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	04/30/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from abuse from other residents in the facility for 1 of 3 residents (Resident 1) reviewed for abuse. This failure placed residents at risk of further abuse, injury, mental anguish and fear. Findings included.Resident 1 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease (a progressive disorder of the brain causing memory loss and poor judgement). The Minimum Data Set Assessment, an assessment tool, dated 03/28/2026 showed Resident 1 was severely cognitively impaired.Resident 1's care plan, dated 10/17/2025 and revised on 04/17/2026, showed Resident 1 had a behavior problem r/t [related to] confused, pacing and wandering with interventions to include approach calmly, redirect as needed, offer options and activities and rule out pain.On 04/30/2026 at 11:05 AM, Staff B, Certified Nursing Assistant (CNA), said they provided care for Resident 1 and Resident 2. Staff B said Resident 1's usual behavior was they ambulated in the hallway, hanging onto the handrails and often entered other resident's rooms. Staff B said Resident 2 was independent with ambulation. Staff B said Resident 2 stayed in their room a lot, but when Resident 2 came into the hallway and saw Resident 1 they made a beeline for Resident 1. Staff B said if Resident 1 was in the dining room and/or the activity room they would get in front of Resident 2 and not allow Resident 2 in. Staff B said they often had to block Resident 2 from getting close to Resident 1, I literally had to stand in the doorway and blocked them and tell them they could not go in. Staff B said on 04/17/2026 they were in the hallway with Resident 2 and witnessed Resident 1 ambulating down the hallway as they usually did. Staff B said Resident 1 entered Resident 2's room. Staff B said Resident 2 immediately headed toward their room and Staff B said they followed but Resident 2 entered their room and shoved Resident 1 to the ground. Staff B said they were able to catch Resident 1 before they hit the floor and lowered the resident to the ground. Staff B demonstrated Resident 2 facing Resident 1 in the room parallel to the door and Resident 2 pushing Resident 1 down. Staff B said this was the second time Resident 2 had shoved Resident 1.Review of Resident 2's care plan, dated 02/10/2026, showed Resident 2 had the history or potential to demonstrate physical behaviors: slams doors, has thrown the overbed table r/t anger, dementia will poor impulse control. The care plan goal was Resident 2 would not harm self or others.Review of Resident 2's medical provider notes, dated 02/26/2026, showed Resident 2 had walked up to another resident and pushed them down, unprovoked.Review of Resident 1's medical provider notes, dated 2/26/2026, showed a resident walked up and pushed Resident 1, unprovoked. The note showed Resident 1 had fallen and hit their head.Review of a facility incident report, dated 04/17/2026, showed Resident 1 was wandering in the hallway of the memory care unit and inadvertently wandered into Resident 2's room. The report showed that Resident 2 was known to be protective of their personal space, approached Resident 1 and to guide Resident 1 out of the room placed their hands on Resident 1's shoulders and pushed Resident 1 toward the exit. The report showed Resident 1 demonstrated mild backward leaning and gait instability and staff provided controlled assistance and lowered Resident 1 to the floor to prevent a fall.On 04/30/2026 at 12:20 PM, Staff B, Certified Nursing Assistant, said Resident 2 was not (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attempting to guide Resident 1 out of their room. Staff B said the residents were standing away from the door and facing each other and the opposite walls of the room as they relayed in their previous interview. Staff B said Resident 2 was not pushing Resident 1 out the door, Staff B said Resident 2 was pushing Resident 1 down to the floor.On 04/30/2026 at 3:26 PM, Staff A, Administrator, said Resident 2 deliberately shoved Resident 1 when they found Resident 1 in their room. Staff A said they did not believe Resident 2 intended to harm Resident 1 but due to their dementia they had reacted. Staff A said they had put interventions in place to keep Resident 1 safe but acknowledged this was the second time Resident 2 had shoved Resident 1.Reference WAC 388-97-0640(1)