

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/12/2025
NAME OF PROVIDER OR SUPPLIER  Roo Lan Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1505 Carpenter Road SE Lacey, WA 98503	

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)
<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49451</b></p> <p>Based on interview and record review the facility failed to ensure staff performed Cardio-Pulmonary Resuscitation (CPR/an emergency procedure consisting of chest compressions combined with giving breaths of air) and failed to assure required staff had unexpired CPR certifications for 1 of 1 resident (Resident 1) who was found unresponsive and had a physician's order for CPR. The failure of facility staff to initiate CPR placed all residents who chose to have CPR initiated at risk for serious injury, harm, impairment or death and represented an Immediate Jeopardy (IJ) situation.</p> <p>On [DATE] at 2:45 PM, the facility was notified of an IJ at CRF 483.24 (a)(3), F678 CPR, the IJ was determined to have begun on [DATE] when the facility failed to perform CPR. The facility's failure placed residents at risk for serious injury, harm, impairment or death. The facility removed the immediacy on [DATE] with an onsite verification by the investigator by review of staff education, verification staff obtained active CPR certifications, conducting staff interviews related to staff re-education regarding CPR policies and procedures which ensured an effective system was in place to safeguard, protect and prevent residents who require CPR.</p> <p>Findings included .</p> <p>Review of the facility's policy, titled Medical Emergency Response, undated showed the following:</p> <ol style="list-style-type: none"> <li>1. The employee who first witnesses or is first on site of a medical emergency, that are trained, will initiate immediate action, including CPR as appropriate, basic first aid and summon for assistance.</li> <li>2. CPR will continue unless: a. There is a DNR [Do Not Resuscitate] in place b. There is obvious signs of clinical death c. Initiating CPR could cause injury or peril to the rescuer.</li> <li>3. A licensed nurse will: a. Assess the situation and determine the severity of the emergency. b. Stay with the resident. c. Designate a staff member to announce a Code Blue, if necessary, notify the physician and call 911 as needed .</li> <li>8. If the resident experiences cardiac arrest, the facility must provide basic life support, including CPR, prior to the arrival of emergency medical services, and: a. In accordance with the resident's advanced directives, or b. In absence of advanced directives or a Do Not Resuscitate order, and c. If the resident does not show obvious signs of clinical death .</li> </ol> <p>(continued on next page)</p>

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident 1 was admitted to the facility [DATE] with diagnoses including bladder cancer and diabetes. The quarterly Minimum Data Set (MDS), an assessment tool, dated [DATE], showed the resident was alert and oriented and required staff assistance for activities of daily living.</p> <p>Resident 1's POLST (Physicians Order for Life Sustaining Treatment) form, dated [DATE], showed to attempt resuscitation/CPR, full treatment, use intubation, advanced airway interventions, mechanical ventilation, cardioversion (medical procedure used to restore a normal heart rhythm by delivering electrical shock) as indicated, transfer to hospital if indicated, including intensive care treatment.</p> <p>Resident 1's nurse's note, dated [DATE] at 7:02 AM, showed at around 11:50 PM a Certified Nursing Assistant (CNA) checked on Resident 1 and noted the resident would not respond back to her. The CNA reported Resident 1 was not breathing. Staff C, Licensed Practical Nurse (LPN) assessed the resident and noted the resident had no chest movement and no pulse. Staff C called Staff E, Registered Nurse (RN), (who's CPR certification was not on file and could not be verified as Staff E would not return calls from facility or state surveyor) to assess Resident 1. Staff E auscultated (listened with a stethoscope) to Resident 1 for a full minute and concluded Resident 1 had passed.</p> <p>Review of the facility investigation included the following statement, dated [DATE], by Staff D, CNA, showed I went to check on [Resident 1] and asked him to wake up. I went to find the nurse and ask her to check on [Resident 1] and she realized he had passed away.</p> <p>Review of the facility investigation showed the following statement by telephone on [DATE] by Staff C: [Staff C] stated at 10:30 PM she was called to [Resident 1's] room by a CNA who said [Resident 1] was not responding to verbal or tactile stimuli. [Staff C] said she went to [Resident 1's] room and found the resident unresponsive. [Staff C] stated she went to get [Staff E]. [Staff E] came to [Resident 1's] bedside and observed [Resident 1] had no signs of life. [Staff C] said [Resident 1] was cool to touch and his jaw was stiff. [Staff C] said there had been a conversation earlier in the day regarding a change of code status but was unsure if that had been completed.</p> <p>In an interview on [DATE] at 4:02 PM, Staff A, Administrator and Staff B, Director of Nursing (DNS)/Registered Nurse said Resident 1 had a POLST which indicated full CPR. They said Resident 1 was found unresponsive by Staff D who left the resident to find a nurse and did not initiate CPR. Staff A and B said Staff C came to Resident 1's bedside, found the resident unresponsive and did not initiate CPR or activate emergency response, and left Resident 1's bedside to find a nurse (Staff E). They said CPR was not initiated and 911 was not notified and the facility did not follow their emergency response protocol and Resident 1 expired in the facility. Staff A and B said during the investigation they noted numerous staff did not have current CPR certification.</p> <p>In an interview on [DATE] at 1:43 PM, Staff C said she was the nurse responsible for Resident 1 on the night he expired. Staff C said she finished passing medications and a CNA reported they thought the resident wasn't breathing. Staff C said she went to Resident 1's room and watched for chest movement and saw no chest movement. Staff C said she called Staff B and they didn't answer. Staff C said she left Resident 1's room to find another nurse to check the resident. Staff C said Staff E, Registered Nurse came to Resident 1's room and agreed Resident 1 had expired. Staff C was asked why they didn't initiate CPR. Staff C said I thought they changed his [Resident 1]'s code status.</p> <p>Reference WAC [DATE] (1)</p>		