

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Fir Lane Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure restorative services (assessed nursing interventions to promote a resident's ability to maintaining functional abilities and independence) were provided for 3 of 3 residents (Resident 10, 6 & 32) reviewed for restorative services. This failure placed residents at risk of physical decline, loss of ability to perform activities of daily living, and a diminished quality of life. Findings included. Resident 10 was admitted to the facility on [DATE] with a diagnosis of paralysis/severe weakness to the left side following a stroke (interruption of blood flow to the brain causing brain damage and other complications). The Quarterly Minimum Data Set assessment (MDS), dated [DATE], showed they were cognitively intact and had received 2 days of restorative services during the assessment period. Review of Resident 10's care plan showed they had a restorative program, last revised on 05/05/2026, for a range of motion program for their left upper arm, as tolerated 6 days a week. Review of Resident 10's restorative evaluations, showed they had not had an evaluation since 03/02/2026, which said the program was on hold due to therapy services. Review of Resident 10's last 30 days of their restorative program task list, showed they only had restorative done on 06/13/2026, 06/27/2026, and 07/10/2026. Review of therapy documentation, showed Resident 10 was discharged from occupational therapy on 03/14/2026 with recommendations for restorative related to activities of daily living and range of motion. Further review showed Resident 10 was seen by physical therapy from 04/08/2026 to 05/07/2026, related to learning how to use a powered wheelchair. During an interview on 07/07/2026 at 08:29 AM, Resident 10 was unaware they were getting restorative services and said they wanted to get those services. During an interview on 07/10/2026 at 11:01 AM, Staff C, MDS Coordinator/Registered Nurse, confirmed they oversaw the restorative department. Regarding Resident 10's restorative program, Staff C said they were supposed to get a restorative program for their left upper arm 6 days a week, but due to staffing it may or may not occur only on Fridays or Saturdays. Staff C confirmed Resident (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10 only participated in restorative therapy 3 times in the past 30 days, due to staffing limitations. Staff C said restorative evaluations should be done quarterly and as needed. When asked if Resident 10 had a current restorative evaluation, Staff C said they had missed the one in June and the last was done in March 2026. Regarding the March restorative evaluation saying Resident 10's restorative therapy was on hold, Staff C said they must have put Resident 10 back into the same program, they did not have the sheet from therapy, and it might have been the same program. Staff C was asked about Resident 10 restarting restorative therapy, if this happened when discharged on 03/14/2026 from occupational therapy. Staff C said Resident 10 went on therapy on 04/08/2026, and the date for restarting the restorative program was 05/05/2026. When asked if they had documentation that therapy agreed to the hold on the restorative program, Staff C said no, they would only have a conversation. During a joint interview on 07/10/2026 at 11:26 AM, Staff A, Administrator, and Staff B, Director of Nursing Services, were asked about Resident 10 and the restorative program. Concern was reviewed that Resident 10 only got restorative 3 times in 30 days, with an evaluation of 6 days a week, and there was an overall staffing concern related to the facility's restorative program. Staff A said their expectation related to meeting residents needs related to restorative services, was for them to meet the needs and recommendations of therapy, and to make a plan that was obtainable. Staff B agreed. When concern was reviewed that pauses of the restorative program were being done, due to an unrelated therapy concern which in then caused delays in services, Staff A said okay. When asked about Resident 10's restorative evaluation not being redone once restarted or quarterly, Staff A said it did not meet expectations. Resident 6 Resident 6 was admitted to the facility on [DATE] with diagnoses of arthritis due to other bacteria of the left shoulder, acute osteomyelitis (infection and inflammation of the bone) of left humerus, spinal stenosis (narrowing of the spaces within the spine) site unspecified, and osteomyelitis of vertebra, lumbar region. The Quarterly MDS assessment documented Resident 6 was cognitively intact. On 07/07/2026 at 9:29 AM, Resident 6 said their insurance had lapsed and Medicare would not approve therapy, but Medicaid would approve restorative therapy but no one from the restorative program had been to see them. Resident 6 said in January they had been to the hospital and could not use their back, it was horribly painful and facility staff were going to work with them but still had not been there. Resident 6 said the house doctor had not gotten an answer about the restorative program for Resident 6 either. Review of Resident 6's care plan, revised on 05/19/2026, documented Resident 6 had limited physical mobility related to a history of bacterial arthritis to their left shoulder, history of osteomyelitis to left humerus, diabetes mellites, congestive heart failure, and respiratory failure. The care plan had Restorative program goals that Resident 6 would participate in the restorative program for the right shoulder and left shoulder and have no decline through the review date. Interventions for the Restorative program were active range of motion with 2-pound weight on right upper extremity and 1 pound weight on left upper extremity through all planes of motion 2-3 sets of 5-10 reps as tolerated. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/09/2026 at 11:25 AM, Staff J, Director of Therapy, reported Resident 6 had been discharged from physical therapy on 05/14/2026 and she had referred them to the restorative program. Review of the Physical Therapy discharge summary, dates of service 04/16/2026-05/14/2026, documented Resident 6 had reached maximum potential with skilled services. On 07/09/2026 at 11:44 AM, Staff C, Minimum Data Set Coordinator/Registered Nurse, when asked if she oversaw the restorative department, said yes. Regarding Resident 6's restorative program, Staff C said it had been spotty because they did not have staff for the program. Staff C said they had been trying to have the program every day but lost 4 staff who had either quit or changed their positions at the facility. Staff C said they were now only offering Restorative one day a week, on Fridays. Staff C confirmed Resident 6 was on the Restorative program and said residents had not been getting their program with it only being offered once a week. Staff C said Resident 6 was discharged from Physical Therapy on 05/14/2026 and was picked up for the Restorative program on 05/19/2026. When asked how many times Resident 6 had received Restorative therapy services since 05/19/2026, Staff C said she could only see back in the record 30 days and Resident 6 had been seen 3 times in the last 30 days, and it had been documented the activity did not occur 5 times which Staff C explained meant there was no staff for those days. When asked how often Resident 6 was scheduled to receive the Restorative program, Staff C said what they did was schedule it every day when they had someone to do the program hoping the resident would get 5 days of restorative a week, and that they had to change the goal to 3 times a week because they weren't meeting the goal of 5 days a week. Staff C said Resident 6 was scheduled to receive the Restorative program 3 days a week. During this same interview Staff C, MDS Coordinator/RN was asked if this met her expectations for a restorative program for residents, and she said no, that it was hard because of staffing. Staff C provided the 30-day history of restorative visits for Resident 6 from 06/10/2026-07/08/2026, which were reviewed and showed between those dates 11 opportunities for the restorative program were recorded, with 1 visit documenting not applicable, and 5 visits documenting did not occur, and 1 visit documenting resident not available. The documentation showed Resident 6 received the restorative program 4 times in 30 days. Resident 32 Resident 32 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 32 was cognitively intact and was receiving restorative services during the assessment period. An order for June 2026 restorative program documented Range of motion perform BLE [bilateral lower extremities] seated exercises with light to mod [moderate] resistance 2-3 sets of 10 reps as tolerated 5-6 days per week. BUE [bilateral upper extremities] [should] exercises with 2 lb [pound] weights flexion, abduction shoulder press and bicep curls 1-2 sets of 10 reps as tolerated 5 days per week. The Task documentation for June 2026 (30 day look back), showed Resident 32 received restorative on 06/14/2026, 06/20/2026, 06/26/2026 & 06/27/2026. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/10/2026 at 10:57 AM, when asked about restorative services specifical listed above, Resident 32 said they had not received any of those specific services in months. Resident 32 said they had been working the physical therapy for the last month due to an ankle injury. Resident 32 said they have not been in or received restorative program services in months. On 07/10/2026 at 11:26 AM, Staff A, Administrator and Staff B, DNS were asked about restorative program services. Staff A said the restorative program was to meet the needs of the resident and to have an obtainable goal. Resident 32's specific restorative program goals were read out loud. Staff A reviewed June 2026's restorative dates and confirmed Resident 32 only received restorative services 4 times during the month of June 2026. Staff A said that did not meet expectations, Resident 32 should have gotten services as orders. Staff B agreed. Reference WAC 388-97 -1060 (3)(d), (j)(ix)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview the facility failed to prevent cross contamination during meal preparation services for 1 of 1 kitchen, reviewed for food service safety. The failure to prevent cross contamination placed residents at risk of foodborne illness (caused by the ingestion of contaminated food or beverages), unsanitary conditions, and diminished quality of life. Findings included . On 07/08/2026 at 11:29 AM, observations of tray line were conducted. Staff I, Dietary Manager, started plating food on dishes for lunch meal service. On 07/08/2026 at 12:03 PM, Staff I touched the chicken stripes on three different plates with a gloved hand and continued to dish up other plates. Staff I did not change their gloves. On 07/08/2026 at 12:05 PM, Staff I touched chicken with a gloved hand and continued to dish up other plates. Staff I did not change their gloves. On 07/08/2026 at 12:05 PM, Staff I touched the small over door (opening and closing) with a gloved hand and continued to dish up plates. Staff I did not change their gloves. On 07/08/2026 at 12:06 PM, Staff I donned (put on) a new pair of gloves. On 07/08/2026 at 12:09 PM, Staff I touched the chicken with a gloved hand and continued to dish up plates. Staff I did not change their gloves. On 07/08/2026 at 12:10 PM, Staff I touched small oven door (opening and closing) with a gloved hand and continued to dish up plates. Staff I did not change their gloves. On 07/08/2026 at 12:11 PM, Staff I touched the cheese on the plate and then opened the small oven door and grabbed burger patty with a gloved hand, then closed the door and continued to dish up plates. Staff I did not change their gloves. On 07/08/2026 at 12:13 PM, Staff I turned on a 2nd oven (the large oven) with a gloved hand. Staff I did not change their gloves. On 07/08/2026 at 12:14 PM, Staff I opened the small oven door with a gloved hand, grabbed beef burger patty with a gloved hand, closed the door and then continued dishing up plates. Staff I did not change their gloves. On 07/08/2026 at 12:15 PM, Staff I opened the small oven, grabbed 2 hot dogs with a gloved hand, closed the oven door and continued to dish up plates. Staff I did not change their gloves. On 07/08/2026 at 12:19 PM, Staff I touched the chicken with a gloved hand and continued to dish up plates. Staff I did not change their gloves. On 07/08/2026 at 12:23 PM, Staff I touched the chicken with a gloved hand. Tray line observations ended at 12:23 PM. On 07/08/2026 at 12:43 PM, when asked if staff should touch the food, Staff I said the food should not have been touched. When observations of food being touched and then touching environmental surfaces, Staff I said they had caught themselves doing it. Staff I said they should not have touched the food and the environmental surfaces; they should have changed their gloves too. Reference WAC 388-97 -1100 (3), -2980		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure binding arbitration agreements were explained in a manner that residents understood, for 3 of 3 residents (Resident 64, 27 & 78) reviewed for binding arbitration (an agreement to use a third-party mediator and waives the right to a trial by jury). This failure placed residents at risk of signing away their rights, not understanding what they had signed, and a diminished quality of life. Findings included. Resident 64 Resident 64 was admitted to the facility on [DATE]. Review of their brief interview for mental status form, dated 06/24/2026, showed they were cognitively intact. Review of Resident 64's arbitration agreement, showed they had signed the form on 07/03/2026. During an interview on 07/08/2026 at 12:18 PM, Resident 64 was asked what their understanding of the arbitration process was when a dispute came up. Resident 64 stated, I don't know. When asked if they knew they were giving up their right to litigation in a court proceeding, Resident 64 said no. Resident 64 then asked what an arbitration agreement was. Resident 64 stated, I don't remember what I signed. I just remember what I was told to sign. I have been suckered into so many things because I sign and don't ask what I am signing. Resident 64 said no, the arbitration agreement was not explained in a way they understood. Resident 27 Resident 27 was admitted to the facility on [DATE]. Review of their brief interview for mental status form, dated 06/24/2026, showed they were cognitively intact. Review of Resident 27's arbitration agreement, showed they had signed the form on 07/03/2026. During an interview on 07/08/2026 at 12:21 PM, Resident 27 was asked what their understanding of the arbitration process was when a dispute came up. Resident 27 asked, What is arbitration?. Resident 27 said they did not know they were giving up their right to litigation in a court proceeding. When asked if they were told the facility could not require them to enter into an arbitration agreement to be admitted or remain at the facility, Resident 27 said there were a lot of things they did not understand, which is why their [AGE] year old son comprehends it for them, they had injured their head 5 years ago, and they have some days were they think pretty good and other days that were harder, and were working on getting a power of attorney. Resident 78 Resident 78 was admitted to the facility on [DATE]. Review of their brief interview for mental status form, dated 06/26/2026, showed they were cognitively intact. Review of Resident 78's arbitration agreement, showed they had signed the form on 06/26/2026. During an interview on 07/08/2026 at 12:11 PM, Resident 78 was asked what their understanding of the arbitration process was when a dispute came up. Resident 78 said they were unclear on this and then asked, Does it have something to do with patient rights?. Resident 78 said arbitration was new to them. When asked if they were told the facility could not require them to enter into an arbitration agreement in order to be admitted, or to remain in the facility, Resident 78 stated, No, I was never told. During an interview on 07/10/2026 at 9:42 AM, Staff A, Administrator, said their expectation was for the arbitration agreements to have been explained in a way that was understandable to the residents or whoever was in charge of their care. No associated WAC		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow gradual dose reduction (GDR) requirements and/or to monitor psychotropic medications (altering the mental state) for 3 of 5 residents (Resident 2, 56 & 32) reviewed for unnecessary medications. This failure placed residents at risk of unnecessary medications, side effects, and a diminished quality of life. Findings included. Review of the facility's policy titled Psychoactive Medication Management, revised 08/2024, showed a GDR attempt should be made unless clinically contraindicated. These contraindications, for a resident with a diagnosis of dementia, were if the resident's target symptoms returned or worsened after the most recent attempt at a GDR within the center and the physician had documented the clinical rationale for why any additional attempted dose reduction at the time would be likely to impair the resident's function or increase distressed behavior. Resident 2 Resident 2 was admitted to the facility on [DATE] with diagnoses of dementia (decline in cognitive function severe enough to interfere with daily life) and depression. The Quarterly Minimum Data Set assessment (MDS), dated [DATE], showed Resident 2 had severe cognitive impairment. Review of Resident 2's GDR documentation, showed on 02/04/2026, the pharmacist had written that Resident 2's trazodone (an antidepressant that can also be used for sleep) medication for insomnia (difficulty sleeping at night) was due for a GDR review. The pharmacist wrote that the interdisciplinary team felt Resident 2 benefited from the current dose and no change was recommended to maintain condition stability. A provider signed the form on 02/11/2026 with no additional documentation or clinical rationale documented by the provider. Review of Resident 2's psychology follow-up progress note, dated 02/06/2026, showed the provider had documented Resident 2 had exhibited daytime sedation and would sleep during the day, which could have been related to the trazodone or their antipsychotic medication. Review of Resident 2's sleep monitor for January 2026, showed the following 14 dates had sleep amounts of 10 hours or greater: 01/01/2026- 14 hours, 01/07/2026-14 hours, 01/13/2026- 15 hours, 01/14/2026- 15 hours, 01/15/2026-15 hours, 01/16/2026- 13 hours, 01/19/2026- 11 hours, 01/20/2026- 16 hours, 01/21/2026-14 hours, 01/23/2026- 13 hours, 01/24/2026-20 hours, 01/27/2026- 13 hours, 01/30/2026- 12 hours, 01/31/2026- 20 hours Review of Resident 2's sleep monitor for February 2026, from 02/01/2026 to 02/11/2026 (date provider signed the GDR form), showed the following eight dates had sleep amounts of 10 hours or greater: 02/01/2026- 11 hours, 02/02/2026-13 hours, 02/03/2026-10 hours, 02/04/2026-15 hours, 02/05/2026-10 hours, 02/06/2026-20 hours, 02/09/2026-11 hours, 02/11/2026-12 hours During an interview on 07/08/2026 at 2:48 PM, Staff D, Resident Care Manager/Registered Nurse (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(RCM/RN), confirmed they were unable to find clinical justification by the provider for not completing the GDR. Staff D said there should have been documentation, and provider follow-up documentation should show the reason for agreeing or disagreeing with the recommendation. Staff D said they also did not see in Resident 2's clinical record why the trazodone dose could not have been decreased, as it was for insomnia and Resident 2 was sleeping for long periods of time. Resident 56 Resident 56 was admitted to the facility on [DATE] with diagnoses of dementia, mild, with other behavioral disturbance, major depressive disorder, insomnia, delusional disorders and anxiety disorder. The Quarterly MDS, dated [DATE], documented Resident 56 was moderately cognitively impaired. Resident 56 had the following active ordered psychotropic medications: Depakote (anti-seizure medication also considered a mood stabilizer), to be given two times a day for anxiety, agitation. Lorazepam (anti-anxiety medication) to be given every 6 hours for anxiety, agitation. Mirtazapine (anti-depressant) to be given at bedtime for depression. Risperdal (antipsychotic medication) to be given two times a day for delusional disorder. Review of Resident 56's Treatment Administration Record (TAR) from 07/01/2026-07/06/2026, showed the following monitoring of target behaviors: Target behavior related to insomnia-fatigue, low energy, irritable. for psychoactive medication. (Psychoactive, term sometimes used interchangeably with psychotropic medication. The monitoring did not specify which psychoactive medication or medication class the target behaviors were being monitored for.) Target behavior- combative behavior/aggression.for psychoactive medication related to dementia with behavior disturbance. (The monitoring did not specify which psychoactive medication or medication class the target behaviors were being monitored for.) Target behavior- may include restlessness, agitation, excessive worry/fear, rapid speech, insomnia, nausea. for psychoactive medication. (The monitoring did not specify which psychoactive medication or medication class the target behaviors were being monitored for.) Target behavior- resident may exhibit behaviors related to yelling towards staff, foul language, confusion. for psychoactive medication. (The monitoring did not specify which psychoactive medication or medication class the target behaviors were being monitored for.) On 07/09/2026 at 3:32 PM, Staff G, RCM/RN, when asked what their expectations were for target (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	being monitored for the clonazepam, Staff G said no, side effects should have been monitored. Reference WAC 388-97-0620 (1)(a)		

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NAME OF PROVIDER OR SUPPLIER Fir Lane Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2430 North 13th Street Shelton, WA 98584	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure bowel interventions were initiated for 3 of 5 sampled residents (Residents 82, 2 & 56) reviewed for quality of care. This failure placed residents at risk for discomfort, health complications and a diminished quality of life. Findings included .Per Facility Bowel Management Policy, entitled Management of Constipation, updated 9/2025 stated: When a resident is identified with No/small Bowel Movement documented for 48hrs, the LN [Licensed Nurse] will assess the resident and determine if the bowel protocol will be initiated. Standard bowel protocol to relieve constipation (in the absence of a bowel obstruction) with a provider order to include the following unless otherwise specified by Provider order: MiraLax 17 grams with 8 ounces of fluid of choice x 1. Bisacodyl Suppository 10mg [milligrams] rectally if no results from the MiraLax in 24hrs. Fleet's Enema (Saline Laxative Enema) 4.50z- Administer 1 bottle as needed rectally if no results from the Bisacodyl Suppository in 12hrs and notify Provider. Resident 82 Resident 82 was admitted to the facility on [DATE] with a diagnosis of dementia (decline in cognitive function severe enough to interfere with daily life). The Quarterly Minimum Data Set, MDS- assessment tool, dated 03/31/2026 documented Resident 82 was unable to complete the interview for cognitive status. A review of Resident 82's Electronic Health Record (EHR) showed orders for:- Miralax Oral Powder Give 1 scoop by mouth two times a day for constipation Dated 01/14/2025- Miralax Oral Powder Give 1 scoop by mouth every 24 hours as needed for constipation Dated 01/14/2025- Dulcolax Suppository Insert 1 suppository rectally every 24 hours as needed for Constipation If no results from Miralax in 24hrs Dated 09/26/2025 - Fleet Enema Insert 1 application rectally every 24 hours as needed for Constipation If no results from Dulcolax in 4-6 hours. If no results from enema, notify Medical Doctor (MD). Dated 09/26/2025 A Review of the bowel record for Resident 82 from 06/08/2026 & 07/07/2026 showed no bowel movement (BM) documented from: -06/08/2026 & 06/15/2026 (8 days)-06/18/2026 & 06/23/2026 (6 days) A review of the June 2026 Medication Administration Record (MAR) showed:-an as needed Dulcolax Suppository was documented as given on 06/11/2026 and 06/16/2026-an as needed Miralax Oral Powder was documented as given on 06/23/2026 On 07/09/2026 at 2:43 PM, Staff D, Resident Care Manager (RCM)/Registered Nurse (RN) said Resident 82 did not have BM's documented per the record. Resident 82 has scheduled Miralax ordered and if that was ineffective the bowel protocol should have been initiated in addition to the scheduled Miralax. On 07/10/2026 at 10:35 AM, Staff B Director of Nursing (DNS) said their expectation was for the staff to follow the bowel protocol. Resident 2 Resident 2 was admitted to the facility on [DATE] with a diagnosis of dementia. The Quarterly MDS, (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated [DATE], showed Resident 2 had severe cognitive impairment. Review of Resident 2's past 30 days of bowel movements, showed they went from 06/07/2026 to 06/11/2026 (5 days) and 06/16/2026 to 06/19/2026 (4 days) without a BM. Review of Resident 2's June 2026 Medication Administration Record (MAR), showed they had been given an as needed bowel movement stimulant, MiraLAX, on 06/10/2026 (day 4 of not having a bowel movement). Review of Resident 2's bowel medications, showed they had the following orders: Miralax- as needed for constipation Dulcolax suppository- every 24 hours as needed for constipation, if no results from Miralax in 24 hours. Fleet Enema- every 24 hours as needed for constipation if no results form Dulcolax in 4-6 hours. During an interview on 07/08/2026 at 2:48 PM, Staff D, RCM/RN, confirmed Resident 2 did not have any as needed bowel medications given on 06/09/2026 or 06/11/2026, or during the period from 06/16/2026 to 06/19/2026. During an interview on 07/10/2026 at 12:28 PM, Staff B, DNS, said their expectation was for doctor's orders to have been followed related to the bowel protocol for Resident 2. Regarding the period of no bowel movement from 06/16/2026 to 06/19/2026, Staff B said a as needed bowel medications should have been given on 06/18/2026 and 06/19/2026. Resident 56 Resident 56 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 56 was moderately cognitively impaired. Resident 56's care plan included alteration in bowel elimination constipation related to decreased mobility, medication(s) side effects, initiated 07/22/2024. The goal was for Resident 56 to have a normal bowel movement at least every 3rd day. Interventions included following facility protocol for bowel management. Resident 56 had the following orders for as needed medications for management of constipation. Polyethylene Glycol powder (Miralax), as needed for constipation, dated 09/25/2026 Dulcolax Suppository, every 24 hours as needed for constipation if no result from Miralax in 24 hours, dated 09/25/2025. Fleet enema, 1 application every 24 hours as needed for constipation if no results from Dulcolax in 4-6 hours. If no results from enema, notify MD. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 56's bowel record for June 2026, showed they did not have a BM from 06/21/2026- 06/25/2026 (5 days). Review of the June 2026 MAR showed no as needed bowel medications were administered from 06/21/2026-06/25/2026. Review of Resident 56's bowel record for May 2026, showed they did not have a BM from 05/20/2026- 05/25/2026 (6 days). Review of the May 2026 MAR showed no as needed bowel medications were administered from 05/20/2026-05/25/2026. Review of Resident 56's bowel record for April 2026, showed they did not have a BM from 04/01/2026-04/09/2026 (9 days). Review of the April 2026 MAR showed no as needed bowel medications were administered from 04/01/2026-04/09/2026. On 07/09/2026 at 4:00 PM, Staff G, RCM/RN, confirmed Resident 56 had no BM recorded for 5 days in June, 6 days in May, and 9 days in April and had not been administered as needed bowel medications during those time periods. When asked if this met her expectations for management of constipation, Staff G said no, if staff were utilizing the bowel protocol the right way her expectations would have been met, but Resident 56 went many days without having a BM and so this did not meet her expectations. Reference WAC 388-97-1060 (1)		

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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 interviews and record review, the facility failed to ensure weekly skin evaluations were completed accurately and wound care was documented on the Treatment Administration Record (TAR) for 1 of 1 sampled Resident (13) reviewed for pressure ulcer (PU). These failures placed the resident at risk of a delay in treatment, deterioration of the PU, and a diminished quality of life. Findings included. Resident 13 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, dated [DATE], documented Resident 13 was cognitively intact and had a stage 2 PU. Skin EvaluationsA review of the Total Body Skin Evaluation Weekly, dated 06/17/2026 and 06/25/2026, documented no skin concerns noted and did not document a PU. On 07/10/2026 at 9:12 AM, Staff G, Registered Nurse (RN)/Resident Care Manager (RCM) said that nothing was documented about Resident 13's PU on 06/17/2026 and 06/25/2026's Total Body Skin Evaluation Weekly and it should have been. Staff G said the skin concerns were not documented accurately and their expectation was the nursing staff document wound care and PU as an issue on the evaluation. On 07/10/2026 at 10:36 AM, Staff B, Director of Nursing Services (DNS), said the Total Body Skin Evaluation Weekly on 06/17/2026 and 06/25/2026 were not charted correctly and said Resident 13's PU should have been documented. Wound Care on the [NAME] review of Resident 13's March 2026 TAR listed an order for: WOUND CARE TO STAGE 2 PRESSURE ULCER 3 times per week and as needed for if soiled/dislodged and the order was discontinued on 04/07/2026. And a blank box with no documentation was noted on 03/31/2026 of the TAR and no as needed wound care was documented on the TAR. A review of Resident 13's April 2026 TAR listed orders for: WOUND CARE TO STAGE 2 PRESSURE ULCER 3 times per week and as needed every day shift every Tue, Thu, Sat for wound care and the order was discontinued on 04/07/2026. A blank box with no documentation was noted on 04/02/2026 and as needed wound care was documented as provided on 04/05/2026. WOUND CARE TO STAGE 2 PRESSURE ULCER 3 times per week and as needed every day shift every Tue, Thu, Sat for wound care and the order was discontinued on 04/14/2026. A blank box with no documentation was noted on 04/14/2026 and PRN wound care was documented as provided on 04/16/2026 and 04/26/2026 on the TAR. A review of Resident 13's May 2026 TAR listed an order for: WOUND CARE TO STAGE 3 PRESSURE ULCER change 3 times a week and as needed every day shift every Tue, Thu, Sat for wound care and the order was discontinued on 06/29/2026. A blank box with no documentation was noted on 05/05/2026, 05/09/2026, 05/14/2026, and 05/30/2026 and as needed wound care was documented as provided on 05/04/2026 and 05/11/2026. A review of Resident 13's June 2026 TAR listed an order for: WOUND CARE TO STAGE 3 PRESSURE ULCER change 3 times a week and as needed every day shift every Tue, Thu, Sat for wound care and the order was discontinued on 06/29/2026. A blank box with no documentation was noted on 06/09/2026 and 06/13/2026 and no as needed wound care was documented on the TAR. On 07/10/2026 at 9:12 AM, Staff G, RN/RCM said they saw the dates without documentation on the TAR and Staff G said they should have been completed and signed off. Staff G said the resident could have received wound care from United Wound Healing on some of those days but the nursing staff could have documented the care provided on the TAR. On 07/10/2026 at 10:36 AM, Staff B, DNS said something should have been charted on the TAR even if Resident 13 was seen by United Wound Healing, was out of the facility, and/or there was an overlap in wound care orders. Staff B said their expectation was if there was an active order then something should have been documented in the box. Reference WAC 388-97-1060 (3)(b)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents requiring dialysis (procedure that filters out waste and excess fluid from the blood, helping to regulate blood pressure) were appropriately monitored and treated for blood pressure and fluid restrictions, and communication from dialysis was accurately recorded into their medical record for 1 of 1 resident (Resident 7) reviewed for dialysis. This failure placed residents at risk of medical complications including fluid overload, and a diminished quality of life. Findings included. Resident 7 was admitted to the facility on [DATE] with diagnoses of end stage renal disease (kidney failure) and dependence on renal dialysis. The Medicare 5 Day Minimum Data Set assessment, dated 06/07/2026, showed Resident 7 was cognitively intact. Review of Resident 7's orders, showed they had hydralazine, a blood pressure medication, ordered on 05/21/2026, to be used every 8 hours as needed for systolic blood pressure (top number) over 170 or diastolic blood pressure (bottom number) over 110. Review of Resident 7's blood pressure readings showed they had elevated blood pressure readings on: 06/26/2026-173/75, 06/28/2026- 174/80 and 182/90, and 07/06/2026-177/71. Review of Resident 7's June and July 2026 Medication Administration Records (MAR), showed hydralazine was not given on 06/26/2026, 06/28/2026, or 07/06/2026. Review of Resident 7's dialysis communication forms, showed on 05/25/2026, dialysis communicated they had given a pneumococcal vaccine. Review of Resident 7's electronic health record (EHR), showed on 06/23/2026 the facility documented under their immunization section that they offered Resident 7 the pneumococcal vaccine, provided education, and the resident refused. This section was not updated with Resident 7's vaccine date from dialysis. Further review of Resident 7's dialysis communication forms, showed on 06/29/2026 Resident 7 had more fluid than normal removed during dialysis. Their pre-dialysis weight was 50.8 kg (112 pounds (lbs.)) and their post-dialysis weight was 46.6 kg (103 lbs.). Review of Resident 7's orders showed a weight order, ordered on 05/15/2026, for post dialysis dry weights to be recorded Monday, Wednesday, and Friday after returning from dialysis. This order did not list the goal dry weight (ideal weight of a resident without excess fluid retention, allowing the body to function best without signs of fluid overload or dehydration) established by dialysis. Review of Resident 7's current fluid restriction order, showed it started on 06/08/2026 for 1,000 milliliters (ml) in 24 hours and nursing was to document the total amount of ml provided per shift. Nursing was to provide 280 ml total, 120 ml during day shift, 120 ml during evening shift, and 40 ml during nighttime shift. Dietary was to provide 720 ml total, 240 ml with breakfast, 240 ml with lunch, and 240 ml with dinner. Review of Resident 7's June 2026 MAR, showed the following total amounts were documented in June and below the 720 ml provided by dietary: 06/09/2026: 710 ml, 06/13/2026: 160 ml, 06/14/2026: 160 ml, 06/15/2026: 470 ml, 06/19/2026: 100 ml, 06/20/2026: 160 ml, 06/21/2026: 470 ml, 06/25/2026: 160 ml, 06/26/2026: 160 ml, 06/27/2026: 470 ml, 06/28/2026: 470 ml, 06/30/2026: 40 ml. The following total amounts were documented in June and above the 1,000 ml fluid restriction: 06/10/2026: 1,070 ml, 06/11/2026: 1,070 ml, 06/22/2026: 1,320 ml, 06/23/2026: 1,320 ml, 06/16/2026: 1,310 ml, 06/17/2026: 1,310 ml. Review of Resident 7's July 2026 MAR, from 07/01/2026 to 07/06/2026, showed the following total amounts were documented and below the 720 ml provided by dietary: 07/01/2026: 160 ml, 07/02/2026: 160 ml, 07/03/2026: 470 ml, 07/04/2026: 470 ml, 07/05/2026: 470 ml, 07/06/2026: 160 ml. During an observation on 07/08/2026 starting at 8:50 AM, Resident 7 was seen resting, with a coffee cup (with hot water in it) and no other drinks on their tray. Their bedside table had a bottled water and plastic cups for pouring the water into. At 9:54 AM, Resident 7 was seen (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	up in bed and eating, now with an additional milk cup they used to pour into their cereal. During an observation and interview on 07/08/2026 at 12:39 PM, Resident 7 was seen eating lunch, had their hot water coffee cup and a 4-ounce unopened apple juice was seen by their water bottle. Resident 7 said they were keeping the apple juice for when they are thirsty. During an interview on 07/09/2026 at 1:28 PM, Staff O, Certified Nursing Assistant, said Resident 7 liked to drink hot water, liked milk with their cereal in the morning, and apple juice. Regarding their milk with breakfast, Staff O said that kitchen would bring milk on the tray, and if they did not then Resident 7 would request it. When asked if Resident 7 was on a fluid restriction, Staff O said they would have to check their run sheet, and then reported the restriction was for 1700 ml and showed their run sheet (observed to show Resident 7 was on a fluid restriction but did not list how much the restriction was, the 1700 number was next to but not part of the fluid restriction note). During an interview on 07/09/2026 at 1:45 PM, Staff I, Dietary Manager, said Resident 7 was supposed to only get one cup of fluids in the morning, and should not get milk unless the hot water was taken off their tray. Staff I confirmed the milk gets delivered in 240 ml cups. During an interview on 07/09/2026 at 1:47 PM, Staff H, Licensed Practical Nurse (LPN), said their role regarding the fluid restriction for Resident 7 was to give 120 ml of fluid with meds during their shift. Staff H did not know about the water bottle at Resident 7's bedside. When asked if they knew Resident 7's dry weight goal, Staff H said no. When asked if they were able to look up the dry weight goal, Staff H said they were not really weighing Resident 7, not since June 13th 2026. After being told about weights on the MAR instead of the vitals section in the EHR, Staff H said another shift was responsible for the weights as they were inputted after Resident 7 came back from dialysis. During an interview on 07/09/2026 at 2:39 PM, Staff N, Resident Care Manager/ LPN, reviewed Resident 7's July 2026 MAR and said the nursing staff was not adding in the breakfast, lunch, or dinner fluid. Staff N said their expectation was for staff to read the order and what it said, to use critical thinking, and to put the total ml for the shift and include the meal fluid as well. When asked if Resident 7 should have both water and milk for breakfast, Staff N said no because breakfast was only 240 ml, and confirmed they had not done a risk and benefits form related to the fluid restriction. After reviewing the observations, Staff N said that was too much fluid at breakfast, and the 4 oz apple juice was too much. Regarding Resident 7's dry weight, Staff N did not readily know what the goal was, did not see it in the care plan, and said they would contact dialysis. When asked how the facility was assessing the changes in how much weight was being taken off during dialysis, Staff N said they put the weights into the EHR and tried to look at Resident 7's whole picture. Regarding reevaluating if the fluid restriction was being followed, Staff N stated, clearly we missed on that. Staff N reviewed the dialysis communication form from 06/29/2026 and acknowledged a large amount of fluid had been taken off Resident 7 (more than baseline, which can indicate the resident had fluid overload). Staff N confirmed Resident 7 was not given hydralazine despite meeting parameters on 06/26/2026, 06/28/2026, and 07/06/2026 and said it should have been given. When asked if Resident 7 had a pneumococcal vaccine since being a resident here, Staff N said they would go to the immunization section, and it showed Resident 7 refused this on 06/23/2026. Staff N said their expectation was for any immunization to have been documented under the immunization section, and the nurse who reviewed Resident 7's dialysis communication form should have added this to the immunization section in the EHR. At 10:34 AM, Staff N said they had gotten a dry weight goal from dialysis of 47 kilograms/103.4 lbs. and they had now updated the care plan. During an interview on 07/10/2026 at 12:28 PM, Staff B, Director of Nursing Services, said their expectation for Resident 7's fluid monitor was for the staff to follow the fluid restriction. Regarding Resident 7's dry weight goal, Staff B said they had expected it in the dialysis documentation, and if there was a concern dialysis (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have reached out to them. Staff B said their expectation for hydralazine, was for the doctor's orders to have been followed. Regarding communication from dialysis and the facility's role, Staff B said they expected dialysis forms to be followed up with after each dialysis session. Reference WAC 388-97 -1900 (1), (6)(a-c)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **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 unnecessary medications by failing to follow medication parameters, ensuring medications had a clear indication for use, re-evaluating necessity of scheduled opioid medication and/or addressing pharmacy recommendations for 3 of 5 sampled residents (Residents 56, 2 & 82) reviewed for unnecessary medications. This failure placed residents at risk of receiving unnecessary medications and at risk of medical complications. Findings included. Resident 56 Resident 56 was admitted to the facility on [DATE] with diagnoses of pain in right hip, pain in left hip, other chronic pain, pain in left shoulder, pain in left ankle and joints of left foot and hypertension (high blood pressure). The Quarterly Minimum Data Set assessment (MDS), dated [DATE], documented Resident 56 was moderately cognitively impaired. Review of Resident 56's orders showed the following order, dated 06/29/2026: Biofreeze Cool the Pain External Gel (pain relieving medication applied directly to the skin), apply to affected area (did not specify where) every 6 hours as needed for pain. Further review showed Resident 56 had a second order, dated 01/07/2026, as follows: Carvedilol oral tablet, give 1 tablet by mouth two times a day related to hypertension, hold for systolic (top number of blood pressure reading) blood pressure less than 110 or heart rate less than 60. Review of Resident 56's Medication Administration Records (MAR) from 07/01/2026-07/07/2026, 06/01/2026-06/30/2026 and 05/01/2026-05/31/2026 showed the medication Carvedilol was given outside of the ordered parameters on the following dates: 07/06/2026- blood pressure 106/66 06/19/2026- blood pressure 104/60 and heart rate 56 06/12/2026- blood pressure 106/60 and heart rate 56 06/01/2026- blood pressure 104/54 05/11/2026- blood pressure 104/60 and heart rate 56 05/25/2026- blood pressure 106/66 On 07/09/2026 at 4:00 PM, Staff G, Resident Care Manager/Registered Nurse (RCM/RN), when asked if Resident 56's ordered Biofreeze should have a location of where to place it, Staff G said it should and confirmed the order did not. Regarding Resident 56's Carvedilol, Staff G confirmed the dates the medication had been given outside of the ordered parameters and said this did not meet her (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expectations. Resident 2 Resident 2 was admitted to the facility on [DATE] with a diagnosis of dementia (decline in cognitive function severe enough to interfere with daily life). The Quarterly MDS, dated [DATE], showed Resident 2 had severe cognitive impairment. Review of Resident 2's pain medications, showed they had an order for 3 times a day scheduled oxycodone (opioid, strong pain medication), ordered on 06/01/2026, which only specified to be held for sedation. Resident 2 had an additional oxycodone order, ordered 06/01/2026, for as needed pain 3-10/10 pain. Resident 2 had an order for Tylenol, for mild discomfort, ordered on 04/14/2026. Review of Resident 2's June 2026 Medication Administration (MAR), showed scheduled oxycodone was given for 0/10 pain or not applicable (no pain) for 41 administrations: on 06/02/2026, 06/04/2026 (3 times), 06/05/2026 (twice), 06/06/2026 (twice), 06/07/2026 (3 times), 06/08/2026, 06/09/2026 (3 times), 06/10/2026 (3 times), 06/11/2026, 06/12/2026, 06/13/2026 (3 times), 06/16/2026, 06/17/2026, 06/18/2026, 06/19/2026 (twice), 06/20/2026 (twice), 06/21/2026 (3 times), 06/22/2026, 06/23/2026, 06/26/2026 (twice), 06/27/2026 (twice), and 06/28/2026 (twice). As needed oxycodone- given 06/08/2026 and 06/20/2026 As needed Tylenol- not given Review of Resident 2's July 07/01/2026 to 07/06/2026 MAR, showed: Scheduled oxycodone was given for 0/10 pain or not applicable (no pain) on: 07/02/2026 (twice), 07/04/2026, 07/05/2026 (3 times), and 07/06/2026 (three times). As needed oxycodone- not given As needed Tylenol- not given Review of Resident 2's June 2026 sleep tracker, showed on days nurses completed the tracker, Resident 2 often exceeded 8 hours of sleep in 24 hours, and had days with longer amounts of sleep such as 06/01/2026 with 14 hours of sleep, 06/06/2026 with 18 hours of sleep (given their schedule opioid twice this day for 0/10 pain), 06/18/2026 with 14 hours of sleep. During an interview on 07/08/2026 at 2:01 PM, Staff F, RN, said Resident 2 was unable to verbalize their pain, they assumed Resident 2 had aches and ailments due to their age, and they found it hard to tell if the scheduled opioid was effective due to Resident 2's fast mood changes at baseline. Staff F was able to see in the record that Resident 2 had not received their as needed Tylenol medication since 05/26/2026. During an interview on 07/08/2026 at 2:48 PM, Staff D, RCM/RN, said for residents with a diagnosis (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Fir Lane Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of dementia, the process for reevaluating the necessity of schedule pain opioids, was for them to offer a non-pharmacological intervention first, Tylenol, then if those were ineffective then the opioid medication. The provider should review weekly if the medications were effectively working, look at the pain scales/staff documentation, and review sleep patterns. Staff D reviewed Resident 2's records and confirmed the scheduled opioid was given for 0/10 pain and without any Tylenol given for June or July 2026. Staff D said their expectation was for the opioid pain medication to have parameters (pain scale) for administering the medication, especially when non-opioid pain medications were available. At 4:13 PM, Staff D said they had followed up with the provider and they would schedule Tylenol, and the opioid medication should be held if not having any pain. During an interview on 07/10/2026 at 12:28 PM, Staff B, Director of Nursing Services (DNS), when asked about expectations regarding Resident 2's opioid being given for 0/10 pain, not giving any as needed Tylenol, and not reassessing for the necessity of the pain medication, said the orders for Tylenol and the opioid had been switched because they agreed with the concern. Resident 82 Resident 82 was admitted to the facility on [DATE] with a diagnosis of dementia. The Quarterly MDS, dated [DATE], documented Resident 82 was unable to complete the interview for cognitive status. A review of Resident 82's Electronic Health Record (EHR) showed an order for: Miralax Oral Powder Give 1 scoop by mouth two times a day for constipation, dated 01/14/2025. A review of the consultant pharmacist's medication regimen review, dated 02/24/2026, documented, Resident has scheduled order for Miralax. Please consider adding hold for loose stools'. On 07/09/2026 at 2:53 PM, Staff B, DNS, said the nursing staff usually put those orders in and it did not look like it was addressed for Resident 82. Staff B said their expectation was for the provider to be updated and the recommendation to be followed and appropriately adjusted. Reference WAC 388-97-1060 (3)(k)(i)		

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NAME OF PROVIDER OR SUPPLIER Fir Lane Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2430 North 13th Street Shelton, WA 98584	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to ensure a medication error rate less than 5 percent (%). During observation of 25 opportunities for error, 1 of 3 Licensed Nurses (Staff H) made 2 errors, an error rate of 8%. This failure placed residents at risk for adverse side effects related to not following parameters and not receiving the correct medication according to the physician orders. Findings included .The facility policy titled Medication Administration updated 12/2024, stated 7. Hold medication per Provider orders if vital signs/blood sugars are outside of the parameters. Notify the Provider per Provider Orders. And 12. Verify the correct medication, expiration date, dose, dosage form, route, and time again by comparing to MAR [Medication Administration Record] before administering. ERROR 1During medication pass observation on 07/08/2026 at 7:51 AM, Staff H, Licensed Practice Nurse (LPN), administered a medication, Lasix (used to treat fluid retention by rapidly increasing urine output, reducing swelling, and lowering blood pressure), to Resident 35, with an order to notify the provider if the systolic blood pressure (the top number in a blood pressure reading and it measures the maximum force your blood exerts against artery walls when your heart beats.) was less than 110 or the pulse (heartbeat) was less than 60. On 07/08/2026 at 10:16 AM, Staff H, LPH, was asked if they took Resident 35's vital signs prior to giving Lasix and Staff H, LPN said no. On 07/08/2026 at 11:01 AM, Staff B, Director of Nursing Services (DNS), said the Lasix order had parameters for the blood pressure and pulse and they were not taken by the nurse prior to administering the medication. We have educated the staff to make sure they follow the parameters of medication orders. ERROR 2During a medication pass observation on 07/08/2026 at 7:51 AM, Staff H, LPN gave Resident 35, 5 ml (milliliter- a metric unit of volume equal to one-thousandth of a liter) of a cough medicine Geri-Tussin and the physician order was NyQuil Cold & Flu 30ml. On 07/08/2026 at 10:16 AM, Staff H, LPN, was asked if Geri-Tussin and NyQuil Cold & Flu were the same medications with the same ingredients. Staff H said no they do not have the same ingredients. Staff H said, the Geri-Tussin was house stock and this was what we had been giving. Staff H said while looking at the Geri-Tussin bottle, I have been giving 5 ml but it says 10 ml on the bottle. Staff H said they had not been giving the correct amount of Geri-Tussin. On 07/08/2026 at 11:01 AM, Staff B, DNS, said Geri-Tussin was the wrong medication, and the order was discontinued. Staff B said the provider was notified. Reference WAC 388-97-1060 (3)(k)(ii)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Fir Lane Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2430 North 13th Street Shelton, WA 98584	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
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 maintain complete and accessible medical records of hospice nursing and hospice health aide visits for 1 of 1 Residents (Resident 3) reviewed for hospice. This failure placed residents at risk of not having a record of assessments and services provided and a decreased quality of care. Findings included. Review of the Nursing Facility Services Agreement with Assured Home Health and Hospice, effective as of 10/01/2019, documented under coordination of care that hospice and the facility should communicate with one another regularly and as needed for each particular hospice patient, and each party was responsible for documenting such communication in its respective clinical records to ensure that the needs of hospice patients were met 24 hours per day. Resident 3 was re-admitted to the facility on [DATE] with hospice services in place. The admission Minimum Data Set assessment, dated 06/17/2026, documented Resident 3 was severely cognitively impaired. On 07/10/2026 at 10:48 AM, review of Resident 3's hospice binder, kept at the nurse's station, showed the hospice certification and plan of care were in the binder but the binder contained no record of hospice nursing or health aide visits. The hospice plan of care showed that Resident 3 was to be seen by the hospice nurse 2 times a week for 13 weeks with 4 as needed visits for urgent symptom management needs or a change in condition. The hospice health aide was to visit 1 time a week for 1 week and then 2 times a week for 12 weeks. Review of the electronic health record (EHR) for Resident 3 showed no record of visits with subsequent visit notes from hospice staff were recorded since admission to the facility on [DATE]. On 07/10/2026 at 10:29 AM, Staff G, Resident Care Manager/Registered Nurse, when asked who was responsible for coordinating hospice care for residents on hospice, said the interdisciplinary team collectively looked at hospice patients but that she would coordinate with the hospice nurse regarding nursing services. When asked how hospice staff visits were recorded, Staff G said the hospice staff would write notes in the resident's hospice binder where the care plan, certificate period, orders and progress notes were written and then it would be uploaded into the resident's EHR. Staff G said Resident 3 received nurse visits, and bath aide visits. When asked if Resident 3 had regular visits from hospice staff, Staff G said that week the hospice nurse had come in 3 times, but Resident 3 had previously been having daily visits. Staff G said Resident 3 went onto hospice services on 06/09/2026. When asked where the hospice visit notes from hospice staff were located for Resident 3, Staff G looked in the EHR and said she would call the hospice and get the documentation. On 07/10/2026 at 10:42 AM, Staff G said the hospice nurse was going to send the documentation of the hospice visits. When asked if the hospice visits should have been documented and in the EHR, Staff G said yes. Review of the Hospice Client Coordination Note Reports (hospice visit notes), received from Staff G on 07/10/2026 at 11:40 AM, showed between 06/11/2026 and 07/09/2026, Resident 3 had 20 nursing visits that had not been recorded in the EHR. No records of health aide visits were provided. Reference WAC 388-97- 1720 (1)(a)(i-iv)(b)		