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	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Cove Post Acute	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a comfortable homelike environment by not providing adequate heat in resident rooms in 3 of 4 hallways reviewed for comfortable temperature. This failure placed residents at risk for diminished quality of life.Findings included.Review of facility documentation titled, Logbook Documentation showed All buildings are required to maintain an ambient temperature throughout resident and patient care areas in a temperature range of 71 to 81 degrees Fahrenheit [F] or at a more restrictive range required by state or local requirements.During a telephone interview on 12/5/2025 at 11:00 AM, Collateral Contact 1 said they placed a digital thermometer in Resident 7's room and installed a temperature app on their phone so they could monitor the temperature of the resident's room as the room had been cold. They said Resident 11's room temperatures were as follows:10/14/2025 12:05 PM - 62 degrees F10/15/2025 2:20 PM - 61.7 degrees F10/16/2025 5:00 AM - 63.1 degrees F11/8/2025 10:12 AM - 64.4 degrees F11/9/2025 11:00 AM - 60.2 degrees FDuring observation and temperature check of facility on 11/24/2025 at 1:41 PM, with Staff C, Maintenance Director, the following room temperatures were observed:Hallway CHallway C - Temperature 65 degrees [NAME] (Rm) 28 - Temperature 67.3 degrees FRm 27 - Temperature 63.3 degrees FRm 26 - Temperature 60.6 degrees F. Resident 12 was in room in her bed and was asked if their room was cold? Resident 12 said Yes, it is coldRm 21 - Temperature 66 degrees FRm 22 - Temperature 61.7 degreesRm 23 - Temperature 59 degrees FRm 24 - Temperature 58.1 degrees FHallway BHall B - Temperature 70 degrees FRm 10 - Temperature 70.9 degrees FRm 11 - Temperature 70 degrees FRm 14 - Temperature 65 degrees F. Resident 10 was seated in their wheelchair in room and was asked if their room was cold. Yes it is, I told them but they told me this room is always cold.Rm 15 - Temperature 65.5 degrees FRm 16 - Temperature 65.5 degrees FRm 17 - Temperature 64.2 degrees FHallway A RM [ROOM NUMBER] - Temperature 59 degrees FRm 6 - Temperature 66 degrees F. Resident 11 was asked if their room was cold and they responded, Yes, it is but I don't mind it coolRM 3 - Temperature 64.2 degrees FRm 2 - Temperature 65.8 degrees FRm 9 - Temperature 70 degrees FDuring an interview on 11/24/2025 at 1:45 PM, Staff C was asked if resident room temperatures were cold. Staff C stated the boiler room controlled the heat in the hallway for Halls A, B, C and D, and each resident room had a heater but to turn on the heat the screen must be removed by maintenance, cleaned and then the heat needed to be manually turned on in each resident room. Staff C stated he did turn on the heat for Resident 7 after her family had concerns the resident room was cold and had turned the heat on in resident's rooms, if requested, but he had not cleaned and turned on heaters in each resident room. He acknowledged most resident rooms in hallway A, B and C did not have heaters on at that time. He acknowledged the facility has had work done on the HVAC (Heating, Ventilation, and Air Conditioning) system and still required parts to be replaced. He stated the last maintenance director and crew had not ensured that resident heaters were cleaned and maintained. Staff C acknowledged room temperatures should be between 71 and 81 degrees F or per resident preference.During an interview on 11/18/2025 at 3:00 PM with Staff D, Licensed Practical Nurse, said there were some heat outages in the facility but could not recall exactly when but that it was over a weekend. Staff D said she told maintenance when she saw him but they didn't call him in. Staff D said they gave extra blankets to residents and that residents were complaining that it was cold.During an interview on 11/18/2025 at 3:30 PM with Resident 13 they were asked if it had been cold in their room? Resident 13 said it had been cold in her room. She stated It was so cold I didn't want my shower.Reference WAC 388-97-0880 (3)

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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 observation, interview, and record review, the facility failed to ensure wound and indwelling catheter (flexible tube inserted into the bladder to drain urine) cares were provided to 1 of 3 residents (Resident 3) reviewed for quality of care. This failure placed residents at risk for developing infection and diminished quality of lifeFindings included .Review of the facility policy, titled Wound Treatment Management, undated, showed, wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing [NAME]. In absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. Treatments will be documented on the Treatment Administration Record or in the electronic health record.Review of the facility policy, titled Catheter Care, undated, showed, catheter care will be performed every shift and as needed by nursing personnel.Resident 8 was admitted to the facility on [DATE] with diagnoses of multiple fractures of pelvis, ribs and 1st vertebrae and a subarachnoid hemorrhage (bleeding into the brain and its surrounding membrane). admission Minimum Data Set (MDS), dated [DATE], showed resident was alert and oriented and required staff assistance for most Activities of Daily Living, had an indwelling catheter and had surgical wounds which required surgical wound care.Review of Resident 8's physician's order, dated 10/27/2025, showed wound care to external fixator (an external metal frame used to stabilize and realign broken bones, especially for complex fractures, by inserting pins through the skin into the bone, which are then connected to the frame outside of the body Included to cleanse pin sites with normal saline daily and as needed. This order was written four days after Resident 8's admission to the facility. Review of Resident 8's physician's order, dated 10/27/2025, showed to monitor external fixator every shift and as needed and to monitor for breakdown two times per day. This order was written four days after Resident 8's admission to the facility.Review of Resident 8's electronic treatment administration record, dated 10/2025, showed treatment for the external fixator was not completed for the first four days after admission.Review of Resident 8's physician's order, dated 10/30/2025, showed to complete FOLEY CATH CARE every shift. This order was placed seven days after admission and the day of the resident's discharge from the facility. Review of Resident 8's physician's order, dated 10/31/2025, showed to Change Foley Cath Bag one time a day every 15 day(s). This order was placed eight days after admission and one day after the resident left the facility.Review of Resident 8's electronic treatment administration record dated 10/2025 showed no documented catheter care was completed.During a telephone interview on 11/21/2025 at 10:35 AM, Collateral Contact 2 stated the facility did not change the resident's surgical dressing for long periods of time and did not complete catheter care. They stated the resident was fed up and left the facility against medical advice (AMA).During an interview on 12/03/2025 at 3:14 PM, Staff B, Director of Nursing (DNS) said Resident 8 was to the facility on [DATE] and the catheter was identified on the care plan as well as the external fixator. Staff B confirmed there was no documentation in the electronic medical record that care was provided for the indwelling catheter until discharge 10/30/25 nor was treatment provided for the external fixator until 10/28/25 (5 days after admission). Staff B said the nurse identified it on the admission assessment but did not obtain treatment orders for the resident's catheter or wounds.Reference WAC 388-97-1060 (1)-(3)