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	12/08/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure that residents received pain medication timely for 2 of 4 [Residents 1 and 2] reviewed for Quality of care. This failure caused Resident 1 and Resident 2 to experience ongoing pain and a diminished quality of life.Findings included. Review of the facility's Pain Management, policy, undated, documented The organization will ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Resident 1 was admitted to the facility on [DATE] for rehabilitation following a hospitalization. The 5-day Minimum Data Set (MDS), an assessment tool, dated 09/13/2025, indicated that Resident 1 was cognitively intact. In an interview on 09/22/2025 at 12:51 PM, Resident 1 said that she was admitted to the facility on [DATE] during the late afternoon. Resident 1 said that she was not given pain medication for countless hours after admission even though she asked. Resident 1 said that she repeatedly asked for pain medication and the nurse said the pharmacy did not have her prescription. Resident 1 said the nurse reported it could be a two hour wait. Resident 1 said she waited for several hours and when she asked again for pain medication, the nurse reported the pain medication was still not available and she was waiting on the pharmacy to deliver medication. Resident 1 said she then called her son out of agony from pain, and to get someone to help her. Resident 1 said her son called 911 to intervene. Resident 1 said she was left in excruciating pain 10/10 pain (10 being highest level of pain 1 being lowest) for hours. Resident 1 started to cry during the interview and stated that the pain she experienced caused her PTSD (Post Traumatic Stress Disorder-condition that develops from experiencing a traumatic event) to come back from an injury she sustained years ago. Resident 1 said that now each time she begins to experience pain she is worried she may have to wait too long for pain medication and the pain will become unmanageable. In an interview on 09/23/2025 at 11:21 AM, Collateral Contact 1 (CC1), Resident 1's son, said that he received a phone call from his mom on 09/06/2025, at about 8:45 PM stating the facility did not have pain medication for her. CC1 reported that he and his wife called the facility 5-6 times and was unable to communicate directly with staff or the nurse. CC1 said at 8:57 PM that his wife called 911 to request intervention for his mother due to her extreme duress from pain. CC1 said he stayed on the phone with 911 dispatch until his mom received pain medication. Review of the pharmacy narcotic log indicated pain medication was retrieved from the cubex, an emergency medication stock supply, at 8:44 PM. Resident 1 was admitted to the facility at approximately 5 PM. [Resident 2] Resident 2 admitted to the facility on [DATE] for rehabilitation after hospitalization. The 5-day MDS dated [DATE], indicated Resident 2 was moderately cognitively impaired. In an interview on 09/22/2025 at 1:28 PM, Resident 2 was heard crying and asking the Nursing Assistant (NA) to tell the nurse again that she was still waiting for a pain pill. The NAC said she would tell the nurse again and exited the room. Resident 2 said she had been asking for a pain pill since 4:00 AM for leg pain. Resident 2 said she was told that she had run out of medication and the nurse was waiting for the doctor to sign for a new prescription. Resident 2 said her leg was hurting so bad that it was spasming causing her to jolt in her bed. Resident 2 said the pain was so intense that it made her cry. Review of Resident 2's September 2025 Medication administration record (MAR), indicated that Resident 2 had last received narcotic pain medication on 09/22/2025 at 1:02 AM. The MAR indicated the next dose was given at 2:05 PM after Resident 2 said she asked for narcotic pain medication at approximately 4:00 AM. Review of Resident 2's Physician Orders, indicated the narcotic pain medication would be available every three hours as needed for pain. In an interview on 09/22/2025 at 1:41 PM, Staff C, Licensed Practical Nurse (LPN), said she did not have any narcotics to give Resident 2. Staff C said that Resident 2 had asked for pain medication between 7:00-7:30 AM. Staff C said that the provider comes in at 8 so she was waiting for the request for additional narcotics to be signed by the provider. When asked why Staff C did not find the provider directly, Staff C said because she thinks the provider was busy. Staff C then finished the interview and went to find the provider directly. In an interview on 09/23/2025 at 2:50 PM, Staff D, Advanced Registered Nurse Practitioner, said she was not told that Resident 2 was out of narcotics. Staff D said she was available in person, by email, or phone and was not notified that Resident 2 had been waiting for pain medication. Staff D said that there was 24/7 provider coverage for patients so there should be no delay in getting medications. In an interview on 09/23/2025 at 1:23 PM Staff A, Administrator, said that there was a system that should allow access to pull medication from the cubex if needed. The nurse

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure that Enhanced Barrier Precautions (EBP) were implemented on 1 of 4 (Resident 2) residents reviewed for infection control. This failure placed the facility at risk of exposing staff and other residents to multidrug-resistant organisms (MDROs) and a diminished quality of life.Findings included.Review of the facility's Enhanced Barrier Precaution (EBP), policy, dated 03/28/2024 documented The purpose of this policy is to outline the guidelines for implementing Enhanced Barrier Precautions (EBP) in order to reduce the transmission of multidrug-resistant organisms (MDROs) within our facility. EBP will be utilized in conjunction with standard precautions to provide targeted gown and glove use during high-contact resident care activities.Resident 2 admitted to the facility on [DATE] for rehabilitation after hospitalization. The 5-day Minimum Data Set (MDS, an assessment tool) assessment, dated 09/26/2025, indicated Resident 2 was moderately cognitively impaired.Review of Resident 2's Care plan, dated 09/19/2025, showed Resident 2 required EBP, due to an open wound.During an observation on 09/22/2025 at 12:16 PM, there was no EBP signage on the door for Resident 2. Resident 2 was noted to have a catheter bag on the side of their bed. Resident 2 said she had the catheter for over a year due to a non-healing pressure ulcer on her buttocks.During an observation on 09/22/2025 at 3:11 PM, nursing assistants went into Resident 2's room to provide direct care for Resident 2 without putting on Personal protective equipment (PPE). There was no EBP signage at the door to indicate the need for EBP.In an interview on 09/23/2025 at 3:09 PM, Staff E, Licensed Practical Nurse and Resident care manager, was asked to verify that Resident 2 had a catheter and to confirm there was no visible EBP signage on the door. Staff E said the admit nurse should have put the signage on the door during the admission process. Staff E said the infection control nurse should also spot check when they run the infection control report. Staff E said the floor nurse should ultimately be responsible to make sure the infection control signage was in place.In an interview on 09/23/2025 at 3:18 PM, Staff F, Nursing Assistant Certified (NAC), said the EBP signs were for contact precautions. Staff F was not sure what kind of things would qualify for these exact precautions. In an interview on 10/15/2025 at 12:52 PM Staff A, Registered Nurse and Administrator, said the admission nurse was responsible to make sure the EBP signage was placed during the admission process. Staff A said she was made aware that the EBP signage was not placed on the door for Resident 2. WAC 388-97-1320 (2)(a)(b)