STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505273	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lacamas Creek Post Acute	740 NE Dallas Street Camas, WA 98607

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 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 interview and record review, the facility failed to notify the resident representative of a need to alter treatment significantly, for 1 of 3 sampled residents (Resident 1) reviewed for change in condition. This failure placed Resident 1 at risk of continued pain, unmet care needs, and a diminished quality of life.Findings included . Resident 1 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS) assessment (an assessment tool), dated 08/04/2025, documented the resident had severe cognitive impairment and a BIMS (Brief Interview for Mental Status- a cognitive assessment) of 00/15 indicating, severe impairment. Resident 1's Electronic Health Record (EHR) Medical Diagnosis list included congestive heart failure (a weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs), chronic osteoarthritis (a degenerative joint disease leading to breakdown of cartilage in joints), and unspecified cognitive impairment. Record review, completed on 10/07/2025, of Resident 1's EHR showed Resident 1 had a legal guardian. Record review of Resident 1's hospital physicians' Progress Note, dated 07/28/2025, showed Resident 1 had been diagnosed with bilateral knee pain related to chronic osteoarthritis.Record review of Resident 1's Physical Medicine and Rehabilitation Evaluation note, dated 07/31/2025, stated, Right knee osteoarthritis. hospital records indicate that she recently received an x-ray which showed right knee osteoarthritis.The patient was offered steroid injections for the right knee; however, she states that she did not want it as she is afraid of needles. Due to her intellectual disability, if she becomes more amenable to the idea of an injection or if she is unable to participate in physical therapy as a result of the knee pain, then I will reach out to her guardian to discuss consent for an injection.Record review of Resident 1's Physical Medicine and Rehabilitation Evaluation note, dated 08/12/2025, stated, Right knee osteoarthritis.hospital records indicate that she recently received an x-ray which showed right knee osteoarthritis. offered a right knee cortisone injection again; however, the patient is afraid of needles. The patient is eligible for right knee cortisone injection if or when she decides she wants one.Record review of Resident 1's Physical Medicine and Rehabilitation Evaluation note, dated 08/14/2025, stated, She [Resident 1] reports that she is still dealing with right knee pain. Right knee osteoarthritis. After reviewing multiple PT [physical therapy] notes, it is evident that her ability to participate in physical therapy is hindered by her right knee pain. Had a lengthy conversation with the patient today regarding injections and her safety concerns with them. Due to her cognitive impairment, I do not believe she fully understands the procedure and the potential outcomes, as she is still declining the procedure entirely.Record review of Resident 1's Physical Medicine and Rehabilitation Evaluation note, dated 08/19/2025, stated, The patient was crying upon arrival to her room. When asked why, she stated that her right leg hurts her. Right knee osteoarthritis.hospital records indicate that she recently received an x-ray which showed right knee osteoarthritis. Discussed a right knee injection once again and tried to address any potential concerns the patient may have regarding the procedure. The patient stated that she is afraid of needles and still denies the injection at this time. She was told that this injection may provide her with a significant amount of relief and given she seems to be very upset about this issue, it may greatly benefit her.Record review of Resident 1's Physical Medicine and Rehabilitation Evaluation note, dated 08/24/2025, stated, .she still has pain in her right knee, she has no other acute pain.pt [patient] after sitting becomes very emotional and starts crying due to knee pain. Right knee osteoarthritis.the patient remains apprehensive towards injections. She is eligible for one if or when she decidesRecord review of Resident 1's Physical Medicine and Rehabilitation Evaluation note, dated 09/09/2025, stated, She reports ongoing right knee pain. Right knee osteoarthritis.the patient remains apprehensive towards injections. She is eligible for one if or when she decidesRecord review of Resident 1's EHR, completed 10/07/2025, showed no documented notification from the facility to the guardian for Resident 1 regarding treatment options to address their right knee pain related to chronic osteoarthritis until a Progress Note, dated 09/17/2025-nearly seven weeks after admission, stated, This LN [licensed nurse] and SS [social services] spoke with guardian, guardian gave verbal consent to perform injection to knee for pain. Provider notified of consent and ordered injection.In an interview on 10/10/2025 at 3:00 PM, Staff B, Registered Nurse and Director of Nursing, confirmed Resident 1 had been diagnosed with an intellectual disability, had a BIMS of 00/15, had a legal guardian, and said the guardian should have been notified by the provider or RCM (Resident Care Manager) regarding treatment options and decisions to address Resident 1s' right knee pain related to chronic osteoarthritis.WAC 388-97-0320

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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 interview, and record review, the facility failed to follow physician orders to obtain daily weights, for 2 of 3 sampled residents (Resident 1 and Resident 2), with diagnosis of heart failure. This failure placed the residents at risk of worsening heart failure, unmet care needs, and a diminished quality of life.Findings included . Resident 1Resident 1 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS) assessment (an assessment tool), dated 08/04/2025, documented the resident had severe cognitive impairment and the Electronic Health Record (EHR) Medical Diagnosis list included congestive heart failure (a weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs), chronic osteoarthritis (a degenerative joint disease leading to breakdown of cartilage in joints), and unspecified cognitive impairment. Record review of Resident 1's physicians' order, dated 7/30/2025, documented, Daily Weights: Weigh resident in the morning before breakfast and after first void, notify MD [medical doctor] if gains 3 pounds in 1 day or 5 pounds in 1 week. Record review of Resident 1's EHR Weight Summary, reviewed 10/07/2025, showed three occasions (09/18/2025, 09/21/2025, 09/22/2025) when Resident 1 was not weighed per physician orders. Record review of Resident 1's Treatment Administration Record (TAR), dated September 2025,, showed three occasions in September 2025 (09/18/2025, 09/21/2025, 09/22/2025) when Resident 1 was not weighed per physician orders; each date Resident 1's daily weights were omitted was accompanied by a documented chart code, 9, indicating, other/see nurses notes. Record review of Resident 1's Progress Notes, reviewed 10/10/2025, show no nurses notes on 09/18/2025, 09/21/2025, nor 09/22/2025 pertaining to the omission of daily weights. Resident 2Resident 2 was admitted to the facility on [DATE]. The 5-Day Minimum Data Set (MDS) assessment, dated 08/16/2025, documented the resident was cognitively intact and the Electronic Health Record (EHR) Medical Diagnosis list included unspecified heart failure (a weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs). Record review of a physicians' order for Resident 2, dated 08/20/2025, documented, Daily Weights: Weigh resident in the morning before breakfast and after first void, notify MD if gains 3 pounds in 1 day or 5 pounds in 1 week. Record review of Resident 2's EHR Weight Summary since admission, reviewed 10/07/2025, showed six occasions in September 2025 (09/14/2025, 09/18/2025, 09/19/2025, 09/20/2025, 09/21/2025, 09/22/2025) when Resident 2 was not weighed per physician orders. Record review of Resident 2's Treatment Administration Record (TAR), dated September 2025, showed six occasions (09/14/2025, 09/18/2025, 09/19/2025, 09/20/2025, 09/21/2025, 09/22/2025) when Resident 2 was not weighed per physician orders; each date the daily weights were omitted was accompanied by a documented chart code. On 09/14/2025 the documented chart code was 7, indicating, sleeping. On 09/14/2025, 09/18/2025, 09/19/2025, 09/20/2025, 09/21/2025, and 09/22/2025 the documented chart code was 9, indicating, other/see nurses notes. Record review of Resident 2's Progress Notes, reviewed 10/10/2025, show no nurses notes on 09/14/2025, 09/18/2025, 09/19/2025, 09/20/2025, nor 09/21/2025 pertaining to the omissions of daily weight. A nursing note on 09/22/2025 said, not able to check resident's weight due to wheelchair scale is broken.In an interview on 10/10/2025 at 3:00PM, Staff B, Director of Nursing Services (DNS) and Registered Nurse (RN), stated that if a resident had an order to obtain daily weights, they should be taken daily as the resident allows. WAC 388-97-1060(1)