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	12/29/2025

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 0770 Level of Harm - Actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. (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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F 0770 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain ordered laboratory services for 1 of 4 sampled residents (Resident 1) reviewed for laboratory services. Resident 1 experienced harm when physician ordered CBC (complete blood count, a lab used in part to determine levels of red blood cells in blood) and BMP labs (basic metabolic panel, a blood test that checks the levels of different substances in your blood including sodium) were not obtained timely for physician evaluation and the resident required transport to the hospital and admission to the intensive care unit where they were diagnosed with profound anemia (low red blood cells) and hyponatremia (low levels of sodium in the blood). Findings included.Record review of the facility policy, titled, Request for Diagnostic Services, dated April 2007, showed, Orders for diagnostic services will be promptly carried out as instructed by the physician's order.Resident 1 admitted to the facility on [DATE]. The 5-day admission Minimum Data Set, an assessment tool, dated 09/11/2025, documented the resident was cognitively intact.Record review of Resident 1's Care Plan, dated 09/08/2025, showed Resident 1 was to have labs (testing) completed per physician's orders and to notify the physician of the results. Record review of Resident 1's physician orders, dated 11/02/2025, documented, CBC and BMP [labs] one time only for nausea for 3 days.Record review of Resident 1's alert note, dated 11/02/2025, documented, RN [Registered Nurse] Weekend Supervisor attempted x1 [one time] to draw labs ordered unsuccessfully AM [morning] shift.Record review of Resident 1's Medication Administration Record (MAR), dated November 2025, did not show documentation that the CBC or BMP labs were collected or completed.Record review of Resident 1's emergency room report, dated 11/05/2025, documented, [Resident 1's] laboratory workup was remarkable for several significant abnormalities including hyponatremia [low sodium in blood], acute renal [kidney] failure, acute anemia [low level of red blood cells], and urinary tract infection as well as elevated lipase [an enzyme that helps digest fats].I did speak with our hospitalist service here. Given he is profoundly anemic [low level of red blood cells] and profoundly hyponatremic [low sodium level in blood] with new acute renal failure with sepsis [blood infection] and AKI [Acute Kidney Injury], they agree that he needs to be at a center where multiple specialties can be consulted. We will reach out to the transfer center to organize transfer to ICU [Intensive Care Unit].In an interview on 12/22/2025 at 9:36 AM, Resident 1 said he was not looked after properly, and he had to go to the hospital ICU because he was so sick. Resident 1 said the facility should have been doing routine blood tests, and that the physician requested the blood tests but the blood tests did not happen.In an interview on 12/23/2025 at 10:21 AM, Staff C, Residential Care Manager/Registered Nurse, said CBC and BMP labs were ordered on 11/02/2025. Staff C reviewed Resident 1's notes and said on 11/02/2025, the weekend supervisor attempted to obtain the labs but was unsuccessful. Staff C said she did not see any documentation of other attempts. Staff C reviewed Resident 1's MAR and said it looked like the labs were not obtained. Staff C said if the lab could not be obtained, the resident's MD (medical doctor) should be made aware.In an interview on 12/23/2025 at 10:50 AM, Staff D, Medical Doctor, said Resident 1's labs were ordered on 11/02/2025. Staff D said he saw the note from the weekend supervisor that documented the blood draw was unsuccessful. Staff D said he wanted Resident 1's blood drawn on 11/03, the day after the unsuccessful blood draw by the weekend supervisor. Staff D said he gave a verbal order for the blood draw on 11/03/2025. Staff D said the order for blood labs was given on a Sunday, and if staff were having issues obtaining the blood the staff should have communicated with the MD on Sunday. Staff D said he did not know why the labs were not obtained. Staff D said the CBC and BMP labs were not obtained, and if the labs were obtained as planned, the resident may have been transferred out of the facility earlier, or given a sodium supplement, depending on the results of the blood labs.In an interview on 12/29/2025 at 10:43 AM, Staff B, Director of Nursing/Registered Nurse, said Resident 1 did have orders for a CBC and BMP that were ordered on 11/02/2025. Staff B said after reviewing Resident 1's electronic medical record that she could not see any results for the labs. Staff B said there was a progress note on 11/02/2025 documenting an unsuccessful blood draw. Staff B said the physician should be notified of the unsuccessful lab draw and orders moved so that the order did not expire in the electronic medical record. After reviewing the MAR, Staff B said the CBC and BMP labs were not obtained on 11/02/2025, 11/03/2025, and 11/04/2025. The resident was then sent to the hospital on [DATE].Reference WAC 388-97 -1620(2)(b)(i)(ii)