STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505525	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lacey Post Acute & Rehabilitation	4524 Intelco Loop SE Lacey, WA 98503

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure transfer training was provided to family resulting in an unsafe discharge for 1 of 3 sample residents (1) reviewed for discharge process. This failure placed residents at risk for an unsafe discharge into the community and a diminished quality of life. Findings included . Resident 1 was admitted to the facility on [DATE] for rehabilitative services. The 5-day Minimum Data Set Assessment, dated 02/29/2025, indicated that Resident 1 was cognitively intact and required moderate assistance from staff for transfers. Review of the hospital Physical Therapy (PT) note, dated 02/22/2025, indicated that Resident 1 was independent with all mobility using a 4 wheeled walker prior to hospitalization. On 04/29/2025 at 12:15 PM, Staff D, Social Services Director, said that the last covered day for stay depends on insurance. Staff D said that the insurance case manager decides when the resident no longer qualifies for therapy services. Staff D was unable to provide documentation that Resident 1's spouse was able to provide the care needed for Resident 1 to safely discharge home. At 12:42 PM, Staff C, Social Services said the facility does a discharge planning care conference shortly after admission to the facility. Staff C said they do not have a formal conference when residents are closer to discharge. Staff C said that Resident 1 was given notice that services where ending on 04/19/2025 as determined by special insurance coverage. Staff C was unable to locate records to indicate that transfer training was provided to the spouse of Resident 1, to ensure he was able to safely care for Resident 1 after she was discharged home. At 12:36 PM, Staff B, Director of Nursing and Registered Nurse, said that the residents progress towards discharge was not documented in the record after weekly skilled rounds. Staff B said that Resident 1 was trained about care needs for discharge. Staff B, said Resident 1 required hands on assist with transfer. Staff B unable to provide documentation that Resident 1's spouse was trained or capable to safely transfer Resident 1 in preparation for discharge. On 05/05/2025, at 9:13 AM, Collateral Contact (CC) 1, spouse/family member, said that Resident 1 required assistance with transfer since being home. CC 1 said he was not provided training for AV to discharge home to his care. CC 1 said he did not feel that AV was safe to return home at the time she was discharged . (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
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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-0120