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	05/29/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident medical records were complete, accurate and readily accessible and that residents personal identifiable information was protected for 1 of 1 resident (Resident 17) reviewed for Hospice services, 1 of 1 resident (Resident 2) reviewed for dialysis services, and 1 of 1 resident (Resident 142) reviewed for identifiable personal health information. These failures placed residents at risk for a loss of privacy, poor/impaired communication and coordination of care with Hospice and Dialysis center staff, and unidentified and/or unmet care needs. Findings included . Findings included . Resident 17Resident 17 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 03/14/2026, showed the resident had a terminal diagnosis and was on Hospice services during the assessment period. Review of Resident 17's electronic health record (EHR) showed there was no Hospice documentation present for the current certification period, to include: documentation the resident was re-certified with a terminal illness, a current coordinated plan of care, documentation of what Hospice services the resident was to receive (e, g,, registered nurse, chaplain, certified nursing assistant, massage therapist), at what frequency, and no documentation of whether those disciplines had visited, if so, when, and what care was provided. On 05/26/2026 at 8:31 AM, observation of the 300 and 400 unit revealed there was a Hospice communication binder on the 400 unit. Review of the binder showed there was no Hospice paperwork in the binder for Resident 17. On 05 /26/2026 at 3:55 PM, Staff H, Licensed Practical Nurse/Unit Manager, explained that the Hospice binder used to be updated regularly and was an effective means of communication but had recently fallen off. When asked if the facility had a copy /documentation of Resident 17's current coordinated plan of care, what Hospice services were to be provided, at what frequency, and whether those disciplines had visited Resident 17, if so, when and what occurred on the visits, Staff H, stated, No. Resident 2Resident 2 was admitted to the facility on [DATE] with diagnoses of hypertension (high blood pressure) and end stage renal disease (kidney failure, requiring dialysis). The Medicare 5-Day MDS, dated [DATE], showed Resident 2 had moderate cognitive impairment. Communication & Documentation with Dialysis (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

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	05/29/2026

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's EHR showed an incomplete record of Resident 2's dialysis treatments. On admission, they were scheduled Tuesday, Thursday, and Saturday for treatment. Resident 2's dialysis schedule changed 05/04/2026, to Monday, Wednesday, Friday. Review of Resident 2's pre/post dialysis evaluations, showed there was a 04/30/2026 dialysis form completed, and not another form completed until 05/20/2026. Review of Resident 2's dialysis communication forms (the paper copies of communication between the facility and the dialysis center), showed there were no paper forms after 04/30/2026, until Resident 2's appointment on 05/27/2026. Further review showed no vital signs were sent to dialysis on the following dates: 04/04/2026, 04/07/2026, 04/21/2026, 05/02/2026, 05/27/2026, and one undated form. The 04/30/2026 form did not have any information from the dialysis center on it. During an interview on 05/26/2026 at 1:48 PM, Staff K, Licensed Practical Nurse/Unit Manager, regarding dialysis communication, said they expected there to have been a transfer assessment, full set of vital signs and a face sheet to have been sent. When the resident returned, they expected staff to enter the rest of the information. Staff K said there should have been a pre/post form in the EHR. When asked if Resident 2 went to dialysis between 04/30/2026 and 05/20/2026, Staff K was unable to determine based on the EHR and said they would need to look for hard copies. Staff K said they needed to make different arrangements with Resident 2 and the dialysis center related to needing a sitter. Regarding the forms that go to and from dialysis, Staff K was unable to find the documentation in Resident 2's EHR. During an interview on 05/29/2026 at 2:41 PM, Staff M, Interim Administrator, was asked if there was any documentation in Resident 2's record to show they were assessed after dialysis or to show what medications were administered during dialysis or of increased fluid removal needs and she said the facility lacked the documentation in their record to show staff were aware of these things and had reached out to the dialysis center to request the communication forms. Resident 127 Resident 127 was admitted to the facility on [DATE] and discharged from the facility on 04/17/2026. The admission MDS, dated [DATE], indicated Resident 127 was cognitively intact. Resident 142 was admitted to the facility on [DATE] and discharged from the facility on 04/16/2026. The Admission/Medicare 5-Day MDS, dated [DATE], indicated Resident 142 was cognitively intact. Resident 127's family member, Collateral Contact 9 (CC9), reported that Resident 127 was discharged home with resident 142's medication. On 05/28/2026 at 11:17 AM, Staff L, Interim Director of Nursing Services/Infection Preventionist, acknowledged that the facility had sent a nurse to Resident 127's home following their discharge from the facility to retrieve Resident 142's medication. Staff L acknowledged this was violation of Resident 142's personal health information. Reference WAC 388-97-1720 (2)(a-m)