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	04/08/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to protect residents receiving narcotic medications from misappropriation on two of three medication carts (Team 2 & Team 3 Carts) from 12/09/2026-03/26/2026, when staff identified concerns that a registered nurse was diverting narcotic medications; however, the facility failed to report, investigate, or take action on the allegations, allowing the suspected diversion to continue. This failure resulted in residents not receiving prescribed pain medications and the potential misappropriation of medications for which residents were financially responsible.Findings included.Review of the facility policy, titled Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation, updated March 2025, showed Misappropriation of Resident Property.Examples of misappropriation of resident property and exploitation that must be reported include, but are not limited to.Missing prescription medications or diversion of a resident's medications, including, but not limited to, controlled substances for staff use or personal gain.Procedure.Investigation.The Center conducts a thorough investigation of potential, suspected and/or allegations of abuse, neglect, and exploitation of residents, misappropriation of resident property, mistreatment, and injuries of unknown source, in accordance with state and federal regulations.Protection.The Center protects residents from physical and psychosocial harm during and after an investigations.Reporting and Response.The Center immediately reports all suspected and/or allegations of abuse, neglect, and exploitation of resident property, mistreatment, and injuries of unknown source in accordance with state and federal law.Review of an email sent to Staff A, Administrator by Staff D, Licensed Practical Nurse, dated 02/06/2026, showed .Several alert and oriented residents have confirmed that they did not request or receive medications at the time she documented them as given.There have been multiple occasions in which [Staff C, Registered Nurse (RN)] has arrived to work appearing impaired.with noticeable head-nodding and difficulty staying awake.Specific medication concerns include.Narcotics signed out for residents such as [Resident 2 and 4] that those residents report they do not receive.Medications suddenly being signed out in 1-2 dose increments that are not typically administered at those times.Discrepancies in the narcotic log, including medications signed out earlier than allowed and not in accordance with proper documentation procedures.Additionally, she frequently leaves the building during her shift and is difficult to locate.Resident 1 was admitted to the facility on [DATE] with diagnoses including infection and inflammatory rection due to internal right hip prothesis. The admission Minimum Data Set (MDS), dated [DATE], showed the resident was alert and oriented, required staff assistance for most activities of daily living and received pain medication as needed.Review of Resident 1's physician's order, dated 03/20/2026, showed an order for Oxycodone (narcotic pain medication) 5 milligrams (mg) give 1 tablet every 6 hours as needed for pain.Review of Resident 1's narcotic sign out log and EMAR (electronic medication administration record) for oxycodone IR (immediate release) 5 mg tablet every 6 hours as needed was signed out by Staff C as administered as follows:03/21/2026 at 4:30 AM and 10:08 PM03/22/2026 at 4:10 AM and 11:01 PM03/23/2026 at 5:48 AM and 10:37 PM03/24/2026 signed out as administered on EMAR at 10:57 PM but not signed out on (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	narcotic log.03/26/26 at 12:40 AM 3:24 PM and 10:00 PM.Review of Resident 1's progress note, dated 03/27/2026, showed .Resident reported not receiving oxycodone during evening shift on 03/26/2026. She had requested pain medication (Oxycodone) on night shift following cares being provided.During observation and interview with Resident 1 on 04/03/2026 at 2:42 PM, the resident was asked if she recalled an incident when she did not receive pain medicine by a nurse. Resident 1 said Yes I remember.I only want medication given to me when I ask for it. She said on that day I asked for pain medicine and the nurse said that I had my quota of oxy [oxycodone] and tylenol and I said oh no I haven't, I hadn't taken either. She was asked if she had any pain from that incident of not receiving the medication. Resident 1 said she had no pain related to the incident but .they were trying to tell me I had already taken it and I have all my faculties. The resident appeared well groomed without signs of pain or distress.Resident 2Resident 2 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease, diabetes, right above the knee amputation and left below the knee amputation. The annual MDS, dated [DATE], showed the resident was alert and oriented, independent for most activities of daily living and received scheduled and as needed pain medication.Review of Resident 2's physician's order, dated 6/19/2025, showed an order for Oxycodone 5 mg give 1 tablet every four hours as needed for pain.Review of Resident 2's EMAR, dated 2/2026 and 3/2026, showed Staff C documented she administered oxycodone 10 mg on twenty-two occasions during the hours of 11 pm and 4:30 AM.During an interview with Resident 2 on 04/07/2026 at 1:17 PM, the resident was asked if they generally requested medications during the night shift. Resident 2 stated he takes medication before he goes to bed in the evening. He said he does not request or receive any medication during night shift until he wakes for dialysis at 5:00 AM on Monday Wednesday and Friday.Resident 3Resident 3 was admitted to the facility on [DATE] with diagnoses including Vascular Dementia (decline in thinking caused by conditions that block or reduce blood flow to the brain) and Spinal Stenosis (narrowing on the spinal canal causing pressure on the nerves and spinal cord). The quarterly MDS, dated [DATE], showed the resident was cognitively impaired and received scheduled and as needed pain medications.Review of Resident 3's physician's order, dated 10/25/2025, showed an order for Hydrocodone (narcotic pain medication) 5/325 mg take 1 tablet by mouth every 8 hours as needed for pain.Review of Resident 3's narcotic log for Hydrocodone 5/325 mg showed the following:The medication was signed out of the narcotic log by Staff C on 03/02/2026 at 12:38 PM and again at 2:53 PM (2 hour and 15 minutes between doses). There was no documentation showing the medication was wasted.Review of Resident 3's EMAR showed Hydrocodone 5-325 mg 1 tablet was signed as administered on 03/02/2026 at 12:38 PM.The medication was signed out by Staff C on 3/25/2026 at 6:01 AM, at the bottom of the page of the narcotic log and on 3/25/2026 at 6:01 AM, signed out again as removed on the top of the following page of the narcotic log. There was no documentation showing the medication was wasted.Review of Resident 3's EMAR showed Hydrocodone 5-325 mg 1 tablet was administered on 3/25/2026 at 6:01 AM.Review of the facility investigation, dated 03/27/2026, showed Resident 1 had reported to staff she had not received any pain medication on 03/26/2026 on the evening shift. Resident 1 stated she only takes oxycodone prior to therapy. During care on night shift her hip was adjusted and she requested oxycodone for pain and the night shift nurse was unable to administer the oxycodone due to it being documented as administered at 10:00 PM. The resident was given Tylenol (non-narcotic) pain medication. Resident 2 was interviewed and stated he never requests or sees a nurse after receiving his evening medications and does not see the nurse until he gets up for dialysis at 5:00 AM on Monday, Wednesday and Friday. Resident 2 stated he does not request medications/narcotics during the night. The resident was alert and oriented. Review of documentation showed Staff C had administered narcotic pain medication between 12:00 AM and 05:00 AM, which is inconsistent with the resident's statement. Staff C was terminated.During an interview with Staff H, Certified Nursing Assistant, on 3/26/2026 at 5:35 AM, when was asked if she had observed any staff who showed signs of impairment while at the facility? .yes [Staff C].we reported it, the administrator came in and (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	saw her.she also leaves the floor at times for a long time.During an interview with Staff A, Administrator, on 3/26/2026 at 11:30 AM, he was asked if he had received any concerns from staff related to night staff showing signs of impairment or concerns related to medication administration. He stated not impairment but he acknowledged he did receive concerns related to Staff C nodding off and did come into the facility that night and did see Staff C nodding off while at the computer. Staff A stated he held a staff meeting and Staff C participated and showed no other signs of impairment. He stated Staff C was counselled on staying alert and present during work hoursDuring an interview with Staff E, LPN on 4/3/2026 at 2:10 PM, she was asked if she was aware of any staff showing signs or impairment or concerns related to medication administration. She stated Staff C had inappropriate behavior and would call or text her demanding she give up her shifts to Staff C.During a telephone interview with Staff D, LPN on 4/3/2026 at 3:19 PM she stated she had reported concerns related to Staff C to the Administrator in February of 2026. She stated she had concerns related to Staff C's behavior and concerns related to narcotics signed out for residents who normally don't take medications on the night shift.During an interview with Staff A on 4/3/2026 at 3:30 PM he was asked to provide documentation of an investigation for the allegations from the staff concerns he received by email on 2/6/2026. Staff A stated he could not provide documentation, and he thought Staff B , Director of Nursing, checked the narcotic counts.During an interview on 4/7/2026 at 11:30 AM, Staff B, Director of Nursing, was asked if she was aware of an email sent to Staff A by a staff member with concerns related to possible drug diversion on 2/6/2026. Staff B stated she had no knowledge of this email, and she had not reported or investigated it. She acknowledged she was made aware of an allegation that Resident 1 had not received pain medication on 3/26/2026. Staff B stated she completed the investigation. She stated the allegation has been substantiated and Staff C was terminated. She stated she was now initiating an investigation related to the email received.During an interview on 4/8/2026 at 2:30 PM, Staff G, Resident Care Manager acknowledged the facility was completing a facility wide audit of residents who received narcotic pain medication and they had found multiple discrepancies related to Staff C.During an interview on 4/8/2026 at 3:58 PM, Staff A acknowledged he received an email on 2/26/2026 from a staff member with concerns related to possible drug diversion and staff behavior. He acknowledged he did not complete an incident report. He stated .don't have any documentation to dispute what [Staff B] said.Reference WAC 388-97-0640 2(a)3(c)(d)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide behavioral health services to 1 resident of 3 residents (Resident 7) reviewed for behaviors. The facility's failure to provide behavioral health services placed residents at risk for increased behaviors and decreased quality of life.Findings included.Review of the facility policy titled Social Services Referrals, updated 07/2015, showed the .Social Services Department responds to or makes appropriate referrals for these and other conditions.Behavioral symptoms.aggression.Resident 7 was admitted to the facility on [DATE] with diagnoses including chronic pain, cellulitis and dementia. The quarterly Minimum Data Set (MDS), an assessment tool, dated 01/04/2026, showed the resident had mild cognitive impairment, exhibited verbal and wandering behaviors, and was independent for mobility.Review of Resident 7's progress notes showed the following:12/06/2026 - Resident 7 was up most of the night. Accusing staff of stealing and made a comment about running over them with her car.12/20/2025- Resident 7 threatening to smash her way out of the facility through the windows. Resident 1 threw a water pitcher at a staff member.12/21/2025 - Resident 7 threatening to smash windows out because she likes the sound of glass breaking. Resident 7 threw a water pitcher towards a staff member.01/07/2026 - Resident 7 attempted to choke a staff member leaving scratches to the staff's neck and hit her knee with the walker. Resident 1 was sent to the hospital for evaluation.01/08/2026 - Resident 7's roommate was removed due to a behavior disturbance of Resident 1.01/27/2026 - Resident 7 became angry and verbally threatening, .you know I can just hit you.02/13/2026 - Resident 7 left the facility unattended and was refusing to return. (Resident 7 was returned to the facility without injury).Review of Resident 7's physician's order, dated 02/18/2026, showed an order for a medication to treat anxiety was ordered for the resident (60 days after first documented behavior)Review of Resident 7's care plan, dated 02/18/2026, showed interventions included as needed mental health referrals.Review of Resident 7's record showed no documentation for a referral for behavioral health or psychiatric services.Observation and interview with Resident 7 on 03/24/2026 at 2:15 PM, showed the resident ambulated in the hallway with a walker. The resident appeared alert and pleasant. No behaviors noted.During an interview with Staff B, Director of Nursing on 03/26/2026 at 12:15 PM, they acknowledged Resident 7 had documented behaviors towards staff and visitors in December 2025 and January 2026 and the facility did not provide behavioral health or psychiatric services for Resident 7. Staff B stated nursing or social services can make recommendations for these services.Reference WAC 388-97-1000(2)(f)(g)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement a system to consistently and accurately reconcile controlled medications, using acceptable standards of practice for controlled substances for 3 of 6 residents (Residents 1, 5 and 6) reviewed for medication administration. This failure placed residents at risk of unmet care needs, unrelieved pain and decreased quality of life.Findings included.Review of the facility policy, titled CONTROLLED SUBSTANCE, undated, showed When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record [narcotic log] when removing the dose from the controlled storage.a. Date and time of administration.b. Amount administered.c. Signature of the nurse administering the dose.5. Administer the controlled medication and document dose administration on the MAR [Medication Administration Record].Resident 1Resident 1 was admitted to the facility on [DATE] with diagnoses including infection and inflammatory rection due to internal right hip prothesis. The admission Minimum Data Set (MDS), an assessment tool, dated 03/26/2026 showed the resident was alert and oriented, required staff assistance for most activities of daily living and received pain medication as needed.Review of Resident 1's physician's order, dated 03/20/2026, showed an order for oxycodone (narcotic pain medication) 5 milligrams (mg) give 1 tablet every 6 hours as needed for pain.Review of Resident 1's narcotic sign-out log and MAR for oxycodone IR (immediate release) 5 mg tablet every 6 hours as needed was signed out by Staff C as administered, as follows:03/24/2026 signed out as administered on EMAR at 10:57 PM but not signed out on narcotic log.03/27/2026 10:12 AM signed out of the narcotic book but not signed out on the EMAR.Resident 5Resident 5 was admitted to the facility on [DATE] with diagnoses of Dementia with psychotic disorder and lumbar fracture. The quarterly MDS, dated [DATE], showed the resident was cognitively impaired and received scheduled and as needed pain medication.Review of Resident 5's physicians order, dated12/05/2025, showed an order for oxycodone IR (immediate release) 5 mg take one tablet by mouth every 4 hours as needed for pain.Review of Resident 5's narcotic log for oxycodone showed the medication was administered on 02/02/2026 at 6:43 PM and again at 8:11 PM (1 hour and 28 minutes between doses).Resident 3Resident 3 was admitted to the facility on [DATE] with diagnoses including Vascular Dementia (decline in thinking caused by conditions that block or reduce blood flow to the brain) and Spinal Stenosis (narrowing on the spinal canal causing pressure on the nerves and spinal cord). The quarterly MDS, dated [DATE], showed the resident was cognitively impaired and received pain medication as needed.Review of Resident 3's physician's order, dated 10/25/2025, showed an order for Hydrocodone (narcotic pain medication) 5/325 mg take 1 tablet by mouth every 8 hours as needed for pain.Review of Resident 3's narcotic log for Hydrocodone 5/325 mg showed the following:A. The medication was signed out of the narcotic log by Staff C on 03/02/2026 at 12:38 PM and again at 2:53 PM (2 hour and 15 minutes between doses). There was no documentation the medication was wasted.i. Review of Resident 3's EMAR showed 1 tablet of Hydrocodone 5-325 mg was signed as administered on 03/02/2026 at 12:38 PM.B. The medication was signed out by Staff C on 03/25/2026 at 6:01 AM, at the bottom of the page of the narcotic log and on 03/25/2026 at 6:01 AM, signed out again as removed on the top of the following page of the narcotic log. No documentation the medication was wasted.ii. Review of Resident 3's EMAR showed Hydrocodone 5-325 mg 1 tablet was administered on 3/25/2026 at 6:01 AM.During an interview on 04/08/2026 at 2:30 PM Staff G, Resident Care Manager, acknowledged discrepancies were present in the EMARS and narcotic logs for these residents.Reference WAC 388-97-1300 (1)(b)(ii)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interview and record review, the facility failed to ensure the administrator implemented and enforced facility policies and procedures related to the reporting and investigation of allegations and the safeguarding of controlled substances, when the administrator was made aware of potential narcotic diversion but failed to report the allegation, conduct a thorough investigation, or implement measures to prevent ongoing access to controlled substances. This failure resulted in a breakdown in administrative oversight and placed residents at risk for not receiving prescribed medications, unrelieved pain, and decreased quality of life.Findings include.Review of an email sent to Staff A, Administrator by Staff D, Licensed Practical Nurse, dated 02/06/2026, showed .Several alert and oriented residents have confirmed that they did not request or receive medications at the time she documented them as given.There have been multiple occasions in which [Staff C, Registered Nurse (RN)] has arrived to work appearing impaired.with noticeable head-nodding and difficulty staying awake.Specific medication concerns include.Narcotics signed out for residents such as [Resident 2 and 4] that those residents report they do not receive.Medications suddenly being signed out in 1-2 dose increments that are not typically administered at those times.Discrepancies in the narcotic log, including medications signed out earlier than allowed and not in accordance with proper documentation procedures.Additionally, she frequently leaves the building during her shift and is difficult to locate.Review of the facility investigation, dated 03/27/2026, showed Resident 1 had reported to staff she had not received any pain medication on 03/26/2026 on the evening shift. Resident 1 stated she only takes oxycodone prior to therapy. During care on night shift her hip was adjusted and she requested oxycodone for pain and the night shift nurse was unable to administer the oxycodone due to it being documented as administered at 10:00 PM. The resident was given Tylenol (non-narcotic) pain medication. Resident 2 was interviewed and stated he never requests or sees a nurse after receiving his evening medications and does not see the nurse until he gets up for dialysis at 5:00 AM on Monday, Wednesday and Friday. Resident 2 stated he does not request medications/narcotics during the night. The resident was alert and oriented. Review of documentation showed Staff C had administered narcotic pain medication between 12:00 AM and 05:00 AM, which is inconsistent with the resident's statement. Staff C was terminated.During a telephone interview with Staff D, LPN on 04/03/2026 at 3:19 PM, she stated she had reported concerns related to Staff C to the Administrator in February 2026. She stated she had concerns related to Staff C's behavior and concerns related to narcotics being signed out for residents who normally didn't take medications on the night shift.During an interview with Staff A on 04/03/2026 at 3:30 PM, he was asked to provide documentation of an investigation for the allegations from the staff concerns he received by email on 02/06/2026 regarding Staff C. Staff A stated he could not provide documentation. Staff A did acknowledge having received concerns related to Staff C, nodding off and said he came into the facility almost immediately and he had observed Staff C nodding off. Staff A stated the nurse had been working extra shifts and she was counseled on staying alert and being present for shifts. When asked for the investigation from the 02/06/2026 allegation, Staff A said he thought the Director of Nursing checked the narcotic counts.During an interview on 04/07/2026 at 11:30 AM, Staff B, Director of Nursing, was asked if she was aware of an email sent to Staff A by a staff member with concerns related to possible drug diversion on 02/06/2026. Staff B stated she had no knowledge of this email, and she had not reported or investigated it. She acknowledged she was made aware of an allegation that Resident 1 had not received pain medication on 03/26/2026. Staff B stated she completed the investigation. She stated the allegation had been substantiated and Staff C was terminated. She stated she was now initiating an investigation related to the email received.During an interview on 04/08/2026 at 3:58 PM, Staff A acknowledged he received an email on 02/26/2026 from a staff member with concerns related to possible drug diversion and staff behavior and provided a copy of the email as documented above, dated 02/06/2026. He acknowledged he did not complete an incident (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	report. He stated, I don't have any documentation to dispute what [Staff B] said.Reference WAC 388-97-1620 (1)Refer to F602