

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/07/2026
NAME OF PROVIDER OR SUPPLIER Lacey Post Acute & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observations, interviews, and record review, the facility failed to ensure that residents were treated with dignity and respect for 2 of 4 (Resident 2 and Resident 3) sampled residents reviewed for quality of care. This failure placed residents at risk for negative outcomes to mental and psychosocial well-being and a diminished quality of life. Findings included. Resident 2 was admitted to the facility on [DATE], with multiple diagnoses for rehab services. Record review of the 5-day Minimum Data Set (MDS, an assessment tool), dated 03/11/2026, showed Resident 2 was alert and oriented. In an observation and interview on 03/16/2026 at 12:16 PM, Resident 2 stated she was waiting for stomach medication. During the interview, Staff B, License Practical Nurse (LPN) entered the room to the side of Resident 2's bed and stated, hey honey I got your pills. Staff B then opened the package of 2 pills and said, here honey put these under your tongue. In an interview on 03/16/2026 at 12:20 PM, Resident 2 said that no one asked her about her name preference but would prefer not to be called honey. Resident 3 Resident 3 was admitted to the facility on [DATE], with multiple diagnoses for rehab services. The 5-day MDS, dated [DATE], showed Resident 3 was alert and oriented. In an observation on 03/16/2026 at 12:16 PM, Staff B walked by Resident 3 and said, hey love do you need anything since I am here? Resident 3 responded no and Staff B said, ok love and left the room. In an interview on 03/16/2026 at 12:21 PM, Resident 3 said she usually goes by her birth name and was not asked about her preference to be called by any other name. In an interview on 03/16/2026 at 12:17 PM, Staff B said both Residents like to be called by their given names. Staff B said they just tend to call residents more endearing names. Staff B said they were not aware of any facility policy or professional standards to only call residents by their preferred names. In an interview on 04/07/2026 at 11:59 AM. Staff A, Administrator and Registered Nurse said that staff should only call residents by their preferred name. WAC 388-97-1080(2)</p>

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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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interviews and record review, the facility failed to ensure that residents were free from unnecessary drugs for 1 of 4 (Resident 1) sampled residents reviewed for unnecessary medications. This failure caused Resident 1 to be given psychotropic medication without prior consent. This failure placed residents at risk for increased side effects and a diminished quality of life. Findings included. Resident 1 was admitted to the facility on [DATE], with multiple diagnoses to include anxiety (a mental and physical state characterized by intense, and persistent worry or fear) and depression (a serious mental disorder characterized by persistent sadness, loss of interest in activities, and low energy). The 5 -day Minimum Data Set (MDS, an assessment tool), dated 03/04/2026, showed Resident 4 was alert and oriented. Record Review of Resident 1's physician order, dated 03/02/2026, showed Haldol (medication to treat mental health conditions) 2 mg (milligrams) orally once daily, to be held until physician order was clarified for accuracy. Record review of Resident 1's March 2026 electronic medication record (EMAR) showed Resident 1 received Haldol on 03/07/2026 without consent for Haldol. In an interview on 03/18/2026 at 1:56 PM, Collateral Contact 1 said her mom (Resident 1) was not supposed to be given Haldol due to a concern with hand tremors. In an interview on 04/07/2026 at 11:59 AM, Staff A, Administrator and Registered Nurse (RN), reviewed Resident 1's medication orders and confirmed that Resident 1 was given Haldol without consent. Staff A said a consent should have been completed prior to giving the psychotropic medication. Reference WAC 388-97-1060(3)(k)(i)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>.Based on observations, interviews and record review, the facility failed to implement appropriate infection control practices when handling medication for 1of 3 (Resident 2) sampled residents reviewed for infection control and prevention. This failure placed residents at risk for the spread of infection transmission in the facility and a diminished quality of life.Findings included.Record review of the facility policy titled, Infection Prevention and Control General Guidelines, dated July 2023, indicated, Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.In an observation on 03/16/2026 at 12:16 PM, Staff B, License Practical Nurse (LPN), entered Resident 2's room to the left side of their bed and said they had stomach medication to give her. Staff B opened two single dose packages with bare hands dropping each pill into their palm. Staff B then handed both pills directly from their hand into Resident 2's hand. Staff B instructed Resident 2 to place the dissolvable pills under her tongue.In an interview on 03/16/2026 at 12:17 PM, Staff B said he should have used gloves or a medication cup instead of handling the medication with his hands. Staff B said they were just in a hurry.In an interview on 04/07/2026 at 11:59 AM, Staff A, Administrator and Registered Nurse, said she would expect nurses to wear gloves when handling medications. Reference WAC 388-97-1320 (1)(a)</p>		