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	06/24/2026

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 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 provide the notice of transfer or discharge and the bed hold policy in writing for 2 of 3 residents (Resident 1 and 2) reviewed for discharge notice. This failure placed residents and/or representatives at risk for lack of advocacy for discharge rights, housing options, and frustration.Findings included.Review of the provider's policy titled, Bed-Hold: Notification Notice of Bed Hold Policy and Return, dated 09/2022, showed when a resident was transferred to a hospital, a written notice will be provided to the resident, family member or responsible party regarding the resident's bed hold rights and the center's bed hold policy, a copy of the completed WA-Nursing Home Transfer or Discharge Notice would be provided to the resident/resident representative at the time of transfer and within 24-hrs after transfer contact the resident/resident representative to explain the bed-hold policy and elicit verbal communication regarding wishes of resident/representative regarding the bed - hold and document the decision in the progress notes of the resident's record or business office.Resident 1 was admitted to the facility on [DATE] and discharged from the facility on 05/04/2026.Review of Resident 1's Letters of Guardianship, dated 04/26/2023, showed Collateral Contact 1 (CC1), was appointed to serve as guardian for full person and conservator of the full estate for Resident 1.Resident 1's WA Nursing Home Transfer or Discharge Notice and Bed Hold Notification, dated 05/04/2026, showed the notice was presented to CC1 on 05/04/2026.Review of a grievance for Resident 1, dated 05/12/2026, showed CC1 had concerns that the facility had not sent the WA [[NAME]] State Transfer and Bed Hold evaluation to CC1 to confirm and sign upon DC [discharge]. The grievance showed the facility staff acknowledged they had provided verbal notification of the discharge to the guardian, but the guardian was not present at time of discharge, and the notice was completed via the phone. The grievance showed the resolution was education provided to SS [social services] to ensure the notice was provided physically to POA [power of attorney] and guardians moving forward.On 05/26/2026 at 11:09 AM, CC1 said the facility failed to notify CC1 that Resident 2 was discharged to the hospital and this was an ongoing issue at the facility for the residents they served. CC1 said they had previously discussed the issue with the facility and were frustrated that it was still an issue.Resident 2 was admitted to the facility on [DATE] and was transferred to the hospital on [DATE]. Resident 2's Minimum Data Set Assessment, dated 05/07/2026, showed the resident was severely cognitively impaired, had unclear speech, was sometimes understood and had a legal guardian.Resident 2's care plan, dated 04/28/2026, showed CC1 was Resident 2's guardian.Resident 2's WA Nursing Home Transfer or Discharge Notice and Bed Hold Notification, dated 05/24/2026, showed the notice was given to Resident 2.Review of Resident 2's medical record on 06/24/2026, showed no documentation CC1 was contacted regarding the WA Nursing Home Transfer or Discharge Notice and Bed Hold Notification and/or provided a written copy.On 06/24/2026 at 12:22 PM, Staff A, Social Service Director, said they were provided education on the WA Nursing Home Transfer or Discharge Notice and Bed Hold Notification policy following Resident 1's grievance. Staff A said they were educated to send a written copy to the residents' guardian in addition to verbal notification. Staff A said they were (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not involved with Resident 2's transfer to the hospital. Staff A said the transfer occurred on a weekend so they did not believe the notice would have been sent by the nursing staff.On 06/24/2026 at 3:03 PM, Staff B, Regional Director of Operations, said the facility followed their policy on transfer, discharge and bed hold. Staff B said the WA Nursing Home Transfer or Discharge Notice and Bed Hold Notification was completed in the medical record and they were able to print the notice and provide it upon request. Staff B said they provided the notification verbally to the resident and/or representative and offered it in written form. Staff B said if the residents and/or representative requested it in written form they would provide it. Staff B reviewed Resident 1's grievance and acknowledged the resolution was to provide the WA Nursing Home Transfer or Discharge Notice and Bed Hold Notification in written form and provided education to the social service staff to provide CC1 with a written copy of the notices. Staff B said Resident 2's WA Nursing Home Transfer or Discharge Notice and Bed Hold Notification was sent with the resident to the hospital. Staff B acknowledged Resident 2 had a guardian and could not comprehend the notice contents. Staff B said the facility had not provided education to the nursing staff and due to the transfer occurring on a weekend, nursing staff did not know to provide a written notice to CC1. Staff B said there was no evidence in Resident 2's medical record that staff followed up with CC1 to provide a written notice and/or to acknowledge CC1 had received the notice sent with Resident 2 to the hospital.Reference WAC 388-97-0120(1)(2)(a)-(d)(3)(a)(4)(b)(5), 0080, 0140(1)(a)-(c)(i)-(iii)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a functional and/or sanitary environment for residents for 2 of 3 sampled residents (Residents 3 &4) reviewed for environment. This failure places residents at risk of discomfort, their environment being unhomelike and unsanitary, and of a diminished quality of life.Findings included.Resident 3's electronic health record showed they were admitted to the facility on [DATE], were in room [ROOM NUMBER], and were discharged on 05/21/2026.During an interview on 06/23/2026 at 9:46 AM, Collateral Contact 2 (CC2), Resident 3's family member, said the facility was filthy.Resident 4 was admitted to the facility on [DATE] and was in room [ROOM NUMBER]. Review of Resident 4's Medication Administration Record for 06/24/2026, showed they had received their morning doses of docusate (stool softener) and MiraLAX (stool softener and stimulant).During an interview and observation on 06/24/2026 at 12:22 PM, Resident 4 said their bathroom was a mess. The bathroom (a shared bathroom between rooms [ROOM NUMBERS]) was observed to have a plastic lining/bag over the toilet that had both urine and stool in it (the toilet should not be flushed with this on it). There was an unlabeled urinal on the floor with 600 milliliters (ml) of dark yellow urine in it, and an unlabeled urinal on the top of the toilet with 650 milliliters of dark yellow urine in it. Resident 4 said staff were supposed to bring them a commode and had not, so the stool and urine in the plastic lining in the toilet was theirs, and they were having diarrhea. Resident 4 said they had just gone pee in there during lunch, most of the stool was from overnight. They said a guy had put the plastic lining on the toilet the previous night, and they had asked staff if they were supposed to go in there. Resident 4 said staff had given them stool softeners. They also said the observed urinals (not theirs) had been present in the bathroom while they had used it. During an interview and observation on 06/24/2026 at 1:06 PM, Staff D, Licensed Practical Nurse, said urinary catheters (tube that goes into the bladder to drain urine) should have their collection bag drained using a urinal or cylinder, which should be dated and labeled with either initials or resident's name. Regarding if urinals with urine in them should be left in a shared bathroom, Staff D said no. Staff D said they were going to get Resident 4 a bedside commode but had not yet. The bathroom was observed to still have the two urinals with urine in them and the toilet with the plastic liner with stool and urine in it. Staff D asked Resident 4 about the toilet, Resident 4 stated, There was a bag there and I just went. Staff D said there may have been a plumbing issue.During an interview on 06/24/2026 at 1:24 PM, Staff E, Maintenance Assistant, said they were unaware of a current plumbing issue, they had gone to fix this toilet at 2:00 AM due to it being clogged, it was fixed, and they did not put the plastic bag over the toilet. During an interview on 06/24/2026 at 2:29 PM, Staff F, Certified Nursing Assistant, said they had been in this bathroom around 7:00 AM, they had emptied the catheter bag for room [ROOM NUMBER]. Their normal process was to empty the catheter bag, dump urine in the toilet, rinse the urinal with water and then rinse that in the toilet. They said they did not normally label urinals, as they would normally put them next to the resident after they were emptied. Staff F said when they had gone to the bathroom to dump the one urinal, there was a bag on the toilet with urine and faces in it, and there already was one urinal with urine in it in the bathroom (the one on the floor). Staff F was unsure what was going on with the toilet, had planned to talk to maintenance before emptying the urinal into the toilet, and left the urinal with urine on the toilet. Staff F said they were aware that Resident 4 needed a bedside commode, they had talked to Staff D about this around 7:00 AM or 7:30 AM, and they were unsuccessful at finding a clean commode for Resident 4. When asked what the plan was for letting Resident 4 use the bathroom, Staff F said it was to get them a clean commode from therapy when they got in at 8:00 AM. Regarding if they had checked in with therapy about the commode, Staff F said they did not check with therapy at 8:00 AM, it was around tray pass which took up a lot of their time. Staff F had just cleaned the bathroom and said they had tried to (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	flush the urine and the toilet was still clogged. During an interview on 06/24/2026 at 3:23 PM, Staff C, Director of Nursing Services, said their expectation for resident bathrooms was for them to be clean and in working order, and if there were any safety issues for it to have been taken care of. Regarding shared bathrooms having urinals with urine left in them, Staff C said this should not happen, they had now addressed this, the nurse aide had put it down in the bathroom because of the condition of the bathroom. After the timeline was explained, Staff C was asked if it met expectations that Resident 4 had no alternative but to keep using the bathroom in this condition, Staff said no it did not meet expectations.Reference WAC 388-97-3220 (1)