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	05/06/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents and/or resident representatives were informed of a long-term medication being discontinued for 1 of 3 sampled residents (Resident 1). This failure disallowed the resident and/or the resident representative to exercise their rights and provide the facility with provider contacts and/or documentation to support continuing the medication.Findings included .Review of the Annual Minimum Data Set (MDS - an assessment tool), dated [DATE], showed Resident 1 was assessed with active diagnoses to include Deep Venous Thrombosis (DVT - blood clot in deep veins), Pulmonary Embolus (PE - blood clot in lungs), or Pulmonary Thrombo-Embolism (PTE - long standing blood clot lodged in pulmonary arteries), and the resident was taking an anticoagulant medication. In addition, Resident 1 was diagnosed with dementia and assessed with severe cognitive impairment.Review of the 2023 Durable Power of Attorney (POA) document for Resident 1 showed the POA was effective immediately, for both financial and health care decision making. Review of the facility face sheet showed the contact information for the POA was listed.Review of admission Orders dated [DATE] showed orders for an anticoagulant (blood thinner) twice a day.Review of the [DATE] Medication Administration Record (MAR) showed the medication was administered through [DATE] and not continued.Record review showed no documentation that the resident and/or representative were notified the medication was not continued.Review of Medical Records showed Resident 1 was hospitalized from [DATE] to [DATE] with diagnoses to include a right lower extremity DVT involving femoral (thigh) veins, and a right external iliac (pelvis) DVT.During an interview on [DATE] at 12:02 PM, Staff D, Registered Nurse, stated in [DATE] they faxed the pharmacy to refill the medication, but the order was not filled. Where there were only two pills remaining, they called the pharmacy, who said the order expired. Staff D stated they called the on-call provider who said Resident 1 did not need anticoagulant medication anymore and did not renew the order. When asked if they notified Resident 1's POA, Staff D stated they did not, but they probably should have.During an interview on [DATE] at 2:56 PM, Resident 1's POA stated that they were not notified that the medication was stopped until they received a call from the facility that Resident 1's leg was swollen. The POA stated they requested the resident be sent to the hospital right away. Resident 1's POA stated if they had told them, or asked them, they could have brought their prior records to show that Resident required anticoagulation therapy for life.During an interview on [DATE] at 1:13 PM, Staff A, Administrator stated Resident 1's POA should have been notified.See WAC 388-97-0260, -300(3)(a).

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