

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505387	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/02/2026
NAME OF PROVIDER OR SUPPLIER Woodard Creek Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents and/or their representatives were offered the opportunity to participate in care conferences for 1 of 3 sampled residents (5) reviewed for care conferences. This failure placed residents at risk for weight loss, pain, and a diminished quality of life. Findings included .Resident 5 was admitted to the facility on [DATE] with diagnoses including failure to thrive, severe protein-calorie malnutrition, and advanced kidney disease. The quarterly minimum data set (MDS), an assessment tool, dated 10/30/2025, documented Resident 5 had severe cognitive impairment and was dependent on staff for assistance with eating. Durable Power of Attorney for Health Care, dated 12/16/2023, designated Resident 5's family member, Collateral Contact (CC5), as their decision maker, if the resident can no longer make decisions. On 01/16/2026 at 11:40 AM, CC5 said he was shocked the last time he saw Resident 5 because of the amount of weight the resident had lost. He said that had not been communicated to him. Family members saw the resident eating without assistance and became concerned the resident was not getting the care they needed. CC5 spoke with the provider to discuss concerns. The doctor said they would schedule a care conference to further discuss concerns. The care conference was never set up and there had been no communication since. CC5 said the communication with the facility was horrible. CC5 said he had concerns with the resident's dietary status, pain, and communication with staff. Review of progress notes, dated 11/19/2025, documented a call to CC5 was made and they would have a care conference the following week to determine if hospice was appropriate. During an interview on 03/02/2026 at 4:50 PM, Staff B, Director of Nursing services and registered nurse, said there was no follow up with CC5 after the note on 11/19/2025. Staff B said no care conference took place. Staff B said Resident 5 was not receiving end of life or hospice services. Staff B said end of life or hospice care needs to be discussed to address the potential for further weight loss and pain. Reference WAC 388-97-0300(3)(a)</p>

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a comprehensive, person-centered care plan that guided staff in providing care for 1 of 13 sampled residents (1) reviewed for care plans. The failure to establish care plans that were individualized placed residents at risk to receive inappropriate and inadequate care to meet their individualized needs. Findings included. Resident 1 was admitted to the facility on [DATE] with diagnoses including alcoholic cirrhosis (scarring of the liver due to conditions such as long-term alcohol use), esophageal varices (enlarged veins in esophagus caused by blocked blood flow in liver), and alcohol dependence. The quarterly minimum data set (MDS), an assessment tool, dated 11/11/2025, documented Resident 1 had no cognitive impairment and was partial to moderately dependent on staff for assistance with activities of daily living. Review of care plan, dated 10/24/2025, documented Resident 1 had cirrhosis of the liver. The staff would monitor for yellowing of the eyes and/or skin, abdominal ascites (fluid buildup in abdomen), and changes in mental status. Staff would order labs and diagnostics as ordered. The care plan, dated 12/13/2025, documented staff would monitor for alcohol withdrawal and check vitals as needed. The care plan did not address issues such as monitoring daily weights, monitoring abdominal girth, or medications used for the conditions. On 01/02/2026 11:05 AM, Resident 1 said she did not always feel like staff understood tasks needed to manage their liver disease and alcohol dependence. I don't think they understand liver disease. Resident 1 said she felt like staff did not understand the importance of things such as obtaining weights and vitals, passing medications on time, passing medication at all, drawing laboratory samples correctly, and applying appropriate skin creams. These were all a part of managing her condition. Resident 1 said the staff did these tasks inconsistently and sometimes not at all. Resident 1 said this had impact on the residents' daily life. Resident 1 felt the care plan did not provide the detail staff needed to care for the residents' health conditions. On 03/02/2026 at 2:07 PM, Staff O, Nursing Assistant, said the staff have inconsistent assignments so they do not always know if the resident needs vitals or weights. Staff O said staff did not always know the residents well. On 03/02/2026 at 4:20 PM, Staff B, Director of Nursing services and registered nurse, said Resident 1's care plan should be more personalized to address the residents' health conditions. Reference (WAC) 388-97-1020(1), (2)(a)(b)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents who fell were assessed/evaluated for increased supervision and/or that a resident-specific fall prevention care plan was implemented for 1 of 3 residents (3) reviewed for falls. These failures put residents at risk for further injury, pain, and a decreased quality of life. Resident 3, who was assessed as a known high fall risk, was on blood thinning medication and had severe cognitive impairment, experienced harm when they had an unwitnessed and unsupervised fall, sustained a left hip fracture and experienced extreme pain as evidenced by the resident's grimacing and yelping when rolled to their left side. Findings included. Resident 3 was admitted to the facility on [DATE] with diagnoses including dementia and metabolic encephalopathy (A brain dysfunction caused by metabolic disturbances). The admission minimum data set (MDS), an assessment tool, dated 10/31/2025, documented Resident 3 has severe cognitive impairment and is dependent on staff for assistance with activities of daily living (ADLs). Review of the resident's care plan, dated 10/27/2025, documented Resident 3 was at risk for falls related to advanced dementia. The resident would wear non-skid socks while out of bed, use the bed in the lowest position, and staff would remind the resident to use the call light. Review of a fall assessment, dated 10/27/2025, documented Resident 3 was a high risk for falls due to a history of falls, incontinence, and used of anticoagulant (prevents clots) medication. Review of nursing progress note, dated 12/10/2025, documented Resident 3 had an unwitnessed fall to the ground in the dining room. It was believed the resident dropped a stuffed animal and reached to grab it. It was unclear if the resident hit their head and was on Eliquis (an anticoagulant used to prevent blood clots). The resident was reporting pain to the left hip and thigh. There was redness to the left hip. Neurological exam was normal. The resident had severe dementia and was difficult to assess. Orders included a stat (immediate) x-ray to rule out a fracture and oxycodone 5 milligrams (mg) every six hours as needed for pain. Review of progress notes, dated 12/10/2025 at 1:18 PM, documented the resident was found on the floor and was pointing to a stuffed kitty. The resident was assisted into the wheelchair with a Hoyer (mechanical lift) and transferred to bed. The resident yelped when attempting to put the Hoyer sling under left hip. A check of Resident 3's skin was completed and no bruising or redness noted. An x-ray was ordered. During position change in the bed [the resident] would grimace and yelp when rolled to [their] left side. Review of progress notes, dated 12/10/2025 at 3:15 PM, documented Resident 3 fell in the dining room. The resident complained of left leg pain. No displacement of the leg was noted. A Hoyer lift was used to put the resident back to bed. The resident showed signs of pain in the left leg, so an x-ray was ordered and the family was notified. Review of progress notes, dated 12/10/2025 at 8:40 PM, documented pain noted. Medication Administration Record (MAR) documented the following: Eliquis 5 mg was given at 5:00 PM. The medication was not held after the fall. Pain level is documented as 0/10 or no pain throughout the AM and PM shifts. Tylenol 650 mg is given at 5:09 PM. Pain level is not noted. Oxycodone 5 mg is given at 8:01 PM for pain of a 7/10. Review of Radiology Results Report, dated 12/10/2025 at 8:15 PM, documented the resident as having a left hip fracture. Review of Hospitalist History & Physical Examination, dated 12/11/2025, documented Resident 3 was in severe pain after the fall. Options were discussed with family. Review of hospital records showed the resident passed away on 12/17/2025, at the hospital. During an interview on 02/18/2026 at 2:42 PM, Staff F, Licensed Practical Nurse, said Resident 3 fell in the dining room. They used a Hoyer to get the resident up off the floor and in to bed. The resident was in pain but did not recall signs of any injury. This is why they used the Hoyer for transfer. The resident could not verbalize pain, but it was obvious by the resident's facial expressions. The resident did get Tylenol during his shift. Staff F was aware the resident was on Eliquis. During an interview on 02/27/2026 at 11:38 AM, Collateral Contact 3 (CC3), Family Member, (continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	said Resident 3 fell somewhere around 12:00 PM - 1:00 PM on 12/10/2025. CC3 said Resident 3 was lifted and moved from the dining room into bed, when they likely already had a fracture to their leg. CC3 felt the resident was not immobilized properly to prevent further injury to the leg. The resident was in pain during this time, as witnessed by CC3. CC3 insisted that the resident get pain medication during this time. The resident needed quite a lot of pain medication once they got to the hospital due to the residents' uncontrolled pain. Resident 3 did not have an x-ray until around 9 PM. Staff never suggested or offered to send the resident to the hospital sooner. The Ambulance crew said staff did not know details about the fall. The staff caring for the resident at the time of the fall had left for the day without following through. The resident passed away on 12/17/2025. On 03/02/2026 at 5:03 PM, Staff B, Director of Nursing services and Registered Nurse, said the resident fell and it was uncertain if they hit their head. The provider was notified as they were present in the facility. Staff B said Resident 3 was on Eliquis and this was a medication of concern with a resident fall with an unknown head injury status. Staff B said there was lack of documentation on the status of the resident after the fall. The resident should have gone to the hospital if there was a concern with a head injury or with increased pain. Staff B could not speak to if staff immobilized the resident's injury.		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to monitor the efficacy for use of an indwelling urinary catheter (a small flexible tube inserted into the bladder to drain urine) for 2 of 3 sampled residents (6 & 11), reviewed for catheter use. This failure placed the residents at increased risk of catheter associated urinary tract infections, pain, and urethral trauma. Findings included. <Resident 6>Resident 6 was admitted to the facility on [DATE] with diagnoses including a left hip fracture and diabetes mellitus. The admission minimum data set (MDS), an assessment tool, dated 10/13/2025, documented Resident 6 has moderate cognitive impairment and is partially/moderately dependent on staff for assistance with activities of daily living. The MDS documented the resident has an indwelling catheter. Review of a care plan, dated 10/07/2025, documented Resident 6 had an indwelling catheter related to benign prostatic hyperplasia (BPH - an enlargement of the prostate). Staff will change catheter per physician orders, maintain catheter anchor, empty and record output and observe for signs and symptoms of infection. On 01/16/2026 at 10:34 AM, Collateral Contact 6 (CC6), Family Member, said the facility refused to take out the resident's indwelling catheter when asked. Staff told the resident he was peeing too much to have the indwelling catheter removed. CC6 said this set back the resident's recovery time. Review of the Hospital Post Acute & Transition of Care Orders, dated 10/06/2025, recommended temporary catheter management per nursing protocol for urinary retention. Review of an admission Nursing Collection Tool, dated 10/06/2025, documented Resident 6 required an indwelling catheter and had a prostate disorder with impaired mobility. The medical reason for catheter was noted as urinary obstruction. The assessment did not address the possible removal of the catheter. Review of a Multidisciplinary Care Conference, dated 10/13/2025, documented Resident 6's care needs were reviewed with CC6 and staff. The facility did not address the resident's indwelling catheter or risk of infection related to the catheter. Review of nursing progress notes, dated 10/19/2025, documented the resident is noted to have an indwelling catheter in place. Blood was noted in the catheter because the resident is trying to pull out the catheter. Review of nursing progress notes, dated 10/20/2025, documented Resident 6 had an outside appointment and it was noted the indwelling catheter was in place since hospitalization. Removal was recommended as the resident was at risk for infection. CC6 wanted the catheter out that day. The resident was transported to another facility that day. The provider ordered a voiding trial (monitoring of the amount a resident urinates) which would need to be completed by the receiving facility. The resident's indwelling catheter was removed without incident. Orthopedic (bone and muscle) specialist notes, dated 10/20/2025, documented concerns the orthopedic provider had related to ongoing use of the indwelling catheter. The provider noted behind schedule [they] still has a catheter in place since hospitalization? Recommend removal when medically deemed. Needs to remove catheter when medically acceptable, high risk catheter infection. has not gotten the care he specifically needs. The facilities 'Alleged Neglect' investigation, dated 11/02/2025, documented CC6 reported concerns about removing the indwelling catheter. A nurse told CC6 they could not remove the catheter. The investigation did not find abuse or neglect. The investigation did not address the continued use of the indwelling catheter. On 02/18/2026 at 3:22 PM, Staff E, licensed practical nurse (LPN), said if a resident had a catheter, they would wait for direction from the nurse manager related to removal of the indwelling catheter. On 03/02/2026 at 2:36 PM, Staff D, LPN and supervisor, said when Resident 6 was admitted to the facility, they did not have good communication with the provider overall. Staff D said they email the provider to ask if they wanted to keep the indwelling catheter in place or remove it. Staff D was unsure if this happened with Resident 6. If the provider wants to remove the catheter, they would document this and start a voiding trial. If the provider wanted to keep the catheter, Staff D would not document this decision in the clinical record. Staff D agreed Resident (continued on next page)</p>		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>6 did not have a justification for continued use of the indwelling catheter. Staff D acknowledged Resident 6 started a voiding trial on the day of discharge, leaving the responsibility to the receiving facility. On 03/02/2026 at 4:45 PM, Staff B, Director of Nursing services and registered nurse, said there was no documentation the staff assessed the resident for appropriateness of continued use of the foley catheter. Resident 11 was admitted to the facility on [DATE] with diagnoses including a fracture of the lower leg and retention of urine. The admission MDS, dated [DATE], documented Resident 11 had no cognitive impairment and was dependent on staff for assistance with ADLs. Care plan, dated 12/16/2025, documented Resident 11 had an indwelling catheter. The space next to reason for catheter was blank. Staff would change catheter per physician orders, maintain catheter anchor, and observe for signs and symptoms of infection. Review of the admission Nursing Collection Tool, dated 12/16/2025, documented Resident 11 had no factors related to urinary incontinence. No justification for continued use of the indwelling catheter is noted in the assessment. Review of provider notes, dated 12/17/2025, documented Resident 11 experienced a urinary tract infection (UTI) and urinary retention while in the hospital. The resident failed voiding trial when attempting to remove the indwelling catheter and was started on a medication for urinary retention. Review of provider notes, dated 12/27/2025, documented Resident 11 asked for the catheter to be removed. Due to infection risk, a trial removal of the indwelling catheter would be attempted. Review of provider notes, dated 01/02/2026, documented staff would remove the indwelling catheter and resident would begin using the bedside commode. Review of the Order Summary report, dated 01/02/2026, documented scan (of the bladder) every shift for 72 hours. If the urine in the bladder was more than 300mL (milliliters) straight catheterization (a catheter that is used just to empty bladder). After a 3rd failed attempt, replace indwelling catheter and notify provider. Progress notes, dated 01/03/2026, documented indwelling catheter was removed. No post void residual (PVR amount of urine in bladder after voiding naturally) were documented in the medical record during this period. Progress notes, dated 01/29/2026, documented Resident 11 requested the indwelling catheter be reinserted. Orders were given to scan the bladder for urine every shift and straight catheterization if the resident if PVR was greater than 350 ml. Order Summary report, dated 01/29/2026, documented a repeat order to scan Resident 11's bladder every shift for 72 hours. If the urine in the bladder was more than 350 ml, straight catheterization. After a 3rd failed attempt, replace the indwelling catheter, and notify provider. Progress notes, dated 01/30/2026, documented a PVR of 643 ml. Straight catheterization resulted in 825 ml of urine. Progress notes, dated 01/30/2026, documented a PVR of 529 ml. Straight catheterization resulted in 600 ml of urine. Progress notes, dated 01/31/2026, documented Resident 11 failed a third voiding trial. An indwelling catheter was inserted. The resident tolerated the procedure well. Progress notes, dated 02/17/2026, documented Resident 11's indwelling catheter was removed. Order Summary report showed no order for indwelling catheter removal was entered in the medical record. No PVR was monitored to ensure the resident could tolerate removal of the catheter. Progress notes, dated 02/17/2026, the IDT (interdisciplinary team) discharge planning noted the resident would need indwelling catheter replacement upon discharge. No other plans in place for caring for or removal of the indwelling catheter. On 02/18/2026 at 3:45 PM, Resident 11 was observed sleeping in bed. The indwelling catheter collection bag was observed attached to side of bed. The catheter tubing was clipped to the side of the bed. The resident's urine was yellow and clear. Progress notes, dated 02/19/2026, documented Resident 11 was having difficulty voiding. The PVR showed 550 ml in the bladder. The straight catheterization resulted in 800 ml. Progress notes, dated 02/19/2026, documented Resident 11 was discharging to an adult family home. There was no mention of care post catheterization, PVRs, or urology follow up. On 03/02/2026 at 2:36 PM, Staff D, Licensed Practical Nurse, said Resident 11 came to the facility with a catheter for urinary retention. Voiding trials were attempted but unsuccessful. The indwelling catheter was removed on 02/17/2026. Resident 11 did require straight catheterization on 02/19/2026, the day before discharge. There was no order for removal of the catheter on 02/17/2026. (continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Staff D said no PVR was done on 01/02/2026 when ordered. No PVR was done when the catheter was removed on 02/17/2026. The resident was transferred to another facility before they could ensure the catheter removal was successful. Staff D said they did not refer the resident to urology for Resident 11's ongoing urinary retention. On 03/02/2026 at 4:45 PM, Staff B, Director of Nursing services and registered nurse, said there was no documentation for a urology consultation. Staff B agreed PVRs were inconsistent before discharge. Staff B could not find an order for removal of the catheter on 02/17/2026. Reference (WAC) 388-97-1060 (2)(a)(iii)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5%, by having an error rate of 23.5%, with 8 errors of 34 medication administration opportunities observed. This failure placed residents at risk of medication complications and a diminished quality of life. Findings included. Medication Administration General Guidelines, dated 01/2023, documented medications administered will be explained to the resident. Medication is administered within 60 minutes of the scheduled time. Once staff administered the medication, they will immediately record the administration in the medical record. On 01/21/2026 7:38 AM, a medication pass performed by Staff G, licensed practical nurse, with the following observations: <Resident 15> Resident 15 was admitted to the facility on [DATE] with diagnoses including spina bifida (a condition where the spine does not fully close in utero) and diabetes mellitus. The admission minimum data set (MDS), an assessment tool, dated 12/04/2025, documented Resident 15 had no cognitive impairment and requires supervision and set-up with activities of daily living (ADLs). On 01/21/2026 7:38 AM, the medication pass to Resident 15 was observed and included administration of Jardiance (a medication given for diabetes mellitus) and duloxetine (used for anxiety). Resident 15 did not receive the scheduled metformin (a medication given for diabetes mellitus). Medication Admin Audit Report, dated 02/04/2026, showed the metformin, Jardiance, and duloxetine were signed off before the medication pass observation at 6:11 AM. The Medication Administration Record (MAR), dated January 2026, documented Resident 15's medications: metformin, Jardiance, and duloxetine were signed off as administer at 6 AM. On 01/21/2026 at 10:24 AM, Staff G said they realized they missed the medication metformin and went to give the medication later. Staff G did not know why he signed off the Jardiance, metformin, and duloxetine at 6:11 AM. Staff G said he had an hour after the medication is due to administer the medication. Staff G said he did not deliver the medication during that time. <Resident 16> Resident 16 was admitted to the facility on [DATE] with diagnoses including influenza and diabetes mellitus. The admission MDS, dated [DATE], documented Resident 16 has no cognitive impairment and was dependent on staff for assistance ADLs. On 01/21/2026 7:58 AM, the medication pass to Resident 16 was observed. The medication abiraterone acetate (given for metastatic prostate cancer) required four tablets for administration. Staff G gave Resident 16 two tablets as that was all that was remaining. There were no other packets of the medication available. The shortage of medication was not explained to the resident when the medication was administered. Medication Admin Aduit Report, dated 02/04/2026, showed the medication was signed off as given at 6:17 AM. There was no notation in the record indicating the resident received only two pills. The Medication Administration Record (MAR), dated January 2026, documented the medication was given at the due time of 6 AM. On 01/21/2026 at 10:24 AM, Staff G could not say why he signed off the medication early. Staff G said replacement pills were on order. <Resident 14> Resident 14 was admitted to the facility on [DATE] with diagnoses including lumbar fracture and diabetes mellitus. The quarterly MDS, dated [DATE], documented Resident 14 has no cognitive impairment and is independent with activities of daily living (ADLs). On 01/21/2026 8:08 AM, the medication pass to Resident 14 was observed and included tizanidine (given for muscle spasms), acetaminophen (given for pain), duloxetine, omeprazole (given for stomach reflux), and Xanax (given for anxiety). The medication pass did not include aspirin (given for blood clots) or torsemide (given for edema) which was due with the other medication. Medication Admin Aduit Report, dated 02/04/2026, showed the acetaminophen, duloxetine, omeprazole, and aspirin were signed off as given at 6:59 AM on 01/21/2026. The Xanax was signed of as given at 7:51 AM. The tizanidine was signed off at 7:46 AM. The torsemide was signed off as given at 8:30 AM. The Medication Administration Record (MAR), dated January 2026, documented Resident 14 was to receive her medication at 6 AM. All the medications were signed off at the designated time. On 01/21/2026 at 10:24 AM, Staff G said he did (continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>not give the torsemide. Staff G said he honestly did not know what happened with the aspirin. Staff G acknowledged all the medications were late.<Resident 1>Resident 1 was admitted to the facility on [DATE] with diagnoses including alcoholic cirrhosis (scarring of the liver due to conditions such as long-term alcohol use), esophageal varices (enlarged veins in esophagus due to blocked blood flow in liver), and attention deficit hyperactivity disorder (ADHD). The quarterly minimum data set (MDS), dated [DATE], documented Resident 1 had no cognitive impairment and was partial to moderately dependent on staff for assistance.On 01/02/2026 at 11:05 AM, Resident 1 said medications were not passed timely and some medications were not passed as all. Resident 1 said at times staff did not wake them up to give them their medications. Resident 1 had medications needed for liver disease, cirrhosis, and ADHD which when not received or received late impacted her.On 01/21/2026 8:16 AM, the medication pass to Resident 1 was observed. The [NAME] eczema relief lotion and amoxicillin (an antibiotic) were not administered to the resident.Medication Admin Audit Report, dated 02/04/2026, documented the [NAME] eczema relief lotion was administered at 10:21 AM. The amoxicillin was signed off as given at 7:13 AM.The Medication Administration Record (MAR), dated January 2026, showed [NAME] eczema relief lotion was not signed off. The amoxicillin was signed off as given at 6 am.On 01/21/2026 at 10:24 AM, Staff G said he could not locate the cream to administer it. Staff G was unsure about the amoxicillin. Staff G acknowledged the medication was late.<Resident 17>Resident 17 was admitted to the facility on [DATE] with diagnoses including lumbar fracture and diabetes mellitus. The annual MDS, dated [DATE], documented Resident 17 had no cognitive impairment and required substantial/maximum to dependent assistance from staff for ADLs.On 01/21/2026 8:26 AM, the medication pass to Resident 17 was observed. Carvedilol (used for heart failure), furosemide (used for edema), isosorbide (used for high blood pressure), bupropion (used for depression), and fluoxetine (used for depression), were passed to the resident. Aspirin and glycolax powder (used for constipation) were not observed to be passed to the resident.Medication Admin Audit Report, dated 02/04/2026, showed glycolax, aspirin, fluoxetine, and bupropion were signed off as administered at 6:27 AM. Isosorbide, carvedilol, and furosemide were signed off at 8:28 AM.The Medication Administration Record (MAR), dated January 2026, documented the medications were due at 6 AM and administered at that time.On 01/21/2026 at 10:24 AM, Staff G could not explain the discrepancies in the administration of medication. Staff G said he comes in at 6 AM so those medications were always going to be late.On 03/02/2026 at 5:03 PM, Staff B, Director of Nursing services and registered nurse, said Staff G was terminated for observed omission of medication during a medication pass. Staff have an hour before and hour after medication is due to be administered otherwise the medication is considered late. If a medication is missing, they are to reach out to her or the unit manager right away.See F-760Reference WAC 388-97-1060 (3)(k)(ii)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505387	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/02/2026
NAME OF PROVIDER OR SUPPLIER Woodard Creek Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were administered as ordered, resulting in repeated medication omissions that constituted significant medication error for 1 of 5 residents (Resident 1) reviewed for medication administration. This failure placed residents at risk for injury and adverse outcomes. Findings included. Resident 1 was admitted to the facility on [DATE] with diagnoses including alcoholic cirrhosis (scarring of the liver due to conditions such as long-term alcohol use), esophageal varices (enlarged veins in esophagus due to blocked blood flow in liver), and attention deficit hyperactivity disorder (ADHD- patterns of inattention, hyperactivity, and impulsivity). The quarterly minimum data set (MDS), an assessment tool, dated 11/11/2025, documented Resident 1 had no cognitive impairment and was partial to moderately dependent on staff for assistance with activities of daily living. On 01/02/2026 11:05 AM, Resident 1 said staff did not pass all of the daily medications, including supplements used for liver disease. Resident 1 said they did not administer Adderall (a medication used for ADHD) consistently. Resident 1 said this affected their ability to make decisions and increased their level of stress. Medication Review Report, dated January 2026, included: Folic acid 1 milligram (mg) once daily Sarna eczema relief lotion 2% twice daily for pruritus (itchy skin) Adderall 15 mg 1 tablet daily for ADHD Carvedilol 3.125 mg twice daily for alcoholic cirrhosis Medication Administration Record (MAR), dated January 2026, documented: Folic acid missed 15 of 21 administrations in January. [NAME] eczema relief lotion missed 9 of 41 administrations in January. Adderall missed 8 of 21 administrations in January. Carvedilol missed 11 of 41 administrations in January. On 01/21/2026, at 8:16 AM, Staff G, licensed practical nurse (LPN), was observed administering medications to Resident 1. Folic acid, thiamine, and [NAME] eczema relief lotion were not administered during the observation. At 10:24 AM, Staff G said he did not pass the medication during the medication pass. Staff G said he could not find the folic acid. He did not go to retrieve more folic acid. Staff G said he found the thiamine and went to give it to the resident but not when scheduled. He did not give the [NAME]. Staff G said the resident had 16 tablets of Adderall. He said he did not give Resident 1 Adderall the day prior as well as many days before. Staff G verified the medication was present but not administered. Staff G could not say why the medication was not administered. On 03/02/2026 at 4:20 PM, Staff B, Director of Nursing services and registered nurse, said all medications ordered should be administered at the time scheduled. Medication missing should be obtained by the nurse from the medication room. If not present, they should report to manager who will promptly obtain the medication. Staff B said Staff G was no longer working for the facility due to omission of medication during observed medication passes. Reference (WAC) 388-97-1620(2)(b)(ii)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure resident records were complete, accurate, readily accessible, and systematically organized for 3 of 4 sampled residents (1, 3, & 4), reviewed for quality of care. This failure placed residents at risk of having an incomplete medical record, unmet care needs, and diminished quality of life. Findings included. Resident 1 was admitted to the facility on [DATE] with diagnoses including alcoholic cirrhosis (scarring of the liver due to conditions such as long-term alcohol use), esophageal varices (enlarged veins in esophagus due to blocked blood flow in liver), and alcohol dependence. The quarterly minimum data set (MDS), an assessment tool, dated 11/11/2025, documented Resident 1 has no cognitive impairment and is partial to moderately dependent on staff for assistance activities of daily living (ADLs). On 01/02/2026 11:05 AM, Resident 1 said they felt like staff did not understand the importance of monitoring weights and vital signs. Resident 1 stated they tracked all the vital signs taken. When they had had outside appointments, they noted weights and vitals are missing. Weight were supposed to be entered daily. Resident 1 said the staff do these tasks inconsistently and sometimes not at all. Resident 1 said this had impact on their daily life. Order Summary Report, February 2026, shows daily weights would be taken. The Treatment Administration Record (TAR), dated December 2025, showed daily weights were missing 5 of 31 days. The TAR, dated January 2026, showed daily weights were missing six times. On 03/02/2026 at 2:07 PM, Staff O, nursing assistant, said the staff had inconsistent assignments so they did not always know if the resident needed vitals or weights. Staff O said the staff do not always know the residents well. On 03/02/2026 at 4:20 PM, Staff B, Director of Nursing services and registered nurse, said staff should be aware of when to take weights and vital signs. They have worked to try and have some consistency with taking vitals. <Resident 3>Resident 3 was admitted to the facility on [DATE] with diagnoses including dementia and metabolic encephalopathy (A brain dysfunction caused by metabolic disturbances). The admission MDS, dated [DATE], documented Resident 3 has severe cognitive impairment and is dependent on staff for assistance with ADLs. Care plan, dated 10/27/2025, documented Resident 3 was at risk for falls related to advanced dementia. The resident would wear non-skid socks while out of bed, use the bed in the lowest position, and staff would remind the resident to use the call light. On 02/27/2026 at 11:38 AM, Family Member 3 (FM) said Resident 3 fell somewhere around 12:00 PM - 1:00 PM on 12/10/2025. The resident was in quite a lot of pain and received quite a lot of pain medication once they got to the hospital. FM 3 said it appeared the resident's pain was not well controlled. When the ambulance crew came, staff did not know details about the fall and the staff caring for the resident had left. Progress notes, dated 12/10/2025, documented the resident was found on the floor after a fall. The resident had left lower extremity pain. An x-ray was ordered. Radiology Results Report, dated 12/10/2025 at 8:15 PM, documented the resident had a left hip fracture. Progress notes, dated 12/10/2025 at 8:40 PM, documented pain noted. The record did not include documentation related to the resident's status before transporting to the hospital. Patient Care Record (EMS/ambulance notes), dated 12/10/2025, the Ambulance notes documented the staff could not articulate the details of Resident 3's fall. Staff explained the resident fell around noon but were unable to get a mobile x-ray unit to x-ray the resident until 8 PM. The staff did not have a copy of the x-ray. It was unknown if the resident hit their head and they were on an anticoagulant. Resident 3's left leg was observed and noted to be twice the size as the right thigh. The resident showed discomfort during the examination and did not tolerate anything near their leg. Resident 3 was yelling and stating to ambulance staff to kill me. On 02/18/2026 at 2:42 PM, Staff F said Resident 3 fell in the dining room. They used a Hoyer (mechanical lift) to get the resident up off the floor and in to bed. The resident was in pain but did not recall signs of any injury. Staff F could not tell the residents' status while waiting to go to the (continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>hospital when reviewing the record. Staff F acknowledge the record was missing documentation. On 03/02/2026 at 5:03 PM, Staff B said there was a lack of documentation on the status of the resident after the fall. Staff B could not speak to if staff immobilized the resident's injury due to missing documentation. <Resident 4>Resident 4 was admitted to the facility on [DATE] with diagnoses including a stroke and chronic obstructive pulmonary disease (COPD - lung disease causing difficulty with breathing). The 5-day Medicare MDS, dated [DATE], documented Resident 4 has no cognitive impairment and is partially/moderately dependent on staff for assistance with ADLs. Care plan, dated 11/14/2025, documented Resident 4 was at risk for falls related to generalized weakness. The resident would wear non-skid socks while out of bed, use the bed in the lowest position, and remind the resident to use the call light. Fall (Un-witnessed), dated 11/21/2025, documented Resident 4 was observed lying on the right lateral side of the bed. No injuries were noted. Vital signs were stable. The resident complained of pain in their head and left shoulder and were transported to the hospital. Progress notes did not reflect the resident's fall. SBAR Communication Form (A form used to communicate the status of the resident to the hospital), dated 11/21/2025, documented Resident 4's condition started on 11/21/2025. The resident has an increased chronic pain to scalp, and the front and rear right shoulder. The form did not document Resident's fall. On 03/02/2026 at 4:55 PM, Staff B said the staff did not document fall in the record or in the hospital communication forms. Reference WAC 399-97-1720(1)(a)(i)-(iv), (b)</p>		