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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505373	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Creek Post Acute	917 South Scheuber Road Centralia, WA 98531

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 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** 40916 Based on interview and record review, the facility failed to ensure a resident was assessed after an unwitnessed fall for 1 of 2 sampled residents (Resident 1) reviewed for quality of care related to falls. This failure placed residents at risk of undiagnosed injuries, increased pain, and a decreased quality of life. Findings included . A facility policy, entitled Falls-Clinical Protocol, dated March 2018, documented, The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc. Resident 1 was admitted to the facility on [DATE]. The admission Minimum Data Set assessment, dated 11/26/2024, documented the resident was cognitively intact and required some assistance with Activities of Daily Living (ADLs). Resident 1's progress notes, dated 12/18/2024 through 01/17/2025, were reviewed for nurses notes and assessments related to a fall on 12/31/2024. No progress notes were found related to the 12/31/2024 fall. A neurological evaluation flow sheet, dated 01/01/2025, 01/02/2025, 01/03/2025, documented neurological evaluations on Resident 1 starting on 01/01/2025 at 3:00 AM. The first three neurological evaluations were documented as completed on 01/01/2025 at 3:00 AM, 4:00 AM, and 5:00 AM. The evaluations were signed by initials matching those of Staff D, Registered Nurse (RN). A review of the employee list documented no other nurses with the same initials. An eINTERACT SBAR (situation, background, assessment and recommendation) summary for providers, dated 01/01/2025 at 10:10 AM, documented, Resident continues to fall while self-toileting at night. The note did not specify what time the fall occurred. The note documented vital signs taken 01/01/2025 at 10:21 AM. A physician's note, dated 01/01/2025 at 9:00 PM, documented, Patient is seen today for a fall. Patient fell and hit the right side of her head. Patient was ambulating with a walker to use the restroom when she felt dizzy and fell down. Patient had a prior fall 2 days ago with no injury. Patient sitting up in the bed, son at bedside. patient has visible bruises on the right side of the forehead and around the right eye. (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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NAME OF PROVIDER OR SUPPLIER South Creek Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 917 South Scheuber Road Centralia, WA 98531	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An IDT (interdisciplinary team) note, dated 01/02/2025 at 9:58 AM, documented, Patient came to LN [licensed nurse] to report that she fell in the night. She stated that she did not recall falling or getting in bed, but that roommate told her what happened. She did have visible bruising to right side of forehead and darkening to right eyelid. Small amount of swelling noted. She denied headache or visual disturbance at time of report. Resident stated that her roommate told her that she fell in the night and got herself back into bed. She did not recall fall. A facility investigation, dated 01/05/2025, documented, [Resident 1] reported today 01/05/2025 that on New Year's Eve on 12/31/2024, she fell , and she reported that the nurse assigned to her [Staff D, Registered Nurse] allegedly did not assess her for the fall. Resident initially reported this fall incident to the ombudsman and the facility initiated the fall incident investigation. During this time, resident did not complain of a particular staff who allegedly did not help her when she fell . During follow up interviews with the resident, she stated that she did not remember the details of the fall and how she ended up falling. When asked when she remembered something after the fall, she mentioned that she barely remembered it as she immediately went back to sleep after the fall. She said that she got up by herself and went back to bed and slept. Follow up interview with [Staff D], she stated during her care, the resident did not complain of anything and resident was not in distress. [Staff D] also stated that resident slept through the night. Staff D's statement about Resident 1's 12/31/2024 fall investigation documented, I worked at [this facility] on 12/31/2024 on NOC [night] shift, during this time, patient was under my care, and she did not report any incident or accident that occurred during my shift. She slept through the night with no acute distress noted after she took meds before she went to bed that night. She did not complain of any pain. Staff E, Certified Nursing Assistant (CNA), statement about Resident 1's 12/31/2024 fall investigation documented, The call light for room [ROOM NUMBER]B was initiated and I responded. [Resident 2] explained her roommate had a fall coming from the bathroom. I then visualized the patient, and she was in her bed however she had a bump on her head, so I reported the information to nurse on duty promptly. The investigation findings of the 12/31/2024 fall of Resident 1 documented, After a careful review of the information gathered, through staff and resident interviews, the facility believes that the nurse on duty that night on New Year's Eve was made aware of the fall incident and did not do her due diligence to assess the resident after the fall incident was reported to her. On 01/17/2025 at 11:28 AM, Resident 1 said she had a fall in the facility on 12/31/2024. Resident 1 said she did not recall waking up after the fall. Resident 1 said her roommate told her about the fall and told her she was between the bathroom and the bed area. Resident 1 said her roommate used the call light to call the nurse and a CNA came, but a nurse never came in the room. Resident 1 said when she woke up in the morning, she had a black eye. Resident 1 said she told an unidentified nurse in the morning about the fall, and the facility began doing neurological checks at that time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:03 PM, Resident 2 said she was sleeping on 12/31/2024 when she woke up and saw the bathroom light was on but her roommate was not in her bed. Resident 2 said she saw her roommate on the floor. Resident 2 said she called Resident 1's name, and Resident 1 got up, said she was alright, and went to her bed. Resident 2 said she used her call light to call for help, and Staff E came in the room. Resident 2 told Staff E that Resident 1 had a fall. Staff E told Resident 2 he was going to get some assistance. Resident 2 said she was waiting for a while and used her call light again. Staff E responded to the call light and Resident 2 told Staff E that no one else had come in the room to assess Resident 1. Resident 2 said Staff E said again he would get someone to assess Resident 1. Resident 2 said no one else came in the room to assess Resident 1, and she stayed up all night waiting for assistance because she was worried about Resident 1. At 12:21 PM, Staff D said she was an agency nurse working on 12/31/2024 from 9:30 PM to 6:00 AM. Staff E said she not aware of Resident 1's fall on 12/31/2024 until four days later when facility management asked her about the fall. Staff D said the last time she saw Resident 1 was when she was passing medications, and she saw Resident 1 in her bed at that time. At 12:25 PM, Staff E said Resident 2 used her call light to call him to the room to inform him Resident 1 had a fall. Staff E said Resident 1 was in her bed, and he looked at her and could see a bump on her head. Staff E said he went to inform the nurse. Staff E said he informed the nurse of the fall and the nurse told him she would go take a look. About 15-20 minutes later Staff E went back to answer Resident 2's call light, and Resident 2 told him no nurse had been in to check on Resident 1. Staff E said he informed the nurse again that Resident 1 was waiting for an assessment. Staff E said the nurse said she would go in to check on the resident. Staff E said he did not personally see any nurse go in to assess Resident 1 after the fall. At 1:43 PM, Staff B, Director of Nursing Services and RN, said falls investigated by the facility should first rule out abuse and neglect especially with an unwitnessed fall with substantial injury. Staff B said a nursing assessment should be completed, neurological checks should be completed, and statements from witnesses collected. Staff B said she expected nurses to immediately initiate interventions to prevent further falls. At 1:49 PM, Staff C, Infection Preventionist and RN, said Resident 1 remembered her fall the day after, when she reported the fall to a nurse manager. Staff C said the facility interviewed Staff D who said she was not aware of the fall, though Staff E said she was notified of the fall. Staff C said the facility substantiated the nurse could have done more and investigated the fall of the resident. Staff C said the facility set expectations with nurses recently that they are the first to investigate, always consider abuse and neglect, and come up with an intervention to prevent re-occurrence. Staff C said he was not sure why a neurological flow sheet was initiated on 01/01/2025 and signed by someone with the same initials as Staff D. Staff C said after reviewing Resident 1's progress notes he did not see documentation about the 12/31/2024 fall from Staff D. Staff C said facility expectation is the nurses need to put an assessment in when a fall occurs. Reference WAC 388-97-1060 (1)