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	06/02/2026

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 0684 Level of Harm - 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 interview and record review, the facility failed to timely recognize and respond to an acute clinical change in condition, contact on-call clinical leaership if the resident's condition does not clearly support in-house monitoring, and contact emergency medical services timely when the resident's condition appeared unstable or life threatening for 1 of 3 residents (Resident 1) reviewed for an acute change of condition. Resident 1 experienced harm when the facility delayed obtaining emergency medical services and access to a higher level of care despite signs and symptoms consistent with a significant change in neurological status. The resident was subsequently transferred to the hospital where they were diagnosed with a non-operable intracranial hemorrhage (brain bleed). Findings included.Resident 1 was admitted to the facility on [DATE] with diagnoses of rib fractures related to a fall (prior to facility admission) and a pulmonary embolus (clot in lung).In an interview on 05/27/2026 at 12:53 PM, Collateral Contact 1 (CC1), hospital staff member, said that Resident 1 discharged from their hospital to the skilled nursing facility on 05/22/2026 after a fall with fractured ribs and sternum. CC1 said Resident 1 was brought back to the hospital on [DATE] at 7:28 PM unresponsive and on mechanical ventilation/life support. CC 1 said the facility staff informed the emergency responders that Resident 1 was last seen responsive on 05/23/2026 between 4:00 PM and 5:00 PM and was not responsive thereafter and they did not call emergency medical services (EMS - 911) until 05/24/2026 at 6:50 PM. CC 1 said Resident was expected to pass away at the hospital.Resident 1's admission evaluation, dated 05/22/2026, showed Resident 1 needed extensive assistance with bed mobility and transfers, was independent with eating and was alert and oriented to person, place, time, situation and verbally appropriate.Resident 1's progress notes, dated 05/23/2026 at 4:28 PM, showed Resident 1 was alert and oriented times three [person, place and time] and made their wants and needs known and showered with assist.On 05/27/2026 at 4:10 PM, Staff A, Registered Nurse, said they were assigned to care for Resident 1 on the day shift on 05/24/2026. Staff A said their shift started at 6:00 AM. Staff A said they received report from the night shift, Resident 1 had slept through the night and there were no concerns reported. Staff A said the nursing assistant reported to Staff A that Resident 1 did not was up for breakfast. Staff A said they went to check on Resident 1 and they could not wake Resident 1 up. Staff A said Resident 1 would stretch, Staff A demonstrated the stretch by extending their arms down in front of them extended. Staff A said Resident 1 appeared to stay sleeping and made snoring sounds. Staff A said Resident 1's vital signs (clinical measurements to include heart rate, respirations and blood pressure) were stable, and they thought Resident 1 was exhausted. Staff A said eventually the staff took Resident 1's breakfast tray away because it had been two hours and Resident 1 still had not woken up. Staff A said they told their nursing assistants to let them know when they changed Resident 1's briefs. Staff A observed Resident 1 during the brief change and the brief was wet, the resident appeared to be sleeping and did not wake up during the care. Staff A said they called the medical provider and told the provider that Resident 1 was a new resident to them but let the provider know the resident had participated in care the day before. Staff A said they painted the picture; vital signs were stable (VSS), oxygen saturation (amount of oxygen circulating in blood) was 94% (normal range (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Actual harm Residents Affected - Few	is 95-100%), respirations were even, regular and the resident was snoring. Staff A said they notified the provider that they were in Resident 1's room and were unable to wake the resident up. Staff A said they notified the provider they had assessed Resident 1's neurological status by using the Glasgow Coma scale (GCS - a clinical scoring tool used to objectively measure a person's level of consciousness with a score of three to eight points indicating severe brain injury/coma), because that was the only way to assess the resident. Staff A said they reported Resident 1 had a GCS score of four and continued to stretch their arms when Staff A touched the resident. Staff A said they knew a GCS score of four was a low score and it was abnormal but beyond that they would need to be educated. Staff A said they asked the provider if they wanted Resident 1 sent back to the hospital. Staff A said the provider said not to send the resident back to the hospital, ordered lab tests STAT (urgently processed), and to call the provider back if Resident 1's vital signs became abnormal. Staff A said they continued checking Resident 1's vital signs every hour and they remained within normal limits and Resident 1 sustained 90% oxygen saturation on room air all day long. Staff A said Resident 1 slept through lunch and dinner and after dinner Staff A said they felt uncomfortable because they still could not wake Resident 1. Staff A called emergency services and paged the provider. Staff A said emergency services responded and asked how long Resident 1 had been nonresponsive and Staff A reported Resident 1 had slept through the night and had not woken up since Staff A started their shift at 6:00 AM.Resident 1's progress notes, dated 05/24/2026 at 9:13 AM, showed the resident slept through AM vitals and breakfast, respirations are regular and even, appears to be snoring, mouth breathing, mouth is dry, does not response to touch, response to water drop on their lips by stretching but does not wake up, VSS and will continue to closely monitor for any changes.Resident 1's progress notes, dated 05/24/2026 at 10:54 AM, showed the resident slept through brief being changed, GCS eye opening response was one (indicating no response), verbal response was one (indicating no response), motor response was two (indicating abnormal extension). The provider was paged and the vital signs were stable.Resident 1's progress notes, dated 05/24/2026 at 2:14 PM showed nursing was unable to wake resident to administer medication, the provider was notified, new orders for a complete blood count and complete metabolic panel [diagnostic laboratory tests] were ordered STAT and to only administer medication if resident could wake up and swallow safely.Resident 1's progress notes, dated 05/24/2026 at 2:16 PM, showed the provider was asked if the resident should be sent out and provider stated, no just keep monitoring.Resident 1's progress notes, dated 05/24/2026 at 6:45 PM showed the resident was unresponsive to voice, touch, external stimuli, the provider was paged, and 911 called.On 05/28/2026 at 3:08 AM, Staff B, Certified Nursing Assistant, said they were assigned to care for Resident 1 during the night shift on 05/23/2026. Staff B said that Resident 1 was a new resident at the facility and did not have a Kardex (care instructions for nursing assistants) completed yet, so they did not know Resident 1's usual behavior or status except what they received in report from the outgoing shift. Staff B said they were told in report by evening shift that Resident 1 had slept the entire shift. Staff B said Resident 1 was in bed when they started their shift, snoring and extremely sleepy. Staff B said Resident 1 would open their eyes briefly when they said their name and look at Staff B but would not say anything and go back to sleep. Staff B said Resident 1 did not say anything the entire shift and slept through Staff B changing their briefs. Staff B said they thought Resident 1 was just exhausted from admission and did not notify their nurse that Resident 1 could not stay awake and/or did not speak.On 05/28/2026 at 8:53 AM, Staff C, Licensed Practical Nurse, said they were assigned to Resident 1 on 05/23/2026 at 6:00 PM to Sunday 05/24/2026 at 6:00 AM. Staff C said when they took over from the previous shift the nurse reported Resident 1 was a new resident and was not wanting to eat much and just wanted to sleep. Staff C said they encouraged Resident 1 to eat but they did not want to. Staff C said they administered Resident 1's medications at 7:45 PM and the resident went back to sleep. Staff C said they checked on Resident 1 during their routine rounds, but the resident was sleeping and they did not wake them.On 05/28/2026 at 10:08 AM, Staff D, Medical Director, said they did not exam and/or see Resident 1. Staff D said they had reviewed the (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	medical record. Staff D said they did not know what Staff A had actually reported to the medical provider but if they received a report that a resident was alert and oriented the prior evening, the staff were unable to wake them, the GCS showed no eye opening, no verbal response and the resident went into extension when touched the course of action would be to send the resident to the hospital. Staff D said they would consider it a medical emergency.On 05/28/2026 at 3:26 PM, Collateral Contact 2 (CC2), Supervisor of On-Call Medical Provider, said their Medical Provider group provides on-call providers for the facility. CC2 said they have a call system that logs all calls coming in from facilities. CC2 said on 05/24/2026 the system logged one call from the facility for Resident 1. CC2 said the call came in at 10:53 AM and was responded to at 10:59 AM by Staff E, Physician Assistant. CC2 said that was the only call logged from the facility for Resident 1.On 06/01/2026 at 12:30 PM, Staff E Physician Assistant, said they were the medical provider on call for the facility on 05/24/2026. Staff E said they received a page regarding Resident 1 at approximately 10:59 AM. Staff E said the nurse from the facility reported that Resident 1 was somnolent (excessively sleepy) and would be due for their pain medication soon. Staff E said they began asking the nurse questions and the nurse responded that Resident 1 responded when they went into the room to complete vital signs, the neurological checks were normal, and Resident 1 was responding to stimuli. Staff E said they instructed the nurse to hold the pain medications due to Resident 1's ongoing somnolence, complete hourly neurological checks, escalate if abnormal vital signs or neurological findings, ordered stat labs and to call if there were any changes. Staff E said at the time of the call they were not aware of Resident 1's diagnosis and/or reason for the admission to the facility. Staff E said they had not reviewed the chart and due to Resident 1 being a new admission there were no chart notes available. When asked if the nurse had reported that Resident 1 was snoring, staff were not able to wake them, and they had completed an assessment using the GCS with a score of four with the resident in extension when touched, Staff E said, absolutely not. Staff E said if the nurse would have reported that Resident 1 had a GCS of four, they would not have asked any further questions and sent them immediately to the emergency room. Staff E said if they had an assessment of snoring, unable to wake a resident, no response to verbal stimuli, no eye response and when they were touched, they went into extension, it could indicate the resident was having a stroke embolus (clot) given the history of a fracture and fall. Staff E said it would be a medical emergency and a delay in care could possibly affect the outcome for a resident presenting that way, it is why we sent out STAT.Review of emergency responder statement dated 06/01/2026, regarding a 911 call on 05/24/2026 for Resident 1, showed the emergency responders arrived at the patient's bedside, the patient presented with unconsciousness, sonorous respirations (breath sounds in an unconscious person that typically indicate a partial airway obstruction often caused by the tongue relaxing and falling back into the throat or by secretions), unequal and non-reactive pupils, and decorticate posturing (an involuntary, rigid body reflex indicating severe damage to the brain or spinal cord), leading them to suspect a possible intracranial hemorrhage and the resident was expeditiously transported as their condition was deemed critical.Resident 1's emergency room medical provider notes, dated 05/24/2026, showed Resident 1 was intubated (a tube placed in your throat to open the airway and connected to a machine to help with breathing) by the emergency services due to oxygen saturation at 70% on room air when they arrived at the facility. Resident 1's CT (computed tomography, a medical imaging test that takes pictures of bones, blood vessels and soft tissues inside the body) scan showed they had a large-volume subdural hematoma (collection of blood between the brain and the brain's outer covering), intraparenchymal hemorrhage (bleeding inside the brain) and evidence of herniation (increased pressure inside the skull forces brain tissue to shift from its normal position into an adjacent space). The note showed given the patient's clinical status, anticoagulation, prolonged downtime, decorticate posturing, blown left pupil, the patient would not benefit from surgical management.Resident 1's hospital provider notes, dated 05/27/2026, showed that Resident 1's hemorrhage was non-surgical and non-survivable, and Resident 1 was transitioned to comfort care (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	(end of life care) on 05/26/2026.On 06/02/2026 at 9:41 AM, Staff F, Assistant Director of Nursing, said if a resident was unresponsive to touch and staff were unable to wake them, they expected the nurse to call 911 and then continue their assessment because time is of the essence. Staff F said some residents could have deep sleep and if vital signs were stable staff might call the provider. Staff F said if a resident sounded like they were snoring, but they could not be awakened, it could indicate an airway that was partially obstructed. Staff F said if a resident is observed stretching, and in extension when they are touched it could indicate abnormal neurological finding. Staff F said an unresponsive resident was an urgent medical issue.Review of the facility's Change in Condition Inservice, dated 05/29/2026, showed that residents exhibiting an acute change in condition, including unresponsiveness or decreased level of consciousness, must be treated as a potential medical emergency and licensed nurses are responsible for immediate clinical assessment and appropriate escalation of care. The in-service showed while provider notification is required, activation of emergency medical services must not be delayed for provider direction when the resident's condition appears unstable or life-threatening. The in-service showed if a provider issues an order to monitor in house the licensed nurse must reassess the resident for clinical stability, clarify specific parameters, frequency of monitoring and transfer criteria, escalate concerns to the provider and/or on-call clinical leadership if the resident's condition does not clearly support in-house monitoring and if the resident remains unresponsive, deteriorates or does not demonstrate clearly reversible cause that is promptly resolved, the nurse is expected to initiate EMS transfer, the nursing staff are accountable for both carrying out provider orders and exercising clinical judgement to ensure timely interventions when a resident's condition exceeds the level of care that can be safely managed in the facility.On 06/02/2026 at 10:57 AM, Staff G, Administrator, said the change of condition in-service was initiated because of the incident with Resident 1 and review of the case. Staff G said after reviewing the case they felt Resident 1's condition could have been addressed sooner and reviewed it with staff, so they are empowered to make decisions. Staff G said they would have expected staff to escalate the call to the provider faster if at 9:13 AM Resident 1 was unresponsive and the staff did not page the provider until 10:54 AM.Reference WAC 388-97-1060 (1)-(3)