving that day. Staff B said the staff had discussed scenarios of the resident refusing to leave with the Administrator and they were told the resident was leaving that day.Resident 1's progress note, dated 02/18/2026, showed Staff D, LPN, provided care to Resident 1.Resident 1's progress notes, dated 02/18/2026 and 02/19/2026, showed Resident 1 was on alert for behavior. No documentation of behaviors was found in the notes except for talking loudly.On 02/24/2026 at 2:52 PM, Staff C, Social Service Director, said their discharge planning process was to determine the resident's goals for discharge on admission and to keep the residents on their radar during their stay, following their medical status and projected discharge date . Staff C said if a resident needed placement with the assistance of Department of Social and Health Services (DSHS), Staff C would discuss the resident's case with the DSHS case managers. Staff C said they tried not to jump the gun on discharge planning for placement if the resident had a medical issue and it was not clear the type and timing of discharge. Staff C said they had spoken to DSHS about Resident 1, but they were waiting to explore placement until Resident 1 was able to bear weight on their leg. Staff C said they did not have time to plan for placement with DSHS for Resident 1 because Resident 1 had to leave immediately.On 02/24/2026 at 3:42 PM, Staff A, Administrator, said the facility discharged Resident 1 because they were not receiving therapy and they were independent with their activities of daily living. Staff A said when Resident 1 was admitted they were unhoused so when the resident was ready for discharge they would go back to being unhoused. Staff A said Resident 1's Transfer and Discharge Notice that indicated Resident 1 was discharged due to the safety of other individuals in the facility was endangered was incorrect. Staff A said it was their understanding Resident 1 no longer needed services and they wanted to go to the homeless shelter. Staff A said the discharge was unrelated to Resident 1's behaviors. Staff A said Resident 1 was referred to their Behavioral Consult when they were admitted but the resident refused, the consultant said to monitor (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident and update the consultant if behavior changed. Staff A said they did not update the consultant when Resident 1's behavior had escalated. Staff A said they recognized they could not discharge someone due to their behaviors without going through a process. Staff A said the usual process for a resident that no longer needed services was the discharge planning process. Staff A said that process involved meeting with the residents, clearing them medically and involved their discharge goals. Staff A said the discharge process involved exploring placement if the resident wanted that. Staff A said they believed Resident 1 wanted to go to the homeless shelter. Staff A said they were not aware at the time of Resident 1's discharge that the Union Gospel Mission, where Resident 1 was discharged to did not have guaranteed beds for overnight stays. Staff A said they found out after Resident 1 was gone. Staff A said Resident 1's family contacted them after discharge about placement options and Staff A had social services contact them with information regarding facilities in the area. Staff A said exploring placement options should have occurred prior to discharge. Staff A said they did not believe staff told Resident 1 they had to leave and the resident never came and asked them if they could stay. Staff A said to their knowledge, Resident 1 did not initiate discharge from the facility. WAC 388-97-0120(1)(b)-(f)(2)-(4), 0140 (1)-(3)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the Long-Term Care Ombudsman of a facility discharge for 1 of 3 (Resident 1) residents reviewed for discharge. This failure placed residents at risk of being inappropriately discharged and lack of advocacy regarding their options and rights.Findings included.Resident 1 was admitted to the facility on [DATE] with diagnoses including ankle infection, mood disorder and substance abuse. Resident 1 was discharged from the facility on 02/19/2026. Resident 1's Minimum Data Set Assessment, dated 01/04/2026, showed Resident 1 was cognitively intact.On 02/23/2026 at 3:09 PM, Resident 1 said Staff C, Social Service Director, told them they had to leave the facility after they had a verbal altercation with a nurse. Resident 1 said they did not want to discharge from the facility but did not believe it was optional. Resident 1 said they asked Staff C what to do because they did not know where to go and Staff C said they would work on a location. Resident 1 said Staff C notified them of where they were going at the last second. Resident 1 said they thought they were going to another facility and/or senior housing, but Staff C gave them a pamphlet of where they were being discharged to, and they thought it was like transitional housing for the homeless. Resident 1 said they thought they would have a bed at the facility and be able to stay at the place for a while until they could find something else. Resident 1 said they were surprised when the facility van dropped them off in the streets of Olympia at a homeless shelter. Resident 1 said the doors to the shelter were locked but there were a lot of people outside waiting to go in. Resident 1 said the shelter opened and allowed them to go in for a meal but there were no beds available for the night. Resident 1 said they were scared and had to wheel a long distance to find a restaurant open and contact family to come and pick them up.Resident 1's Transfer and Discharge notice, dated 02/18/2026, showed Resident 1 was discharged because the safety of other individuals in the facility was endangered due to the clinical or behavioral status of the resident. The notice showed it was given to Resident 1 on 02/17/2026 and the date of discharge was 02/19/2026.Resident 1's Recapitulation of Stay, dated 02/19/2026, showed Resident 1's dc [discharge] was happening r/t [related to] Resident 1 was very aggressive and verbally abusive to staff on and off along with smelling ethoh [alcohol] on the resident. The Recapitulation showed Resident 1 was being discharged to a shelter.Review of Resident 1's medical record on 02/25/2026, showed no documentation that the Long-Term Care Ombudsman had been notified of Resident 1's discharge.On 02/24/2026 at 3:40 PM, Staff C, Social Service Director, said they had not sent Resident 1's Transfer and Discharge Notice to the Long-Term Care Ombudsman, I send them at the end of the month.Reference WAC 388-97-0120 (5)(b)