STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505254	A. Building B. Wing	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roo Lan Health & Rehab	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)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to obtain weights and failed to provide a recommended nutritional supplement for 1 of 3 (Resident 1) residents reviewed for nutrition. The facility's failure placed residents at risk for weight loss and decreased quality of life.Findings included.Review of the facility's policy, titled, Nutritional Management, undated, showed nutritional recommendations may be made by the dietician based on the resident's preferences, goals, clinical condition and other factors and followed up with the physician/practitioner for orders as per facility policy.Resident 1 was admitted to the facility on [DATE] with diagnoses including non-traumatic subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain), cerebral aneurysm (weakness in the blood vessel in the brain that balloons and fills with blood), hemiplegia/hemiparesis (muscle weakness or partial paralysis on one side of the body) and dysphagia (difficulty in swallowing). The Minimum Data Set (MDS), an assessment tool, dated 05/13/2025, documented Resident 1 was cognitively intact, was on a mechanically altered diet and required staff supervision to eat.Review of a Physician's Orders for Resident 1, dated 05/09/2025, showed an order for admission weights (wt) for three days.Resident 1's weight, documented on 05/12/2025, was 138.3 pounds (lbs). No other weights were documented until 07/11/2025.Resident 1's Nutrition evaluation, dated 05/12/2025, showed Resident 1's weight was 144 lbs, ideal wt was 161 lbs, eating 50% of the previous nine meals, pureed diet, pudding thick, and to add Benecalorie (nutritional supplement designed to combat unintended weight loss) three times per day.Review of Resident 1's care plan, dated 06/07/2025, showed a potential/nutritional problem related to dysphagia (difficulty swallowing) with interventions including weekly weights.Review of Resident 1's Nutrition at risk (NAR) documentation, dated 06/24/2025, showed to obtain updated weight to confirm adequacy of intake (requested from nursing).Review of Resident 1's Nutrition at risk (NAR) documentation, dated 07/01/2025, showed to obtain updated weight to confirm adequacy of intake (requested from nursing).In an interview on 07/11/2025 at 1:10 PM, Staff B, Director of Nursing, acknowledged Resident 1 was at risk for weight loss and the resident did not have admission weights for the first three days and was not weighed weekly thereafter. Staff B acknowledged the Dietician recommended benicalorie (a nutritional supplement), the Dietician recommendation was not forwarded to the physician and Resident 1 did not receive the recommended dietary supplement. Reference WAC 388-97-1060(3)(h)

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