| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505387 | A. Building<br>B. Wing | 01/07/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Woodard Creek Health & Rehabilitation | 3333 Ensign Road Northeast<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure results of allegations/investigations were reported to the State Agency Hotline within 5 working days for 3 of 3 residents (2, 3, & 4) reviewed for abuse and neglect. This failure placed residents at risk for potential unmet needs and decreased quality of life. Findings include:Resident 2Resident 2 was admitted to the facility on [DATE] with diagnoses of sepsis and pneumonia. The quarterly Minimum Data Set (MDS), dated [DATE], documented Resident 2 had severe cognitive impairment and was dependent on staff with activities of daily living (ADLs).The facility investigation, dated 09/23/2025, documented an allegation staff did not change the resident's tube feeding and the resident was without food for an extended period. The 5-day follow-up investigation submitted to the State Agency was missing interviews of sample residents.Interviews of staff were requested on 12/11/2025 and 12/18/2025 and none were provided.Resident 3Resident 3 was admitted to the facility on [DATE] with diagnoses of a stroke with left side weakness. The admission MDS, dated [DATE], documented Resident 3 had no cognitive impairment and was dependent on staff with ADLs.The facility investigation, dated 10/02/2025, documented Resident 3 reported staff were rude and unprofessional to the resident. The 5-day follow-up investigation submitted to the State Agency was missing interviews of staff.Interviews of staff were requested on 12/11/2025 and 12/18/2025 and none were provided.Resident 4Resident 4 was admitted to the facility on [DATE] with diagnoses of urinary tract infection and morbid obesity. The quarterly MDS, dated [DATE], documented Resident 4 had no cognitive impairment and was dependent on staff with ADLs.The facility investigation, dated 11/04/2025, documented Resident 4 received care from a male staff member after requesting only female care givers. The 5-day follow-up investigation submitted to the State Agency was missing interviews of sample residents.Interviews of residents were requested on 12/11/2025 and 12/18/2025 and none were provided.On 01/07/2026 at 3:57 pm, Staff B, Director of Nursing and Registered Nurse (RN), said staff and resident interviews should be included in the facility investigations. On 01/07/2026 at 4:41 pm, Staff A, Administrator, said staff and resident interviews should be done with investigations and reported to the State Agency.Reference WAC 388-97-0640(5)(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 |
|---|---|---|

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assess, monitor and intervene upon a change in the resident's respiratory status in accordance with standards of practice for 1 of 9 residents (2) reviewed for care and services. This failure placed residents at risk of unmet care needs and decreased quality of life.Findings include:Resident 2 was admitted to the facility on [DATE] with diagnoses of sepsis and pneumonia. The quarterly Minimum Data Set (MDS), dated [DATE], documented Resident 2 had severe cognitive impairment and was dependent on staff with activities of daily living.The care plan, dated 10/30/2025, documented Resident 2 was at elevated risk for pneumonia due to use of a chronic nasogastric tube (a tube going into the stomach that provides artificial feedings). The care plan documented staff would administer nebulizers as ordered and observe for signs and symptoms of pneumonia.On 12/11/2025 at 12:58 pm, Resident 2 was observed laying in their bed. The residents' breathing was non-labored. The resident appeared comfortable.Progress notes, dated 10/14/2025, documented Resident 2's family asked about the resident needing a nebulizer (a machine which aerosolizes medication to breath into lungs) treatments. The resident was noted to be uncomfortable and making a distressing face while coughing. A chest x-ray was ordered.Radiology Results Report, dated 10/14/2025, documented a chest x-ray showed the right upper lung had atelectasis (a collapse to a portion of the lung due to loss of air) versus consolidation (air is replaced in the lungs with pus, blood, or substance) related to pneumonia.Progress notes, dated 10/16/2025, documented the resident will receive albuterol (a medication used to open airways in lungs) three times a day for four days then repeat a chest x-ray. The family reported Resident 2 was short of breath (SOB). Staff did not find concerns upon assessment.Progress notes, dated 10/17/2025, documented Resident 2's family requested a nebulizer treatment.The Medication Treatment Record, dated November 2025, documented Resident 2 received nebulizer treatment with albuterol three times a day on 10/16/2025 through 10/20/2025.No follow up x-ray was completed on 10/20/2025.The progress notes did not include documentation from 10/18/2025 to 10/23/2025.Progress notes, dated 10/23/2025, documented Resident 2 had increased congestion and required suctioning to the airways. An x-ray was ordered and nebulizers given. The resident had a temperature of 101.4 degrees. The resident was transferred to the hospital.The hospital History & Physical, dated 10/23/2025, documented Resident 2 had progressive respiratory symptoms for two weeks with shortness of breath and altered breathing sounds for the previous week. The resident had a temperature of 101 degrees the previous night and a few days ago. The family said the resident had respiratory symptoms for two weeks and had no treatment besides nebulizers. The resident was diagnosed with pneumonia, sepsis, and acute respiratory failure.On 01/07/2026 at 4:16 pm, Staff B, Director of Nursing and Registered Nurse (RN), said staff did notify the provider on 10/14/2025 when there was an initial change in condition. Staff B said there was no documentation from 10/18/2025 to 10/23/2025 to show the status of the resident. Staff B said on the 23rd of October, the resident went to the hospital for pneumonia. Staff B said staff should have been documenting Resident 2's status considering the change in their condition.On 01/07/2026 at 4:41 pm, Staff A, Administrator, said there was no follow-up chest x-ray in the medical record. Staff A said they agreed staff should have documented the resident's status when they had a change in condition.Reference WAC 388-97-1060(1) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received assistance with meals for intake for 2 of 5 residents (1 & 7) reviewed for nutrition and hydration. The facility failed to promptly identify weight loss and implement interventions to prevent further weight loss for 2 of 4 residents (5 & 7) sampled for weight loss. This failure placed residents at risk for impaired nutrition, impaired hydration, and a decline in health status.Findings include:Resident 1Resident 1 was admitted to the facility on [DATE] with diagnoses of dementia and a stroke. The quarterly Minimum Data Set (MDS), dated [DATE], documented Resident 1 haf moderate cognitive impairment and requires assistance with meals.The care plan, dated 10/22/2025, documented Resident 1 had swallowing difficulties and requires 1:1 assistance at meals and cueing to eat. The care plan documented staff would encourage the resident to go to the dining room for meals.Review of the 'Eating History,' dated 12/04/2025 to 01/02/2026, documented Resident 1 was provided with a set up meal (no assistance from staff) 19/87 times.Review of the 'Nutritional at-Risk Assessment,' dated 10/28/2025, documented Resident 1 liked to eat independently in the dining room and due to chewing and swallowing issues, the resident required 1:1 assistance with meals.Review of the 'Order Details,' dated 04/23/2025, documented Resident 1 required 1:1 assistance with meals and cues to eat.Review of the 'Dietary Ticket,' a quick reference for staff for dietary needs, documented Resident 1 required 1:1 assistance with meal and cue to eat.On 12/24/2025, at 1:44 pm, Resident 1 was observed sitting in bed, eating their lunch meal independently. No staff were observed in or near the resident's room during the continuous observation. The resident continued to eat independently until 2:14 pm when they gently coughed, clearing their throat.On 12/24/2025 at 2:15 pm, Staff H, nursing assistant (NA), said he would assist Resident 1 with meals when helping their roommate. Staff H said this meant watching Resident 1 when they eat. Staff H said it was difficult to monitor Resident 1 or any resident who required supervision due to staffing levels. Staff H said they would, at times, leave Resident 2 to eat independently. Staff H said Resident 1 was on aspiration precautions (precautions used to prevent food from entering the airways).On 12/31/2025, at 1:26 pm, Resident 1 was observed sitting in bed, eating their lunch meal independently. Family was present but did not assist Resident 1 with eating. Throughout the continuous observation, no staff were observed in or near the resident's room through 2:30 pm, when the resident was done eating.On 12/31/2025 at 2:30 pm, Staff G, NA, said Resident 1 does not require assistance with meals. Staff G said staff levels make it hard to supervise all residents who require it.On 01/07/2026 at 1:46 pm, Staff E, dietary manager, said Resident 1 required 1:1 supervision with meals. Staff E said the resident would refuse help and liked to eat on their own and staff should provide 1:1 supervision regardless.On 01/07/2026 at 2:23 pm, Staff F, dietary technician, said staff needed to try and assist Resident 1 with eating. Staff F said the resident liked to eat independently. Staff F said, we may need to look at the care plan again.On 01/07/2026 at 4:04 pm, Staff B, Director of Nursing and Registered Nurse (RN), said Resident 1 required 1:1 supervision with eating due to a coughing and choking history. Staff B said staff should encourage the resident to go to the dining room. Resident 5Resident 5 was admitted to the facility on [DATE] with diagnoses of a colostomy and hypothyroidism. The admission MDS, dated [DATE], documented Resident 5 had no cognitive impairment and required staff to set up meals.The care plan, dated 11/01/2025, documented Resident 5 was at risk for weight loss due to advanced age. The care plan documented staff would obtain weights and track meal intake.The Nutritional at Risk Assessment, dated 11/10/2025, documented Resident 5's usual body weight was 160-161 pounds with no current weight loss. The resident's current weight was 166.6 pounds. The resident had surgical wounds to their<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | abdomen. The goal for the resident was to have no weight loss through review period.The Weight Summary, dated 10/26/2025 to 12/30/2025, documented the following weights:12/30/2025 - 154.9 pounds 12/23/2025 - 155.5 pounds 12/09/2025 - 156.9 pounds 12/02/2025 - 158.2 pounds 11/11/2025 - 167.2 pounds 10/31/2025 - 167.4 pounds 10/26/2025 - 166.6 pounds The medical record did not address Resident 5's weight loss.On 01/07/2026 at 1:46 pm, Staff E, said staff address weight loss at a weekly meeting. Resident 5's weight loss should have been addressed at the weight loss meeting.On 01/07/2026 at 2:23 pm, Staff F, said weight loss was addressed at a weekly weight loss meeting. Staff F said she documents her findings on weight loss on her computer, but not on the medical record. Staff F said whoever was documenting the meeting would add her notes on weight loss. Staff F said Resident 5 did not have documentation in the medical record related to their weight loss. A response to the resident's weight loss should have been documented.On 01/07/2026 at 4:04 pm, Staff B, said weight loss should be assessed, and an intervention should be put into place.Resident 7Resident 7 was admitted to the facility on [DATE] with diagnoses of dementia and congestive heart failure. The quarterly MDS, dated [DATE], documented Resident 7 had no cognitive impairment and required staff to set up meals.The care plan, dated 09/05/2025, documented Resident 7 was at risk for weight loss and malnutrition. The care plan documented staff would encourage the resident to eat and obtain weights as ordered. The care plan documented staff would set up for meals for the resident and offer cues and reminders to eat to improve intake.Observations of mealsOn 12/31/2025 at 1:26 pm, Resident 7 was observed to sit in bed with head of bed at a 45-degree angle. Resident 7's food tray was sitting on bedside table. The tray was not set up. At 1:45 pm, the food tray was set up for the resident. The resident made no attempts to eat. Staff were not present in room during continuous observation. At 2:04 pm, the resident attempted to eat independently. The resident had to pull their body toward the food tray to reach food due to the height of the head of the bed (HOB). The resident continued to eat and finished at 2:20 pm. Staff removed the tray at 2:30 pm.On 12/31/2025 at 2:30 pm, Staff G, NA, said Resident 7 did not require assistance with meals.Review of the Dietary Ticket, showed the resident required assistance with tray set up and intermittent supervision, sitting in a bolt upright position.Review of Order Details, dated 09/09/2025, documented Resident 7 required 1:1 assistance for all meals.Weight LossWeight Summary, dated 09/05/2025 to 12/19/2025, documented the following weights for Resident 7:12/19/2025 - 194.8 pounds 10/20/2025 - 205.0 pounds10/10/2025 - 209.3 pounds 10/02/2025 - 212.2 pounds09/26/2025 - 210.6 pounds09/14/2025 - 214.8 pounds09/05/2025 - 210.6 poundsReview of the 'Nutritional at-Risk Assessment,' dated 09/03/2025, showed Resident 7's weight was 214.8 pounds and was stable. The assessment documented the resident required extensive assistance with meals requiring 1:1 supervision with meals. The assessment documented Resident 7 would have no weight loss through the review period. On 01/07/2026 at 1:46 pm, Staff E, said Resident 7's weight loss should have been addressed at the weekly weight loss meeting. Staff E said Resident 7 required assistance with tray set up, 1:1 and intermittent supervision sitting in a bolt upright position. Staff E said the resident's HOB should be upright. On 01/07/2026At 2:23 pm, Staff F, said weight loss was addressed at a weekly weight loss meeting. Staff F said it was difficult to obtain weights timely from staff. Staff F said she documented her findings on weight loss on her computer, but not on the medical record. Whoever was documenting the meeting would add her notes on weight loss. Staff F said Resident 7 did not have documentation in the medical record related to their weight loss. Documentation and a response to the weight loss should have been documented.On 01/07/2026At 4:04 pm, Staff B, said weight loss should be assessed and an intervention should be put into place. Resident 7's dietary orders should have been followed.Reference: WAC 388-97-1060(3)(h) |