

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

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Form Approved OMB
No. 0938-0391

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 07/30/2026
NAME OF PROVIDER OR SUPPLIER Olympia Transitional Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on observation, interview and record review, the facility failed to provide adequate fluids, within reach of the residents, to maintain hydration for 1 of 4 hallways (Dementia Unit) reviewed for hydration. This failure placed residents at risk for dehydration, medical complications and a diminished quality of life. The findings included. Review of the facility procedure, titled Hydration Rounds Procedure updated 01/21/2026 documented .1. Day shift to collect water pitchers when collecting lunch trays. 2. Eve [evening] shift to retrieve clean water pitchers from the kitchen, fill them with ice water, and pass the pitchers out to residents on the hall. On 07/29/2026 at 3:20 PM, observations were made with Staff C, Unit Manager on the dementia unit (a secure dedicated wing providing 24 - hour nursing care, specialized memory loss supervision, and structured cognitive activities for patients with Alzheimer's or other Dementias) showed 11 residents did not have a water pitcher or any fluids available to drink at their bedside. During an interview on 07/29/2026 at 3:30 PM, Staff C was asked how residents are to have water if the water pitchers were removed at lunch (12:00 PM) and were not returned for several hours by the next shift. Staff C acknowledged the facility has a process for staff to pick up dirty water pitchers with the lunch trays and evening shift staff are to return clean water pitchers to resident rooms. Staff C stated she was unsure why water pitchers were not replaced and acknowledged 11 residents did not have water available in their rooms at that time. During an interview on 07/29/2026 at 4:30 PM, Staff A, Administrator, acknowledged the facility had completed corrective actions related to hydration in the dementia unit. He stated his expectation would be for residents to always have access to water or fluids at their bedside. Reference WAC 388-97-1060(3)(i)		

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