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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505243	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olympia Transitional Care and Rehabilitation	430 Lilly Road Northeast Olympia, WA 98506

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 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** 49451 Based on interview and record review the facility failed to complete wound care per physician's orders for 1 of 3 residents (Resident 2) reviewed for quality of care. This failure placed residents at risk for prolonged wound healing and infection. Findings included . Resident 2 was admitted to the facility on [DATE] with diagnoses including diabetes, orthopedic aftercare following surgical amputation and peripheral vascular disease (condition reduces blood flow to arms, legs, or other parts of the body). The 5-day Minimum Data Set, an assessment tool, dated 07/30/2024, showed Resident 2 had cognitive impairment and was dependent on staff for bathing, toilet use and transfers. Resident 2's admission assessment, dated 07/23/2024, showed Resident 2 had a 21.5 centimeter surgical incision with staples. Review of a physician's order, dated 08/12/2024, showed the resident had a surgical incision to left knee to be cleaned with wound cleanser, skin prep applied and cover with a dry dressing daily and ace wrap every day as needed. Resident 2's electronic treatment administration record (ETAR) showed the treatment was not signed as completed on 08/12/2024 and was documented as completed on 08/13/2024 and 08/14/2024. Review of Resident 2's provider note, dated 08/14/2024, showed unacceptable management of [Resident 2's] wound. Review of a statement by Registered Nurse, Staff C showed I did not do the dressing that I signed for on 8/13 and 8/14. When I looked at the TAR I did not read entirely and thought it was for monitoring of the dressing instead of a dressing change. On 10/04/2024 at 11:00 AM, Director of Nursing Services, Registered Nurse, Staff B, acknowledged Resident 2's surgical dressing was not changed daily per physician's orders on 8/12/2024, 08/13/2024 and 08/14/2024 and the resident was no longer a resident at the facility. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/04/2024
NAME OF PROVIDER OR SUPPLIER: Olympia Transitional Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 430 Lilly Road Northeast Olympia, WA 98506	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/04/2023 Staff A, Administrator and Staff B, said after the incident was reported to them they immediately began working on and developed an internal plan of correction which included, in-servicing of staff, audits of skin related records and skin sweeps (observing all resident's skin). Staff A said they had achieved compliance as of 08/26/2024. Review of documentation and interviews determined the facility had achieved compliance as of 08/26//2024. Past noncompliance - no plan of correction required Reference WAC 388-97-1060 (1) .