STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505387	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodard Creek Health & Rehabilitation	3333 Ensign Road Northeast Olympia, WA 98506

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure allegations involving abuse were immediately reported, within two hours, to Law Enforcement for 1 of 1 sampled resident (4) reviewed for abuse. The facility failed to ensure residents leaving against medical advice (AMA) were logged and/or reported to the Adult Protective Services (APS) and/or the State Agency for 3 of 6 sampled residents (3, 5, & 6) reviewed for discharge. This failure placed residents at risk for potential abuse/neglect and a diminished quality of life. Findings included .Review of the facility's policy, Abuse Investigation and Reporting, dated 10/01/2021, documented an alleged violation of abuse will be reported immediately, but not later than two hours if the alleged violation involves abuse. All alleged violations involving abuse will be reported, by the facility Administrator, to law enforcement officials (if applicable).Reporting of Allegations to State AgencyResident 4Resident 4 was admitted to the facility on [DATE] with diagnoses of Parkinsonism syndrome (tremors, stiffness, slowness of movement, and difficulty maintaining balance) and chronic pain. The 5-day Medicare minimum data set (MDS), an assessment tool, dated 07/08/2025, documented Resident 4 had moderate cognitive impairment and was dependent on staff for many activities of daily living (ADLs).The incident report, dated 08/01/2025, documented Resident 4 made an allegation of sexual abuse by a staff member.On 09/04/2025 at 4:40 pm, Staff A said he did not report the allegation of abuse to Law Enforcement within the 2-hour reporting period. Staff A said he did not know why he did not report when he reported to the State Agency. Staff A said he should have reported within 2 hours.AMAReview of the facility policy, Discharging a Resident Without a Physician's Approval, dated 10/01/2021, documented the facility will make all reasonable efforts to ensure that the resident is educated on risks associated with leaving the facility without a physician's approval. Efforts will be made to ensure the resident has safest discharge possible. If the facility feels that the resident's safety may be in jeopardy with the discharge, the facility may make a referral to Adult Protective Services or other community support system.Resident 3Resident 3 was admitted to the facility on [DATE] with diagnoses of congestive heart failure (the heart cannot pump blood effectively enough to meet the body's needs) and cirrhosis (advanced scarring of the liver). The Annual MDS, dated [DATE], documented Resident 3 had no cognitive impairment and was independent with ADLs.Review of progress notes, dated 06/08/2025, documented Resident 3 left the building AMA. The resident would not wait to take the facility stored medications.Review of the June 2025 Accident and Incident log did not document Resident 3's AMA. No documentation showed whether APS was contacted related to a potentially unsafe discharge. On 09/04/2025 at 3:23 pm, Staff B Registered Nurse (RN) and Director of Nursing (DNS), said this discharge should have been called to APS for Resident's AMA.At 4:14 pm, Staff A, Administrator, said Resident 3's discharge should have been called to APS.Resident 5Resident 5 was admitted to the facility on [DATE] with diagnoses of hip fracture and anxiety disorder. The admission MDS, dated [DATE], documented Resident 5 had no cognitive impairment and required set-up assistance from staff with many ADLs.Review of progress notes, dated 06/06/2025, documented Resident 5 was not in their room at the beginning of the shift and their lunch tray was untouched.Review of progress notes, dated 06/07/2025, documented Resident 5 was not seen at the beginning of the shift. Staff called family and awaited a response. One family member responded and had not seen the resident. The last witnessed sighting of Resident 5 was during the am medication pass on 06/06/2025.Review of progress notes, dated 06/07/2025, documented Resident 5 did not return on 06/06/2025 after the resident signed out stating they were going to get a wheelchair for their pending discharge. Family initially did not know where Resident 5 was but soon located the resident. Resident 5's departure was considered an AMA discharge as the resident did not return to the facility on [DATE].On 09/04/2025 at 3:23 pm, Staff B said she was off when this incident occurred. Staff B said she would have called this into the State Agency as an elopement. Staff B said this discharge should have been called to APS.On 09/04/2025 at 4:14 pm, Staff A said he was not sure this discharge should have been considered an elopement because the resident signed out of the facility. Staff A said the resident did not return to the facility as expected and the staff did not know where the resident was. Staff A said this discharge should have been called to APS.Resident 6Resident 6 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs) and oxygen dependence. No MDS was completed.Review of progress notes, dated 07/29/2025, documented Resident 6 was requesting to leave AMA. Staff notified the Administrator and family following facility protocol for AMA

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure signs of psychosocial outcome related to allegations of abuse were monitored for 1 of 4 sampled residents (4) reviewed for abuse. This failure placed residents at risk of abuse, neglect and a decreased quality of life.Findings included .Resident 4 was admitted to the facility on [DATE] with diagnoses of Parkinsonism syndrome (tremors, stiffness, slowness of movement, and difficulty maintaining balance) and chronic pain. The 5-day Medicare MDS, dated [DATE], documented Resident 4 had moderate cognitive impairment and was dependent on staff for many ADLs.Review of Resident 4's care plan, dated 08/01/2025, documented Resident 4 suffered from Post Traumatic Stress Syndrome (mental health problem that can occur after a traumatic event) due to a history of physical and emotional abuse (a sexual assault) while in a nursing facility as a child.Review of facility incident report, dated 08/01/2025, documented Resident 4 made an allegation of sexual abuse by a staff. The investigation did not address the monitoring of potential psychosocial wellbeing.Review of physician orders, dated 08/01/2025, documented staff will monitor the resident for psychosocial wellbeing, observe and chart a progress note for behavior, refusal of care, social isolation, and pain management, and notify the provider of any of the above concerns, and monitor every shift for five days.A review of the progress notes did not show monitoring for psychosocial wellbeing related to the allegation of sexual abuse.On 09/04/2025 at 3:23 pm, Staff B said there was no monitoring of Resident 4's potential psychosocial being related to the abuse allegation. Staff B said staff should have documented monitoring.Reference WAC 388-97-0640(5)(a)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assist residents with discharge needs to ensure a timely discharge for 1 of 3 residents (1) reviewed for discharge planning. The facility failed to ensure discharge planning reflected the resident's discharge status for 1 of 3 residents (3) reviewed for discharge planning. This failure placed residents at risk for unmet care needs, psychological distress, risk for re-hospitalization, and a decreased quality of life.Findings included .Resident 1Resident 1 was admitted to the facility on [DATE] with diagnoses of blood clot in the lungs and chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs). The admission minimum data set (MDS), an assessment tool, dated 07/09/2025, documented Resident 1 had no cognitive impairment and was moderately dependent on staff for many activities of daily living (ADLs).Review of Resident 1's care plan, dated 07/03/2025, documented Resident 1 would be at the facility short term. Staff would coordinate with the physician regarding discharge plans, make community DME (medical equipment) referrals as indicated, make community referrals as needed, and contact local agencies if necessary.On 07/28/2025 at 11:44 am, Resident 1's power of attorney (POA) said she had been struggling to get the facility to assist with setting up a primary care provider (PCP) in the community and assist with setting up caregivers in the home. The POA had asked on several occasions for assistance with these tasks and she had been told this was not the facility's responsibility. There was a long wait for her to set up with a PCP and Resident 1 had medical conditions which required attention to sooner. The POA had run into constant communication issues and dead ends with the facility to address these issues. Resident 1 had a history of eloping from this and other facilities, leaving against medical advice (AMA), and was threatening to leave AMA if they were not discharged the next day, the scheduled discharge date . The POA stated the discharged scheduled for the following day was unsafe due to the lack of a PCP and caregivers.Review of the admission Nursing Collection Tool, dated 07/02/2025, documented Resident 1 wanted to leave AMA and just didn't want to be here. Staff were able to convince the resident to stay. The elopement evaluation portion of the assessment documented Resident 1 had verbally expressed a desire or plan to leave the facility unsupervised, had a history of attempts to elopement in the previous six months, and had family/responsible party who voiced concerns the resident would try and leave the facility.Review of a Social Service Initial Evaluation, dated 07/08/2025, documented Resident 1 wanted to go home independently and lived alone. It was noted the plan for discharge did not meet the residents' needs. The section on the physician's input on the resident's discharge was left blank. The anticipated length of stay at the facility was left blank. Who will assist the resident with meal preparation, grocery shopping, and transportation was left blank. The home health type/name was left blank. Additional agencies and services provided to the resident was left blank.Review of progress notes, dated 07/02/2025, documented Resident 1 was adamant they were not going to stay at the facility, shortly after admission. The POA was contacted who explained the resident had an extensive history of leaving facilities AMA, almost every one, over the previous 20 years.Review of progress notes, dated 07/07/2025, documented Resident 1 had eloped from the facility. The resident will now require the use of a wander guard (a bracelet that alarms when the resident leaves the building).Review of progress notes, dated 07/08/2025, documented Resident 1 just wants to go home to their dog and is going home today no matter what. [Resident 1] is alert and oriented.Review of progress notes, dated 07/09/2025, documented Resident 1 continues to verbalize desire to go home.Review of progress notes, dated 07/24/2025, documented Resident 1's POA refused to sign the admission agreement due to concerns with discharge.Review of progress notes, dated 07/25/2025, documented Resident 1's POA was upset because the facility was not finding the resident a PCP in the community. The POA was told it was not up to us to find a PCP in the community. The POA said the facility was throwing the resident out and this was an unsafe discharge.During an interview on 07/29/2025 at 9:52 am, Staff D, Director of Rehab, said it was recommended by therapy that Resident 1 had caregiver support a couple hours a day.During an interview on 07/29/2025 at 10:00 am, the POA said she would not be picking up the resident that day for discharge because the facility did not assist with a PCP and caregivers. The POA said it would be an unsafe discharge as a result.During an interview on 07/29/2025 at 12:22 pm, Staff F, social services, said there had been shifting staff assisting with Resident 1's discharge making it confusing. Staff F said she had not been working on the discharge for long. Staff F stated it was expected that the POA would set up PCP and caregivers on her own and the POA thought this was on the

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a discharge summary for 1 of 3 residents (2) reviewed for discharge planning. The facility failed to provide written bed hold notices at the time of a therapeutic leave for 1 of 1 sampled resident (3) reviewed for therapeutic leaves. This failure placed the residents at risk for lack of knowledge regarding their right to hold their bed, protection of resident rights during transfers, and a diminished quality of life.Findings included .Discharge SummaryThe facility policy, Transfer or Discharge, Preparing a Resident For, dated 10/01/2021, documented a post-discharge plan is developed for each resident prior to his or her transfer or discharge. Nursing services and/or social services is responsible for preparing a discharge summary and post-discharge plan and completing a discharge note in the medical record.Resident 2Resident 2 was admitted to the facility on [DATE] with diagnoses including dementia and dysphasia. No minimum data set (MDS), an assessment tool, was completed.Review of care plan, dated 06/25/2025, documented Resident 2 was to reside at the facility on a short-term basis. Staff would review and update discharge plans with the resident when needed.Review of Social Service Initial Assessment, dated 06/24/2025, documented Resident 2 would return home after their stay at the facility. Review of progress notes, dated 07/01/2025, documented Resident 2 was transferring to another long-term care facility. Medications reviewed with the resident and family. Belongings were sent with the resident. Review of discharge POC - Resident discharge instructions, dated [DATE], were blank.Review of the medical record showed no Discharge Summary was completed or sent to the receiving facility.On 09/04/2025 at 3:03 pm, Staff B Registered Nurse (RN) and Director of Nursing (DNS), said for Resident 2 they sent the receiving facilities orders, progress note, medication/treatment administration and provider notes. Staff B said they didn't always complete the discharge summary or instructions. Staff B said they should have been doing it.Resident 3Resident 3 was admitted to the facility on [DATE] with diagnoses of congestive heart failure (the heart cannot pump blood effectively enough to meet the body's needs) and cirrhosis (advanced scarring of the liver). The Annual MDS, dated [DATE], documented Resident 3 had no cognitive impairment and was independent with activities of daily living.Review of care plan, dated 04/09/2025, documented Resident 3 was staying at the facility long-term, and the discharge plan would be reviewed with the resident.Review of progress notes, dated 05/02/2025, documented Resident 3 left on a leave of absence (LOA). The medical record did not indicate when the resident returned from the LOA. There was no documentation showing a bed hold was offered.Review of progress notes, dated 05/23/2025, documented Resident 3 left on a LOA until 05/27/2025. There was no documentation showing a bed hold was offered.On 09/04/2025 at 1:12 pm, Staff E, social services, said Resident 3 would leave often on therapeutic leaves (LOA). Staff E said they did not provide bed holds to residents leaving on therapeutic leaves and were not aware of the requirement.Reference WAC 388-97-0080 (1)(b)(2)(a)(d)(6)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure resident care plans were reviewed, revised, and accurately reflected resident care needs for 2 of 13 sampled residents (2 & 4) reviewed for care plan revisions. This failure placed residents at risk for unidentified and unmet care needs and a diminished quality of life.Findings included .Resident 2Resident 2 was admitted to the facility on [DATE] with diagnoses including dementia and dysphasia. No minimum data set (MDS), an assessment tool, was completed.Review of the care plan, dated 06/25/2025, documented Resident 2 was at risk for dehydration, weight loss, or malnutrition related to advanced age. Interventions included checking weights as ordered.Review of physician orders, dated 06/24/2025, documented Resident 2 required moderately thick liquids with thin water between meals, small bites of food and sips of water, and use of a chin tuck, swallowing twice with every bite and/or sip.The Diet Nutritional Assessment, dated 06/278/2025, documented Resident 2 required moderately thick liquids with thin water between meals, small bites of food and sips of water, and use a chin tuck, swallowing twice with every bite and/or sip. The resident was identified at risk for malnutrition related to CHF, Parkinson's disease and diabetes mellitus.On 09/04/2025 at 3:03 pm, Staff B Registered Nurse (RN) and Director of Nursing (DNS), said the care plan should have been updated to include Resident 2's specific dietary needs.Resident 4Resident 4 was admitted to the facility on [DATE] with diagnoses of Parkinsonism syndrome (tremors, stiffness, slowness of movement, and difficulty maintaining balance) and chronic pain. The 5-day Medicare MDS, dated [DATE], documented Resident 4 had moderate cognitive impairment and was dependent on staff for many activities of daily living.The care plan, dated 08/01/2025, documented Resident 4 suffered from Post Traumatic Stress Syndrome (mental health problem that can occur after a traumatic event) due to a history of physical and emotional abuse (a sexual assault) while in a nursing facility as a child.The incident report, dated 08/01/2025, documented Resident 4 made an allegation of sexual abuse by a staff.On 09/04/2025 at 3:23 pm, Staff B said Resident 4's care plan was not revised to include the allegation of sexual abuse on 08/01/2025.Reference WAC: 388-97-1020 (2)(e)(f)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to initiate interventions to prevent elopements or act on an elopement for 2 of 3 residents (1, 5) reviewed for elopement. The facility failed to ensure discharges Against Medical Advice (AMA) were safe for 2 of 4 residents (3 & 6) reviewed for AMA discharges. This failure placed residents at risk of unmet needs, diminished quality of life, and other negative health outcomes.Findings included .ElopementResident 1Resident 1 was admitted to the facility on [DATE] with diagnoses of blood clot in the lungs and chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs). The admission minimum data set (MDS), an assessment tool, dated 07/09/2025, documented Resident 1 had no cognitive impairment and was moderately dependent on staff for many activities of daily living (ADLs).The admission Nursing Collection Tool, dated 07/02/2025, documented Resident 1 wanted to leave AMA and just didn't want to be here. Staff were able to convince the resident to stay. The elopement evaluation portion of the assessment documented Resident 1 verbally expressed a desire or plan to leave the facility unsupervised, had a history of attempts to elope in the previous six months, and his family/responsible party who voiced concerns the resident would try and leave the facility. Recommendations noted the resident was at risk for elopement, and to implement the care plan interventions and evaluate the need for a wander bracelet. The resident would be given an AMA form if he attempted to leave. No wander bracelet was placed and no indication as to why was noted.Review of progress notes, dated 07/02/2025, documented Resident 1 was adamant he was not going to stay at the facility, shortly after admission. The Power of Attorney (POA) was contacted who explained the resident had an extensive history of leaving facilities AMA, almost everyone, over the past 20 years. The POA suggested informing Resident 1 that their dog was boarded.Review of the care plan was reviewed and there was no mention of Resident 1's risk of elopement. The care plan did not mention reminding the resident their dog was boarded.Review of progress notes, dated 07/07/2025, documented Resident 1 had eloped from the facility.On 07/28/2025 at 11:44 am, Resident 1's POA said the resident had a history of leaving every healthcare facility AMA.On 07/29/2025 at 12:43 pm, Resident 1 said they planned on leaving the facility. The resident said they figured out how much a cab cost to get home. Resident 1 could not articulate why they wanted to leave, just that they wanted to go home in the cab.On 09/04/2025 at 3:47 pm, Staff B registered nurse (RN) and Director of Nursing (DNS), said she was unaware of Resident 1's or the POA's statements of the resident's desire to leave AMA upon admission. Staff B said the staff should have been more proactive at that time. Interventions should have been implemented to prevent elopement.Resident 5Resident 5 was admitted to the facility on [DATE] with diagnoses of hip fracture and anxiety disorder. The admission MDS, dated [DATE], documented Resident 5 had no cognitive impairment and required set-up assistance from staff with many ADLs.The care plan, dated 04/14/2025, documented Resident 5 was expected to stay at the facility on a short-term basis. Interventions included coordinating with a physician with discharge plans.No elopement assessment was noted in a review of the medical record.Progress notes, dated 06/06/2025, documented Resident 5 was not in their room at the beginning of the shift and their lunch tray was untouched. Progress notes, dated 06/07/2025, documented Resident 5 was not seen at the beginning of the shift. Called family and awaiting a response. One family member responded and had not seen the resident. Last Resident 5 was seen was morning medication pass on 06/06/2025.Progress notes, dated 06/07/2025, documented Resident 5 did not return on 06/06/2025 after they the resident signed out stating they were going to get a wheelchair for their pending discharge. Family initially did not know where Resident 5 was but soon located the resident. Resident 5's departure is considered an AMA discharge as the resident did not return to the facility on [DATE].On 09/04/2025 at 3:23 pm, Staff B said she was off when the incident occurred. Staff B said she would consider this an elopement and feels elopement protocol should have been followed.On 09/04/2025 at 4:14 pm, Staff A said he was not sure Resident 5's absence should have been considered an elopement because the resident signed out of the facility. Staff A admitted the resident did not return to the facility as expected and the staff did not know where the resident was for a period.AMAThe facility policy, Discharging a Resident Without a Physician's Approval, dated 10/01/2021, documented the facility would make all reasonable efforts to ensure that the resident was educated on risks associated with leaving the facility without a physician's approval. Efforts would be made to ensure the resident had safest discharge possible. Staff would promptly notify the attending physician of the resident's wishes to be discharged. The