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	07/25/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide assistance with completing the advance directives (AD); and obtaining and maintaining Durable Power of Attorney (DPOA) documentation for 1 of 5 sampled residents (Resident 27) reviewed for ADs. This failure placed residents at a potential risk for losing their right to have their healthcare preferences and/or decisions honored.Findings included.Resident 27 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (an assessment tool), dated 05/29/2025, showed Resident 27 was alert and oriented. Record review of Resident 27's Social History Assessment, dated 11/26/2024, documented Resident 27 was their own responsible/legal guardian, had a Living Will and Do Not Resuscitate (DNR).Record review of Resident 27's electronic record did not have documentation the advanced directive had been reviewed on a quarterly basis.In an interview on 07/24/2025 at 9:51 AM, Staff E, Social Services Director, stated advanced directives were reviewed quarterly and annually for long term residents. Staff E stated advanced directives were reviewed during the care conference which were reviewed quarterly and annually. Staff E stated she could not find any additional information regarding an advanced directive for Resident 27.Reference WAC 388-97-0280(3)(c)(i)

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 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 initiate bowel interventions for 1 of 5 residents (Resident 27) reviewed for constipation. This failure to initiate interventions placed residents at risk of discomfort, experiencing health complications and a diminished quality of life. Findings included.Record review of the facility policy, titled, Bowel Protocol, dated February 2019, showed it was the facility policy to monitor and provide interventions to ensure routine bowel elimination by residents of the facility. At the beginning of each shift the Licensed Nurse would pull the resident bowel management report and identify residents that had not had a bowel movement for three days. The Licensed Nurse would review the residents Medication Administration Record to determine if the as needed bowel protocol had been initiated by the previous shift. Residents that did not have a bowel movement for three days would be given Milk of Magnesia (medication to help with constipation). If there was no bowel movement by the next shift, a Dulcolax suppository (medication to help with constipation) would be given. If a resident exceeded four days without a bowel movement, the licensed nurse would complete an abdominal assessment, and the physician would be notified.Resident 27 was admitted to the facility on [DATE]. The quarterly Minimum Data Set assessment, dated 05/29/2025, showed Resident 27 was alert and oriented. Review of the Bowel Movement (BM) task sheet, dated 06/25/2025 through 07/24/2025, documented Resident 27 had a BM on 07/01/2025 at 4:29 AM. Resident 27's next BM was on 07/05/2025 at 1:59 PM, approximately 105.5 hours since the last BM.Review of Resident 27's Medication Administration Record, dated July 2025, did not show documentation of medication intervention for no BM after 72 hours. In an interview on 07/24/2025 at 1:31 PM, Staff F, Registered Nurse, said the bowel protocol should be initiated 72 hours after the last BM. In an interview on 07/24/2025 at 1:35 PM, Staff B, Director of Nursing Services/Registered Nurse, said the bowel protocol should be initiated 72 hours after the last BM. Staff B said after reviewing the medical records the bowel protocol for Resident 27 should have been initiated on 07/04/2025. Reference WAC 388-97-1060(1)(3)(c)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to implement infection control practices when providing wound care for 1 of 1 residents (Resident 28) reviewed for pressure ulcers. This failure placed residents at risk for potential infection and a diminished quality of life. Findings included.Resident 28 was admitted to the facility on [DATE]. The Medicare quarterly Minimum Data Set assessment, dated 07/09/2025, documented Resident 28 was severely cognitively impaired and dependent for activities of daily living. Record review of Resident 28's electronic health record, titled, UNITED WOUND HEALING Wound, Ostomy, Lymphedema, Burn, and Dermatological Medicine, dated 06/18/2025, documented Resident 28 had an unstageable bilateral sacrococcyx [tail bone] pressure ulcer.Record review of Resident 28's physician's order, dated 07/02/2025, documented, Wound care: Bilateral sacrococcyx c/f [concerning/for] terminal skin failure - Cleanse wound with NS [Normal Saline]/Wound cleanser and gauze - Treat periwound [around the wound] with skin prep and allow to dry - Apply anasept gel to the wound bed, followed by collagen - Cover with bordered dressing Change: Daily and as needed for accidental removal, saturation and/or soiling as needed for soilage, dislodgement.In an observation on 07/24/2025 at 12:55 PM, Staff D, Resident Care Manager/Licensed Practical Nurse (LPN), provided wound care to Resident 28. Staff D had a clean field [clean area with wound supplies] set up on Resident 28's bedside table. Staff D was observed moving wound dressing packages from the clean field and placed them on Resident 28's bed. Staff D proceeded to open the dressing packages and provide wound care. Resident 28 was observed to have a bowel movement (BM). Staff D provided incontinence care and proceeded to apply anasept gel to the wound bed. Staff D was asked if Resident 28's wounds needed to be cleansed after having a BM and prior to applying Anasept gel to the wound. Staff D stated, I probably should clean it, and proceeded to clean the wound with NS.In an interview on 07/25/2025 at 10:29 AM, Staff C, Infection Control Nurse/LPN, said it was the expectation when licensed nurses provided wound care, they maintained a clean field and reclean sacral wounds with NS or wound cleanser if a resident had a BM.Reference WAC 388-97-1320 (2)(a)