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	01/02/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - 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 provide staff supervision and implement fall prevention strategies for a resident assessed at high fall risk for 1 of 3 residents (Resident 1) reviewed for falls. Resident 1, who had at least three prior unwitnessed falls from their bed, experienced harm when they were positioned on the edge of their bed unsupervised, was subsequently found on the floor and required transfer to the hospital where they were diagnosed with multiple fractures at the right wrist. This failure placed resident at risk for falls, injury and decreased quality of life. The findings included.Resident 1 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD) (kidneys are failing and can no longer filter waste from the blood and requires dialysis or a kidney transplant), and atrial fibrillation (irregular and often rapid heart rhythm). The resident's Minimum Data Set assessment, dated 10/16/2025, showed the resident was cognitively intact, had no behaviors, used a wheelchair (w/c) and required substantial staff assistance for rolling, sit to lie positioning, dependent on staff for chair to bed transfers and was frequently incontinent of bladder and bowel.Review of Resident 1's Physical Therapy (PT) Evaluation, dated 04/26/2025, showed .Patient presents with balance deficits, decreased safety awareness, decreased static balance (trouble staying steady while standing still), joint mobility/integrity deficits, postural alignment/control and strength impairments which requires skilled PT services .Review of Resident 1's PT Discharge summary, dated [DATE], showed .Roll left and right .Partial/Moderate Assist .Sit to lying . Substantial/Maximal Assist .Lying sitting on side of bed .Substantial/Maximal Assist .Sit to stand . Partial/Moderate Assist .Patient has reached maximum potential with skilled services .Review of a facility document titled Therapy RA [Restorative Aid] Referral Form, undated showed .Precautions R [right] shoulder chronic dislocation .Comments .Requires frequent rest breaks, easily fatigued .Fall #1Review of Resident 1's progress note, dated 08/13/2025, showed the resident had an unwitnessed fall in his room and sustained a laceration to the right temple. The resident was transferred to the hospital for evaluation and treatment and received sutures to the laceration.Review of Resident 1's progress note, dated 08/14/2025, showed the resident stated he sat near the edge of the bed and slid to the floor. The intervention implemented was to ensure the resident was not sitting at the edge of the bed, offer resident to sit in w/c or go to the dining room for meals.Fall #2Review of a facility documentation for Resident 1's fall dated 09/20/2025 showed the resident had an unwitnessed fall from the resident's bed and was found on the floor leaning on his bed with an abrasion to his left knee. The documentation showed predisposing physiological factors include loss of balance. Resident 1 was assessed and assisted back to bed using a mechanical lift. Facility investigation showed the resident was unable to describe what happened and sustained an injury [abrasion] to the left knee. New intervention to do frequent checks when the resident was in bed.Resident 1's Fall Assessment, dated 09/20/2025, showed score of 80 (high risk 45 and higher).Review if Resident 1's care plan, revised 9/22/2025, showed resident at risk for falls with intervention to encourage resident to be up in w/c for meals in dining room and reposition resident in the middle of the bed.Fall #3Review of the facility documentation, dated 10/22/2025, showed Resident 1 had an unwitnessed fall and was found on the floor in the resident's room, near his bed by the window. Resident 1 stated they slid down to the floor. The investigation showed the resident continuously leaned on his left side, despite being repositioned. The resident reported the mattress shifted causing him to slide to the floor. Intervention implemented was to ensure mattress was securely fastened to the bed frame and resident positioned away from the edge of the bed when sleeping. Resident 1's Falls Assessment, dated 10/22/2025, showed score 60 (high risk for > 45).Review of Resident 1's care plan, revised 10/24/2025, showed during safety rounds ensure the mattress was well secured.Fall #4Review of the facility investigation, dated 11/29/2025 at 5:55 PM, showed Resident 1 had an unwitnessed fall in the resident's room. The resident returned from dialysis around 12:00 PM. At 4:30 PM, Staff C, Certified Nursing Assistant (CNA) offered to transfer Resident 1 to his w/c but the resident stated he preferred to have dinner in his room while sitting at edge of the bed. The resident was served his meal seated at the edge of the bed. Resident 1's roommate notified staff Resident 1 was on the floor. The fall resulted in the resident sustaining a non-displaced (cracked but stays in alignment) right distal radial (forearm bone on the thumb side) metaphysis (weaker section of bone) fracture.Review of hospital documentation, dated 12/01/2025, showed the resident sustained a non-displaced distal right radial metaphysis fracture and suspected non-displaced ulnar metaphysis fracture without joint malalignment. A