STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505289	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birch Creek Post Acute & Rehabilitation	5601 S Orchard Street Tacoma, WA 98409

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 interview and record review the facility failed to provide adequate supervision, identify fall trends and implement progressive resident centered interventions for 1 of 3 residents (Resident 6) reviewed for falls. Resident 6, who had 5 falls since [DATE] and a decline in their strength/condition, experienced harm when they fell and broke their ankle that required transfer to the emergency department for evaluation and treatment. This failure placed residents at risk of repeated falls and injuries.Findings included.Review of the facility Falls and Fall Risk Management policy, dated [DATE], showed staff would identify interventions related to residents' specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.Review of the admission Minimum Data Set (MDS - an assessment tool), dated [DATE], showed Resident 6 was independent with transfers, required supervision walking up to 50 feet, was occasionally incontinent of urine, had fallen prior to admission and had one noninjury fall in the facility since their admission on [DATE].The Care Area Assessment (CAA), dated [DATE], showed Resident 6 was at the facility related to cancer which put the resident at risk for pain, falls, and ADL (Activities of Daily Living) decline. According to the CAA, falls and urinary incontinence would be addressed in the care plan with the overall objective of improvement and to minimize risks. The rationale documented was for staff to assist with ADLS at routine intervals and as needed. Resident was working with therapies for strengthening, gait training, and ADL retraining. Verbal reminders will be provided as needed for the resident to use call lights and wait for staff assistance.Review of the Care Plan (CP), dated [DATE], showed no urinary or ADL care plan, and no plan for toileting. The CP did address that Resident 6 was at risk for falls and instructed staff to remind the resident to use their call light to ask for assistance with ADLS. In addition, the resident should wear footwear to prevent slipping, bedside table/items within reach and bed locked in lowest position.Review of the resident's record showed that on [DATE], Resident 6 fell next to their bed. According to the resident they slipped. The environment was noted to have two sets of shoes next to bedside where the resident fell, there was water on the floor, and the resident's socks were slightly askew from gripper area. The area was cleaned up and extra shoes placed into closet, water cleaned up, and socks were replaced with new ones. Review of the Incident Investigation, dated [DATE], showed the investigation identified environmental factors of clutter, crowding, and items on the floor, and that the resident was using their own skid socks and the walker was in place, but the CP was updated with new intervention to encourage use of their walker with transfers and ambulation.Review of the Fall CP showed a [DATE] additions to remind the resident to use their FWW [front wheeled walker] to perform ADLS. Two additional interventions were added on [DATE], both of which were the same as the original CP interventions, non-skid socks while out of bed, place bed in lowest position while out of bed.During an interview on [DATE] at 3:06 PM, when asked where the walker was located during the fall that occurred on [DATE], Staff B, interim Director of Nursing, stated they didn't know as they were not at the facility at that time, and added that maybe Resident 6 was trying to walk without their assistive device.Review of the Quarterly MDS, dated [DATE], showed Resident 6 had moderate cognitive impairment, was assessed as independent with (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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Discussed plan with resident, and resident agreeable.Review of the Fall CP, dated [DATE], showed neither of the interventions regarding frequent rounding and toileting were implemented as planned.During an interview on [DATE] at 3:06 PM, Staff B stated while reading the investigation, showed the facility were not able to do any additional interventions because the resident was transported to the hospital.Review of the [DATE] fall investigation conclusion showed statements obtained from residents aide indicates resident was observed sleeping in his bed less than 30 minutes prior to incident, at which time resident only requested a blanket and did not request to use bathroom. Resident also did not make use of call bell which further indicates resident may have impulsively decided to use restroom on his own, resulting in fall. Previous interventions put in place include keeping items within reach, making sure resident had proper foot wear and non skid socks when appropriate. Education and reorientation given, as additional intervention.Review of the census showed the resident was in the bed furthest away from the bathroom during their whole stay at the facility. Resident 6 fell after getting up to go to the bathroom on [DATE], fell in the bathroom on [DATE], found [DATE] on the floor close to the bathroom door, and on [DATE] found in the bathroom on the floor. None of the facility investigations identified this trend or addressed toileting options.Review of the Comprehensive CP, dated [DATE], showed no toileting plan.A [DATE] Nursing Note showed Resident 6 had an X-ray taken and they had a left ankle fracture. The provider was notified and the resident sent to the emergency room for further evaluation.Review of the discharge return anticipated MDS, dated [DATE], showed the resident had an unplanned hospital transfer, was occasionally incontinent of urine, did not have a condition or chronic disease that would result in a life expectancy of less than six months, and sustained two or more falls since last MDS, one with a minor injury and one with a major injury.Review of Emergency Department (ED) notes, dated [DATE] at 6:56 AM, showed the resident was seen in the emergency department yesterday for evaluation of left ankle pain after a fall. Patient denied head injury or loss of consciousness. ED workup notable for acute mildly displaced fracture of the left distal fibula. A splint was placed on patient's left lower extremity and he was advised to be non weightbearing on the left lower extremity. He was referred to follow-up with orthopedic surgery as outpatient. Patient was discharged back to his care facility. However, he became agitated and aggressive with EMS during transport and therefore brought back to the emergency department for assistance in management of aggressive behavior. Patient arrived in the ED agitated, combative, confused. He was placed in soft restraints and received medications for agitation.Record review showed Resident 6 readmitted to the facility on [DATE]. A [DATE] provider note showed the resident had multiple medical conditions, including cancer, recently hospitalized for acute encephalopathy, ground-level fall found to have an acute mildly displaced right ankle fracture and pelvic fractures. Hospital course complicated by delirium with agitation and increased pain, requiring pharmacological restraints. Orthopedic was consulted for ankle and pelvic fracture but recommended against any surgical interventions. Palliative care was consulted and patient opted for hospice care. He was discharged to the facility with plan for hospice care services. Resident was deceased in the early hours of the morning on [DATE].During an interview on [DATE] at 2:26 PM, Resident 17 stated Resident 6 would get up to go to the bathroom and trip. Often their underwear would be around their ankle. Resident 17 stated they would call out for staff, and they would come, put Resident 6 into bed and remind them to call before getting up. When asked if Resident 6 would call, Resident 17 replied, No.During an interview on [DATE] at 2:38 PM, Staff G, Licensed Practical Nurse (LPN), stated staff were working with Resident 6 to use the call light to go to the bathroom, but Resident 6 was used to being independent and doing things themselves, so they would get up. Staff G stated Resident 6 could demonstrate how to use the call light, they just wouldn't use it. During an interview on [DATE] at 12:01 PM, Staff F, Resident Care Manager, stated most of the time, Resident (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 3 residents (Resident 1) reviewed for urinary catheters (a flexible tube inserted into the bladder through the urethra to drain urine) were assessed for complications associated with indwelling urinary catheters. Failure of the facility to coordinate with urology and monitor for urinary retention following catheter removal, resulted in harm to Resident 1 when they experienced prolonged pain and discomfort as evidenced by crying out and a change in level of consciousness. Findings included.Review of Taber's Cyclopedic Medical Dictionary, 19th edition, showed a bladder has a normal storage capacity of approximately 500 milliliters (ML).Review of the undated Urinary Catheter Care Policy; staff would observe the resident for complications associated with urinary catheters. If the resident indicates that their bladder is full or that they need to urinate, notify the physician or supervisor. Report any complaints a resident may have of burning, tenderness, or pain.<RESIDENT 1>Review of the Minimum Data Set (MDS - an assessment tool), dated 11/26/2025, showed Resident 1 was frequently incontinent of urine, and required substantial assistance with toileting hygiene. Resident 1 was hospitalized [DATE]-[DATE]. Review of the MDS dated [DATE], showed Resident 1 had an indwelling urinary catheter with a diagnosis of obstructive uropathy (a condition where urine flow is blocked, causing it to back up and potentially damage one or both kidneys).Review of a hospital discharge note, dated 12/03/2025, showed the resident had acute kidney injury due to urinary retention, which improved after urinary catheter placement. Discharge instructions included to follow-up with urology for urinary retention and given the resident's significant retention and Acute Renal Failure (ARF), staff should not be attempting Foley removal in the Skilled Nursing Facility.Review of the hospital discharge orders, dated 12/03/2025, showed the indication for catheter use was Acute Urinary Retention, the catheter was placed on 12/03/2025 and was deemed permanent. The orders directed urinary catheter management per nursing protocol.Review of the Catheter Care Plan (CP), dated 12/03/2026, showed the staff were directed to empty catheter as needed and record MLs.Review of the last 30 days of documentation for bladder elimination showed Continence not rated due to indwelling catheter. Further review of the nursing assistant documentation and the licensed nurse documentation on the February 2026 and March 2026 Treatment Administration Records (TAR) showed no documented urinary output in MLs.During an interview on 03/26/2026 at 11:50 AM, Staff F, Resident Care Manager (RCM), reviewed Resident 1's medical record for documented output in MLs and stated, I don't see any.Review of an appointment reminder, dated 12/31/2025, showed Resident 1 had an Urology appointment scheduled for 02/26/2026 at 9:00 AM.Review of progress notes showed a Nursing Note, dated 02/26/2026 at 11:44 AM, that Resident 1 returned from the appointment with no new orders. An Alert Note, timed 2:24 PM, showed the urinary catheter was discontinued at the appointment and staff were monitoring for retention or pain. Review of the progress notes showed no documented bladder assessment, or urinary output.Review of Bladder Elimination documentation by Nursing Assistants showed documentation on 02/26/2026 at 9:10 PM, that Resident 1 did not void on evening shift.Review of the February 2026 Treatment Administration Record (TAR) showed nursing staff documented provision of catheter care on 02/26/2026 second shift, on 02/27/2026 first and second shift, when there was not a catheter in place.An Alert Note, dated 02/28/2026 at 4:18 AM, showed Resident 1 had emesis (vomited) twice (02/27/2026 at 5:00 PM, and 02/28/2026 at 3:30 AM). The provider was notified and SBAR (Situation, Background, Appearance, Review and Notify) reported at 4:00 AM.Review of the SBAR, dated 02/28/2026, showed the resident's pulse was high at 119 beats per minute, Respiratory rate was high at 20 breaths per minute, the resident had an altered level of consciousness, with edema (swelling), nausea and/or vomiting and decreased urine output.Review of a Nursing Note, dated 02/28/2026 at 5:07 PM, showed Resident 1 was in bed and lethargic, unable to (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident as determined by resident assessments and individual plans of care. The facility failed to ensure the nursing staff (Staff H, Licensed Practical Nurse (LPN), Staff I, Registered Nurse (RN) & Staff G, LPN) administered medications according to professional standards of practice for 10 of 10 residents (Residents 7, 9, 8, 3, 16, 15, 11, 13, 14, & 1) reviewed for medication administration. This failure placed facility residents at risk of medication errors and poor outcomes.Findings included.Review of the facility 01/2023 Medication Administration Policy and Procedure showed medications would be administered as prescribed in accordance with manufacturers' specifications, and good nursing principles and practices. Medications are administered in accordance with written orders from the prescriber. No expired medication will be administered to a resident, certain products such as multi-dose vials have specified shortened end-of-use dating, once opened, to ensure medication purity and potency. Medications are administered within 60 minutes of scheduled time. The individual who administers the medication dose, records the administration on the resident's Medication Administration Record (MAR) immediately following the medication being given.<RESIDENT INTERVIEWS>During an interview on [DATE] at 10:43 AM, Resident 7 stated, sometimes when they had agency nurses their medications were not given at the time they usually got their medications.During an interview on [DATE] at 10:55 AM, Resident 9 stated, the agency nurses don't read the full instructions regarding their medications.During an interview on [DATE] at 11:09 AM, Resident 8 stated, their meds were administered a little bit late, but they only complained a couple of times.During an interview on [DATE] at 12:32 PM, Resident 3 stated, they always received their medications late and they frequently had to ask for them. Resident 3 understood they had to request their as needed medications but said they should get their routinely scheduled medications without asking.During an interview on [DATE] at 10:19 AM, Resident 16 stated that the nurses were frequently slow about bringing their medications.<RESIDENT 15>Review of Resident 15's Diabetes Mellitus Care Plan, dated [DATE], showed an intervention to administer Insulin as ordered.Review of the MAR, dated [DATE], showed an order for sliding scale Humalog/Lispro Insulin to be administered before meals and at bedtime. The Insulin was ordered to be administered at 11:30 AM.On [DATE] at 1:06 PM, Staff H, LPN, was observed during medication observation to draw the physician ordered units of Humalog/Lispro Insulin from a multi-dose vial, that was dated as opened 02/16 (no year included) and thus expired.The Insulin was administered at 1:11 PM, almost one hour and 45 minutes after the dose was due.<RESIDENT 11>Review of Resident 11's CP, dated [DATE], instructed staff to administer medications as ordered. Review of the MAR, dated [DATE], showed orders for Gabapentin oral tablet for pain, orders for Oxybutynin tablet for neurogenic bladder, and orders for Baclofen tablets for Multiple Sclerosis (MS) each to be given three times a day at 8:00 AM, 2:00 PM, and 8:00 PM; and Tizanidine tablet to be given four times a day for spasticity, at 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM.On [DATE] at 1:14 PM, Staff H was observed to pour all four medications and administer them to Resident 11. In an interview at that time, Staff H acknowledged the Tizanidine was a little late, but that Resident 11 wanted them at that time.During an interview on [DATE] at 1:18 pm, Resident 11 stated that the nurses typically gave all those medications together and that it was not something they requested.<RESIDENT 13>Review of the Diabetes CP, dated [DATE], showed the intervention to administer Insulin as ordered.Review of the MAR, dated [DATE], showed orders for sliding scale Humalog/Lispro Insulin to be administered at 12:00 PM.On [DATE] at 1:51 PM, Staff I, RN, was observed to take Resident 13's blood sugar, and draw up corresponding dose of Insulin, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505289	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birch Creek Post Acute & Rehabilitation	5601 S Orchard Street Tacoma, WA 98409

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	almost two hours after it was due. Resident 13 refused the insulin when offered. In an interview at that time, Resident 13 stated they had finished eating lunch earlier.<RESIDENT 14>Review of Resident 14's Pain CP, dated [DATE], showed interventions to administer medication as ordered.Review of the MAR, dated [DATE], showed orders for Methocarbamol tablet four times a day, scheduled to be administered at 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM.On [DATE] at 1:59 PM, Resident 14 approached the medication cart and requested methocarbamol and Tylenol for pain. Staff I was observed to administer as needed Tylenol as ordered. Resident 14 then asked, Where's the methocarbamol? and Staff I told Resident 14 they had already given it to them. Resident 14 stated they were supposed to get it at noon, as it was ordered four times a day. Staff I was then observed to administer the Methocarbamol, two hours after it was due.<RESIDENT 1>Review of Resident 1's Risk for pain CP, dated [DATE], showed interventions to administer medication as ordered.Review of the [DATE] MAR showed orders for Tramadol tablet three times a day for pain, scheduled at 8:00 AM, 2:00 PM and 8:00 PM.On [DATE] at 11:54 AM, Staff G, LPN, was observed to retrieve an as needed pain medication requested by Resident 1. Looking at the computer, none of Resident 1's 8:00 AM medications were documented as administered. In an interview at that time, Staff G stated they gave them they just had not yet documented they were administered.During an interview on [DATE] at 12:05 PM, Resident 1 stated their medications were sometimes late, but they had received their morning medication on time.On [DATE] at 2:05 PM, Staff I was observed to prepare the Tramadol dose that was due at 2:00 PM. Review of the narcotic book showed the last dose was documented as administered on [DATE] at 8:00 PM and 42 pills remained, but looking at the card of pills showed only 40 pills remaining.In an interview at that time, Staff I stated they gave the Tramadol at 8:00 AM, as ordered, but did not sign it out at that time. Staff I then proceeded to sign out both the 8:00 AM and 2:00 PM doses.During an interview on [DATE] at 4:35 PM, Staff A, Administrator, stated many of the medication concerns brought forward by residents involved agency/temporary nurses and they were actively recruiting nursing staff. REFERENCE: WAC 388-97-1080(1)