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	06/22/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a comfortable homelike environment by not providing adequate temperatures in resident rooms in 1 of 4 hallways reviewed for comfortable temperature. This failure placed residents at risk for diminished quality of life.The findings included.During the facility tour with Staff C, Maintenance Director, room temperatures were checked in four halls. The following temperatures were noted:room [ROOM NUMBER] - 84.4 degrees Fahrenheit (F)room [ROOM NUMBER] - 80 degrees [NAME] 4 - 80.2 degrees [NAME] 6 - 82.2 degrees [NAME] 7 - 84.5 degrees [NAME] 9 - 82 degrees [NAME] 11 - 84 degrees FDuring an interview on 06/15/2026 at 4:20 PM, Resident 9 stated her room was too warm.During an interview on 06/15/2026 at 4:22 PM, Resident 7 stated to Staff C the room was too hot and requested the window open. During an interview on 06/15/2026 at 4:25 PM, Resident 11 stated the room was too warm. The resident stated the fan that was in the room burnt out and the facility did not have another fan to replace it.During an interview on 06/15/2026 at 4:30 PM, Staff C acknowledged air conditioning was in the hallways of the facility and resident rooms did not have air conditioning units. Staff C stated the outside temperatures had been warm. Staff C said the facility did not have access to fans for resident rooms at that time. He said he had just ordered 10 fans this day. Staff C acknowledged resident room temperatures should be kept between 71 - 81 degrees F and several rooms in the A hallway were above 81 degrees.During an interview on 06/22/2026 at 2:30 PM, Staff A, Administrator, acknowledged resident room temperatures were to be maintained between 71-81 degrees, and several resident rooms were above 81 degrees. Reference WAC 388-97-0880 (3)

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 - Some	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 ensure new interventions were appropriately developed or timely initiated in an effort to prevent future falls and failed to supervise residents to prevent falls for 3 of 4 sampled residents (Residents 1, 2 and 3) reviewed for accidents. These failures placed residents at risk of injuries, and a diminished quality of life.Findings included .Review of the facility policy, titled Fall Management, dated 10/05/2025, showed .The facility will assess the resident upon admission/readmission, quarterly, with significant change in condition, and with any fall event for any fall risks and will identify appropriate interventions to minimize the risk of injury related to falls.The interventions to reduce the risk of falls should be individualized based on the resident's risk factors and fall history.Resident 1Resident 1 was admitted to the facility on [DATE] with diagnoses including dementia (a decline in mental ability that is severe enough to interfere with daily life) with behavior disturbance for respite care (short-term relief for caregivers by offering temporary care for a loved one, allowing caregivers to rest, travel, or attend to personal needs).Resident 1's admission summary, dated [DATE], documented the resident was forgetful, ambulated with a cane, required limited assistance/supervision to go to the bathroom for safety and had bilateral hearing aids.Resident 1's fall risk assessment, dated 06/02/2026, showed a score of 25 indicating the resident was moderate risk of falling.Resident 1's care plan, dated 06/16/2026, documented the resident was low risk for falls with a score of 25. The care plan showed an intervention to encourage the resident to use the call light for assistance. (Resident 1 with diagnoses of dementia). No other intervention was implemented on the care plan to prevent falls.Resident 1's progress note, dated 06/05/2026, documented the resident had an unwitnessed fall in the resident's room at approximately 3:45 AM and sustained numerous skin tears to the right side of the body.Resident 2Resident 2 was admitted to the facility on [DATE] with diagnoses including Diabetes, Spinal Stenosis (narrowing of the spaces between the spine which puts pressure on the spinal cord and nerves) and Fibromyalgia (a chronic condition characterized by widespread muscle pain, profound fatigue and cognitive issues). The resident's admission Minimum Data Set (MDS), an assessment tool, dated 04/20/2026, showed mild cognitive impairment, required staff supervision for transfers, ambulation and bathing/showers.Fall #1Resident 2's fall risk assessment, dated 04/22/2026, showed the resident was at high risk for falls.Review of the facility falls investigation, dated 04/22/2026, showed the resident was taken to the shower room and left unattended. The resident had an unwitnessed fall in the shower and was found by staff with no injuries.Fall #2Review of Resident 2's falls investigation, dated 05/04/2026, showed the resident had an unwitnessed fall in the resident's bathroom without injury. The intervention implemented was to complete a medication review.Fall #3Review of Resident 2's falls investigation, dated 05/29/2026, showed the resident had an unwitnessed fall in the resident's room without injury. The intervention implemented was to post a reminder sign in the resident room. Observation of Resident 2 on 06/17/2026 at 2:45 PM, with Staff E, Licensed Practical Nurse showed Resident 2 lying on the bed. A walker was in front of the bathroom door and no reminder sign was posted in the resident's room. Resident 2 was unable to answer any questions and appeared very confused.Fall #4Review of Resident 2's falls investigation, dated 06/04/2026, showed the resident had an unwitnessed fall in the resident's room without injury. The care plan, revised date 06/17/2026, documented an intervention not to leave the resident in the bathroom unattended. (13 days post fall)Resident 3Resident 3 was admitted to the facility on [DATE] with diagnoses including End Stage Renal Disease, Diabetes and Dementia. The resident's 5-day MDS, dated [DATE], showed the resident had cognitive impairment, impairment to upper extremities, was dependent on staff for transfers, bathing and toileting, was occasionally incontinent of bladder and frequently incontinent of bowel.Resident 3's falls risk assessment dated [DATE] showed the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident was high risk for falls.Review of the facility falls investigations showed Resident 3 had 5 falls from 04/20/2026 - 06/13/2026 without injury.Review of Resident falls investigation dated 05/02/2026 documented the resident had an unwitnessed fall in the resident's room. No intervention was implemented timely on the resident's care plan after the fall on 05/02/2026.Review of Resident 3's falls investigation dated 06/13/2026 documented the resident had a witnessed fall in the resident's room. No intervention was implemented timely on the resident's care plan after the fall on 06/13/2026.During an interview on 06/17/2026 at 3:35 PM, Staff B, Assistant Director of Nursing (ADON) acknowledged staff are required to supervise residents in the shower who require supervision and interventions are to be implemented timely after a fall by nursing.During an interview on 06/22/2026 at 2:30 PM, Staff A, Administrator acknowledged nursing is responsible for initiation of a falls investigation and implementing an intervention after a fall. He stated daily rounds are to be completed by nurse managers to ensure interventions are in place.Reference WAC 388-97-1060(3)(g)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of the facility policy, observation, interview and record review the facility failed to document timely dishwasher temperatures, failed to complete dishwasher chemical sanitation testing and failed to serve food at appropriate temperatures for 2 of 4 halls reviewed. This failure placed residents at increased risk for foodborne illnesses and decreased quality of life. The findings included.Review of the facility policy titled, Dishwasher Temperature, undated showed .4. For low temperature dishwashers (chemical sanitation) .The wash temperature shall be 120 [degrees] F [Fahrenheit].The sanitizing solution shall be 50 ppm (parts per million) hypochlorite (chlorine) (solution used for widespread disinfection) on dish surface in final rinse.5. Chemical solutions shall be maintained at the correct concentration, based on periodic testing, at least once per shift, and for the effective contact time according to manufacturer's guidelines. Results of concentration checks shall be recorded.6. Water temperatures shall be measured and recorded prior to each meal/or after the dishwasher has been emptied or refilled for cleaning purposes.Observation of the kitchen on 06/17/2026 at 12:45 PM, with Staff D, Dietary Manager showed a dishwasher temperature log for June 2026 was completed from June 1 through June 20th (date of observation 6/17/26). No log for the chemical testing of the dishwasher for June 2026 was found. The Dietary Manager requested a Staff F, Dietary Aid responsible for dishwashing to assist in finding the chemical strips. Staff F retrieved test strips from under the dishwasher. Staff D acknowledged Staff F had been using the wrong test strips and was unable to find the correct test strips at this time. Staff D acknowledged the log for the chemical testing of the dishwasher for June 2026 was missing and the dishwasher temperature logs were filled out incorrectly and should not have been filled out before the date the temperature was taken. Staff D stated he contacted the company who maintains the dishwasher to check the dishwasher and bring the appropriate test strips. Observation in the dining room on 06/17/2026 at 12:20 PM, with Staff D. The food temperatures of the last tray to be served in the dining room were checked by Staff D. The meat (chicken) temperature was 131 degrees. Staff served the food tray to Resident 13 in the dining room.Observation of dining service for Hall B on 06/17/2026 at 12:40 PM, with Staff D. The tray cart was delivered, and staff were passing food trays. Staff D took food temperatures of numerous food items on the tray and food temperature were below 135 degrees. Staff D returned the food cart to the kitchen to be reheated.Observation of dining service for Hall D on 06/18/2026 at 12:40 PM, with Staff D. The tray cart was to be delivered to Resident 4's room. Staff D took food temperatures of the chicken and it was 129 degrees. Staff D took food temperatures of numerous food items on several food trays for Hall D and all food temperatures were below 135 degrees. 1 tray had been delivered to a resident on Hall D prior to Staff D taking food temperatures. Staff D returned the food cart to the kitchen to be reheated.During an interview on 06/17/2026 at 1:00 PM, Resident 4 stated he does not like the food. He said the food is under or overcooked, served cold and sometimes the dishes are dirty.During an interview on 06/22/2026 at 3:00 PM, Staff A Administrator, acknowledged staff did not follow the facility policy for chemical testing for the dishwasher. Staff A acknowledged the facility was having problems maintaining food temperatures at the appropriate temperature and the facility was taking measures to correct the issue. Reference WAC 388-97-1100(3)