

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER South Creek Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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. (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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure vital signs were obtained upon admission to the facility and before administration of a blood pressure medication for 1 of 4 sampled residents (Resident 1) reviewed for vital signs monitoring. This failure placed residents at risk of unmet care needs and a diminished quality of life. Findings included. Record review of the facility policy, Admitting the Resident: Role of the Nursing Assistant, dated September 2013, documented, The following information should be recorded in the resident's medical record. The resident's vital signs. Resident 1 admitted to the facility on [DATE]. The Medicare 5-day Minimum Data Set, an assessment tool, dated 06/15/2025, documented the resident was cognitively intact. The resident discharged from the facility on 06/15/2025. Record review of Resident 1's physician's order, dated 06/16/2025, documented, [check] Blood Pressure weekly prior to giving antihypertensive [blood pressure] medication. Notify MD [Medical Doctor] for systolic [blood pressure top number] less than 100. Record review of Resident 1's physician's order, dated 06/16/2025, documented, [Check] Blood Pressure daily x2 weeks prior to administering antihypertensive medication. Notify MD if systolic less than 100. Record review of Resident 1's physician's order, dated 06/16/2025, documented, Metoprolol Succinate [blood pressure medication] ER [Extended Release] Tablet Extended Release 24Hour 50 MG [milligrams] Give 1 tablet by mouth one time a day for hypertension [high blood pressure]. Record review of Resident 1's electronic medical record failed to document the resident's vital signs, including blood pressure or pulse. Record review of Resident 1's Medication Administration Record, dated June 2025, documented the resident was given Metoprolol on 06/15/2025. In an interview on 07/24/2025 at 12:34 PM, Staff C, Registered Nurse, said vital signs were obtained on newly admitted residents within one to two hours. Staff C said Certified Nursing Assistants (CNAs) or nurses would obtain the vital signs, write them down on a vital signs sheet, and then the nurse would review the vital signs and enter them into the resident's electronic medical record. Staff C said before administration of blood pressure medications, vital signs were assessed first. Staff C said the vital signs should be in the residents' electronic medical records. In an interview on 07/24/2025 at 12:48 PM, Staff D, Licensed Practical Nurse, said newly admitted residents should have vital signs assessed as soon as possible. Staff D said vital signs were documented on a vital signs sheet, then entered into the resident's electronic medical record. Staff D said a resident's vital signs should be obtained before a blood pressure medication was given. In an interview on 07/24/2025 at 1:28 PM, Staff E, Residential Care Manager/Registered Nurse, said nurses and CNAs should orient newly admitted residents right away. Staff E said vital signs were obtained and documented on a sheet of paper, given to the nurse to review, and entered into the resident's electronic medical record. Staff E said before a blood pressure medication was administered, vital signs including blood pressure should be obtained. Staff E confirmed the resident was administered Metoprolol, a blood pressure medication, on 06/15/2025. Staff E reviewed Resident 1's electronic medical record and could not find vital signs for admission to the facility or before administration of a blood pressure medication. In an interview on 07/24/2025 at 2:05 PM, Staff B, Director of Nursing/Registered Nurse, said vital signs should be assessed upon admission to the facility. Staff B said vital signs were documented on a sheet, given to the nurse to review, and entered in to the resident's electronic medical record. Staff B said best practice was for nurses to obtain a resident's vital signs before administration of blood pressure medications such as Metoprolol. Staff B said she was unable to see any vital signs documented in the resident's electronic medical record. Reference WAC 388-97-1060 (1)</p>		