STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505507	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shelton Health and Rehabilitation	153 Johns Court Shelton, WA 98584

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate staff supervision to ensure fall prevention interventions were adequate, effective, and/or implemented for residents assessed at high fall risk for 3 of 4 residents (Resident 1, 2 and 4) reviewed for falls. Resident 1, who had eight unwitnessed falls from their bed, experienced harm when two of the unwitnessed falls resulted in injury that required transportation to the hospital for treatment. Resident 1 sustained a fracture of the lumbar (lower back) spine during one of the falls and sustained facial fractures in a separate fall occurrence. These failures placed residents at risk for further falls, injury, and decreased quality of life. Findings include:Review of the facility policy, titled Fall Management and Neurological Check, updated 01/2025, showed .the LN [Licensed Nurse] updates care plans reflecting individualized intervention in an attempt to reduce or prevent falls.The resident care plan is reviewed quarterly and after a fall to determine effectiveness of current interventions.A new intervention is not required with each new fall, as not all falls require an intervention nor a change in intervention. A systematic review of current interventions is completed post fall and root cause is identified.Should a new intervention be implemented, previous interventions are reviewed for discontinuation to determine if they are ineffective.Resident 1Resident 1 was admitted to the facility on [DATE] with diagnoses including dementia (loss of memory, language and problem solving), seizures and atrial fibrillation (irregular and often rapid heart rhythm). The resident's Minimum Data Set (MDS) assessment, dated 10/09/2025, showed the resident had cognitive impairment, had verbal behaviors, used a wheelchair (w/c), required assistance for sit to lie positioning, chair to bed transfers and toilet transfers, was occasionally incontinent of bladder, always incontinent of bowel and had two or more falls since admission.Review of Resident 1's fall risk assessment, dated 01/21/2025, showed a score of 105. A score greater (>) than 45 indicates a high falls risk.Fall 1Review of a facility documentation for Resident 1's fall, dated 10/26/2025, showed the resident had an unwitnessed fall and sustained a bruise to the forehead. An intervention to place a fall mat was implemented.Fall 2Review of a facility documentation for Resident 1's fall, dated 11/27/2025, showed the resident had an unwitnessed fall without injury. An intervention for lab testing and a urinalysis was implemented.Fall 3Review of facility documentation for Resident 1's fall, dated 11/30/2025, showed the resident had an unwitnessed fall in their room and did not sustain an injury. The facility documented an intervention to monitor latent injuries. No intervention was implemented to prevent further falls.Review of a Computed Tomography (CT) (medical imaging technique) report, dated 12/03/2025, showed .Acute to subacute superior end plate fracture [broken bone] at the L2 [lower back] vertebral body.Review of a progress note, dated 12/03/2025 at 7:50 PM, showed the resident returned from the hospital and a CT scan showed a wedge compression fracture of the 2nd vertebrae.Review of a Nurse Practitioner note, dated 12/03/2025, showed the resident was found on the floor and had a fall on 11/30/2025 and .she (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 0689 Level of Harm - Actual harm Residents Affected - Few	reports severe back pain that is described as sharp, stabbing.Xray of lumbar [lower back] and thoracic [midsection] spine showed multilevel compression fx [fracture].Called 911 for transportation to ER for further imaging and acuity staging.Fall 4Review of Resident 1's progress note, dated 12/12/2025 at 02:29 AM, showed the resident had an unwitnessed fall .was bleeding from her right nostril and right side of her mouth. Crying.Resident stated.got out of bed to potty, but fell.C/o [complains of] headache and back pain.EMTs arrived at facility.Resident was transported by ambulance to.hospital.Review of Resident 1's hospital emergency department note, dated 12/12/2025, showed [Resident] presents to Emergency Department with a fall and facial injury today.c/o headache and has swelling to right periorbital [area around the eye] region and right cheek.Fall was unwitnessed.Review of Resident 1's hospital documentation, dated 12/12/2025, showed a CT with acute maxillofacial (upper jaw and face) fractures involving the right orbital lateral wall and floor (part of the eye socket), the right maxillary sinus anterior (cheek area) and lateral walls (nasal area). Findings included subcutaneous edema (swelling) and hematoma (localized swelling of blood that is caused by a vessel rupture) at right side of face.Review of Resident 1's care plan, revised 12/12/2025, showed an intervention for a fall mat to the right side of the bed was implemented.Fall 5Review of facility documentation for Resident 1's fall, dated 12/12/2025 at 3:00 PM (2nd fall on 12/12/2025), showed Resident 1 had an unwitnessed fall in their room. Resident 1 struck their face and had blood in their nostrils. An intervention for a pharmacy review and a bedside commode was implemented.Fall 6Review of a progress note for Resident 1, dated 12/25/2025 at 9:30 AM, showed the resident had an unwitnessed fall in their room without injury.Education given to resident of importance to wait for assistance for safety.verbalized understanding.assisted to recliner in room, with call light. (Resident with cognitive impairment).Review of Resident 1's care plan, revised 12/26/2025, showed no new intervention implemented to supervise the resident.Fall 7Review of facility documentation for Resident 1's fall, dated 12/26/2025, showed the resident had an unwitnessed fall in their room and sustained a bruise to the left knee.Review of Resident 1's care plan ,revised 12/29/2025, showed they would add a soft touch call light for easier use.Fall 8Review of facility documentation for Resident 1's fall, dated 01/06/2026, showed the resident had an unwitnessed fall in their room. The resident sustained a laceration to the right eyebrow and was transferred to the hospital and returned to the facility. The facility changed the resident's room to increase supervision on 01/06/2026.Review of Resident 1's provider note, dated 01/07/2026, showed .The patient was seen for a re-admission after having a fall and hitting her right side of her face and requiring CT scans, and sutures above right eye.Observation of Resident 1 on 01/14/2026 at 2:00 PM, showed the resident resting in bed with a regular call bell in the resident's hand.Observation of Resident 1 on 01/15/2026 at 12:25 PM, with Staff C, Licensed Practical Nurse, showed the resident seated in a w/c in their room with a regular call bell in the resident's hand. Staff C acknowledged the resident did not have a soft call light as indicated on the care plan.Resident 2Resident 2 was admitted to the facility on [DATE] with diagnoses including prostate cancer with metastasis, diabetes and bipolar disorder. The resident's MDS assessment, dated 11/27/2025, showed the resident had cognitive impairment, had no behaviors, used a w/c, required staff assistance for sit to lie positioning, chair to bed transfers, was frequently incontinent of bladder and bowel, and had two or more falls since admission.Review of facility documentation showed Resident 2 had 11 falls without injury from 11/22/2025 - 01/14/2026.Review of a falls risk assessment, dated 11/21/2025, showed a score of 65. Score greater than 45 indicates resident is at high risk for falls.Review of facility documentation for Resident 2's fall, dated 11/25/2025, showed the resident had an unwitnessed fall. The intervention implemented was to monitor for latent injuries.Review of facility (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	documentation for Resident 2's fall, dated 11/28/2025 at 12:30 PM, showed the resident had an unwitnessed fall outside the dining room. The resident was placed outside the dining room after eating the lunch meal by staff. The intervention implemented was to provide training to the resident to stay in the dining room. (Resident with severe cognitive impairment)Review of facility documentation for Resident 2's fall, dated 11/28/2025 at 9:20 PM, showed the resident had an unwitnessed fall from his bed. No intervention was implemented to prevent further falls.Review of facility documentation for Resident 2's fall, dated 12/19/2025, showed the resident had an unwitnessed fall near the nursing station. During an interview on 01/14/2026 at 2:30 PM, Staff B, Director of Nursing Services and Registered Nurse said the intervention had been to place the resident on 1:1 supervision with a staff member.Review of facility documentation for Resident 2's fall, dated 12/20/2025 at 3:50 AM, showed the resident was observed crawling out of bed by a staff member. (Resident was on 1:1 staff supervision)During an interview on 01/14/2026 at 2:30 PM, the DNS acknowledged Resident 2 had 12 falls from 11/22/2025 - 1/14/2026 and was placed on 1:1 staff supervision from 12/19/2025 - 01/01/2026. The DNS acknowledged Resident 2 had cognitive impairment and educating the resident was not an appropriate intervention to prevent further falls.Resident 4Resident 4 was admitted to the facility on [DATE] with diagnoses including hemiplegia (paralysis affecting one side of the body), hemiparesis (weakness on one side of the body), epilepsy and vascular dementia (decline in thinking skills caused by damaged blood vessels in the brain). The resident's quarterly MDS assessment, dated 12/09/2025, showed the resident had cognitive impairment, had no behaviors, used a w/c and walker, required staff assistance for sit to lie positioning, chair to bed transfers, was frequently incontinent of bladder and bowel, and had two or more falls since admission.Review of facility documentation showed Resident 4 had five falls without injury from 10/30/2025 - 01/14/2026.Review of a falls risk assessment, dated 09/15/2025, showed a score of 55. Score greater than 45 indicates resident is at high risk for falls.Review of facility documentation for Resident 4's fall, dated 12/30/2025, showed the resident had an unwitnessed fall in the resident's room. An intervention of a bedside commode was implemented.Review of facility documentation for Resident 4's fall, dated 01/12/2026, showed the resident had an unwitnessed fall in the resident's room. No intervention was implemented after the fall to prevent further falls. Documentation showed a fall mat was placed at the bedside.Review of facility documentation for Resident 4's fall, dated 01/14/2026, showed the resident had an unwitnessed fall in the resident's room. No intervention was implemented after the fall to prevent further falls. Documentation showed .already on fall monitoring.Observation on 01/16/2026 at 1:00 PM, with Staff D, Licensed Practical Nurse showed Resident 4 resting in bed in his room. There was no fall mat or bedside commode in the resident's room. Staff D acknowledged the fall mat and bedside commode were not in Resident 4's room.During an interview with Staff A, Administrator and Staff B, DNS acknowledged Resident 1 had a fall on 11/27/2025 and 12/12/2025 and sustained a lumbar and facial fractures and interventions were not implemented to prevent further falls. They stated the facility policy indicated that every fall does not require a new intervention but does need to be reviewed. They acknowledged new fall interventions were not implemented after falls for Residents 1, 2 and 3.Reference WAC 388-97-1060 (3)(g)