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	01/13/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to secure cigarettes and failed to complete a smoking assessment for 1 of 3 residents (8) reviewed for accident hazards. The facility also failed to maintain an environment with adequate lighting (the lights were turned off) related to resident safety for 31 for 31 residents utilizing the smoking area. These failures placed residents at risk for accidents, injury and a diminished quality of life. Findings included .Resident 8 Resident 8 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS, an assessment tool), dated 11/07/2025, documented the resident was cognitively intact and had current tobacco use. Unsecured Cigarettes On 01/05/2026 at 12:11 PM, Resident 8 said I have my cigarettes in my drawer. Cigarettes were observed in the top drawer of the cabinet by Resident 8's bed. On 01/06/2026 at 12:59 PM, Staff Q, Licensed Practical Nurse, went into Resident 8's room and collected the cigarettes from the drawer by the bed. Staff Q said they should have been locked in the treatment cart with Resident 8's name on it. On 01/13/2026 at 8:04 AM, Staff B, Director of Nursing Services said he spoke to Resident 8 and Resident 8 said they recently purchased the cigarettes. Staff B said his expectation was for the residents to give staff their cigarettes when they purchased them so they could be locked up in the treatment cart. Smoking Assessment A review of Resident 8's smoking assessment, dated 11/01/2025, showed blanks (no documentation) for headings: medications, resident behaviors, and nursing assessment of smoking safety. On 01/12/2026 at 8:30 AM, Staff D, Resident Care Manager/Registered Nurse said Resident 8's smoking assessment was not complete and said they would have to go back and reevaluate Resident 8. Adequate Lighting in Smoking Area On 01/07/2026 at 12:30 PM, the resident smoking area was observed. To access the resident smoking area, residents exited the building through the dining room door, proceeded down a wide concrete area (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 - Minimal harm or potential for actual harm Residents Affected - Few	that led to the back of the building, then turned left down on the sidewalk that ran between the back of the facility and a wood fence (a string of flood lights were observed running along the top of the fence). The sidewalk was straight with exception of a small left, right, S curve at the end that had to be navigated before reaching the smoking area which consisted of three freestanding canopies. On the right side of the S curve, there was a 4-6 inch drop off or rut between the edge of the sidewalk and a large planter that was positioned next to the sidewalk. Tracks from wheels were visible in the dirt/mud at the bottom of the rut. On 01/07/2026 at 12:33 PM, Staff CC, Helping Hands, who supervises smoking, and Residents 52, 19 and 89 were in the smoking area. When asked if there had been any issues with lighting Staff CC said yes and explained some residents were smoking pot and a whiskey bottle was found near the smoking area. Due to this, facility management decided to stop turning the flood lights on that provided lighting for the smoking area after dark. When asked if residents still used the area after dark and whether it created a safety hazard, Resident 19 called out Yes, I am lucky I didn't flip over and hit my head and motioned to the rut along the edge of the sidewalk on the S curve. Residents 19 and 89 both indicated it was dangerous due to the narrow sidewalk, uneven surfaces and it was pitch black. Staff CC confirmed residents continued to use the smoking area in the dark and reported that the first night the lights were off Resident 52 fell while walking back from the smoking area. Staff CC said she was not present at the time of the fall, but Resident 52 told her the next day while he was smoking. Resident 52, who was present and listening, said he was walking back from the smoking area, and it was pitch black because the lights were off and then suddenly, he was on the ground and a girl came and helped him. Resident 52 said he wasn't sure why or what caused him to fall because he couldn't see. On 01/08/2026 at 4:45 AM, the string of flood lights along the top of the fence were on and effectively lit the pathway and smoking area. Two weathered solar lights were observed by the center smoking canopy but projected only a very faint glow. No lighting was present on the back of the building. The sole source of light was provided by the string of flood lights. On 01/13/2026 at 1:13 PM, while observing multiple areas along the sidewalk where there were immediate 2–6-inch drop-offs, Staff CC approached and reported that residents had gone off the edge and got stuck. Staff CC explained the ruts along the sidewalk leading to the front of the building were where Residents 86 and 69's electric wheelchairs would go off the edge because the sidewalk was too narrow and indicated sometimes, they could get out on their own with their electric wheelchairs and sometimes they needed assistance. Tracks from wheels were visible in the mud at the bottom of the ruts. On 01/13/2026 at 1:58 PM, Staff B, Director of Nursing Services, toured the courtyard and confirmed the ruts along the edge of the sidewalk. On 01/13/2026 at 2:28 PM, Staff A, Administrator, acknowledged the facility stopped turning on the lights for the smoking area but said prior to doing so, they placed solar lights in the courtyard so residents would have light and could still safely access the smoking area but indicated the solar lights malfunctioned. On 01/15/2026 two receipts for solar lights were received via email at 4:36 PM. One receipt showed a four pack of solar path lights that was purchased on 01/09/2026 and the other showed a two head motion sensor light that was purchased on 01/14/2026. These purchases occurred after the lighting for the smoking area had been reinstated. Reference WAC 388-97-1060 (3)(g)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on interview and record review, the facility failed to ensure residents approved of a 15-hour mealtime gap and were served a nourishing snack at bedtime, when the time between the dinner and breakfast meals was increased to 15 hours. This failure placed residents at risk of feelings of hunger and inadequate nutrition.Findings included.Review of the Resident Council (a self-governed, resident-led group) Minutes, dated 08/07/2025, included the following mealtime schedule:a) The Main Dining room was served dinner at 4:30 PM and breakfast at 7:30 AM (for a total of 15 hours in between meals).b) The A Hall was served dinner at 5:00 PM and breakfast at 8:00 AM (15 hours in between meals).c) The B Hall was served dinner at 5:20 PM and breakfast at 8:20 AM (15 hours in between meals).d) The C Hall was served dinner at 5:40 PM and breakfast at 8:40 AM (15 hours in between meals).e) The D hall was served dinner at 6:00 PM and breakfast at 9:00 AM (15 hours in between meals).Further review of the Resident Council Minutes, dated 08/07/2025, showed the dining time had been changed, and a flyer had been passed out and explained to each resident, done by Staff H, Activity Director. On 01/12/2026 at 9:04 AM, Resident 6, a member of Resident Council, was asked if the 15-hour gap between meals was voted on by resident council or if they were informed of the change. Resident 6 said the resident council was just told what the new mealtimes would be. Resident 6 said the facility told them the change was happening, the council did not vote, and if voting had been an option they would have voted against it. Resident 6 said this was why the facility put out snacks, but the residents had to ask for the snacks. On 01/12/2026 at 9:45 AM, Resident 25, when asked if they were offered a snack every evening said, it was hit and miss, and staff would say there were no snacks available.On 01/12/2026 at 12:38 PM, Resident 66, when asked if they were offered a snack every evening, said they had to ask for snacks and they never got them, staff would say they were out. On 01/08/2026 at 2:50 PM, Staff G, Dietary Manager, when asked about snacks said Certified Nursing Assistants (CNAs) and residents could come to the kitchen door to request them. Staff G said they would put a snack tray out after breakfast where the coffee was at the front desk and again at night before the last people leave. When asked about residents that were bed bound, Staff G said they were trying to think of a great system, CNAs or nurses could come get snacks for residents, but she would like to start a program for people that they did not see.On 01/09/2025 at 9:54 AM, Staff G was asked about the 15-hour gap between meals and if a substantial snack was offered, Staff G said that sandwiches, juice, milk were available. When asked if these were offered to residents in their rooms, Staff G said in the evening the CNA or nurse would get the sandwich for the residents, and she did not know if staff was going room to room offering them.On 01/12/2026 at 9:35 AM, Staff H, Activities Director, with Staff J, Activity Aide, present for interview. When asked if snacks were offered to residents in the evening, Staff H said she offered snacks throughout the day from her activities cart, at about 11:00 AM and 2:00 PM and that Staff J, would be doing it again at 6:00 PM. Staff H said there was a refrigerator that was stocked at night for the residents that they had access to with sandwiches and items for diabetics. On 01/12/2026 at 11:44 AM, Staff A, Administrator, when asked if a nourishing snack was served at bedtime, said yes, we have a cart, after dinner at 8:00 PM. When told residents reported they had to request a snack, Staff A said, they had got hit with this before and that was part of the adjustment, now CNAs and activities handed out snacks. Staff A said CNAs were supposed to go around with water and offer snacks, and activities went around with snacks at 8:00 PM. Staff A said Staff J, Activity Aide, would do an offering at 8-8:30 PM. When asked if there was documentation of the 8-8:30 PM snack, Staff A said (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there was no documentation.On 01/12/2026 at 12:23 PM, Staff J, Staff H, and Staff I, Admissions Coordinator, were interviewed. Staff J said they would do a snack cart at 3:00 PM and 8:00 PM. Staff H then said they just implemented new snack times, they would be 10:00 AM, 3:00 PM, and 8:00 PM. Staff H confirmed these new times were started that day.On 01/12/2026 at 12:30 PM, Staff K, Registered Dietician, when told the facility had 15 hours between dinner and breakfast and asked if anyone had made her aware of that, Staff K said no, but she knew the facility had evening snacks available. Staff K said she was unaware that when the time between mealtimes goes beyond 14 hours a nourishing snack must be served.On 01/13/2026 at 9:13 AM, an email request for facility policies to include snack policy was sent. At 11:54 AM, a return email was received from the facility that the policy for snacks was not included, due to them currently revising the offering/serving bedtimes snacks policy. Reference WAC 388-97-1120(1)(3)(a)(b)