

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 04/21/2026
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interviews and record review, the facility failed to provide goods and services to residents that are necessary to avoid physical harm, pain, mental anguish or emotional distress for 1of 4 sampled residents (Resident 1) reviewed for neglect. This failure placed residents at risk of injuries related to falls and a diminished quality of life.Findings included.Resident 1 was admitted to the facility on [DATE], with multiple diagnoses for rehabilitation services. Record review of the 5-day minimum data set, an assessment tool, dated 03/24/2026, documented Resident 1 was moderately cognitively impaired.Record review of Resident 1's Electronic Health Record (EHR) showed Resident 1 had a fall from bed on 03/24/2026 at 9:15 PM, stating he needed to have a bowel movement.Record review of Resident 1's EHR showed Resident 1 had fallen from bed on 03/25/2026 at 1:06 AM, stating he needed to have a bowel movement.Record review of Resident 1's EHR showed facility intervention to include a 1:1 sitter for safety, until another intervention could be provided.Record review of Resident 1's EHR showed Resident 1 had a fall from bed on 03/25/2026 at 06:40 AM, stating he just wanted to get up and go to the bathroom.In an interview, and record review on 04/21/2026 at 11:59 AM, Staff A, Administrator and Registered Nurse said she had received a call from staff regarding multiple falls by Resident 1. Facility staff had indicated that Resident 1 was restless and confused, therefore implementing a 1:1 sitter for the safety of Resident 1, until another more sustainable intervention could be made. Staff A said that the dayshift nurse dismissed the 1:1 sitter during the morning shift change, leaving Resident 1 unattended. Staff A was unable to find a follow up assessment indicating that Resident 1 was no longer restless or confused, prior to his 3rd fall and removal of the 1:1 sitter. Staff A said she would have expected the nurse to reassess Resident 1 for safety before removing the 1:1 sitter.Reference WAC 388-97-0640 (1)</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interviews and record review, the facility failed to collaborate care and services and complete assessments for 1 of 2 residents (Resident 2) reviewed for dialysis (a procedure that acts as an artificial kidney, filtering waste products, toxins, and excess fluid from the blood). This failure placed residents at risk for compromised health outcomes and a diminished quality of life. Findings included. Record review of the facility policy, titled, End Stage Renal Disease (permanent kidney failure, requiring dialysis)-Care of the Resident, undated, documented, (5) The nursing facility staff will provide immediate monitoring and documentation of the status of the resident's condition and resident's access site(s) upon return from the treatment to observe for bleeding or other complications. (3.b) the communication process between the nursing facility and the dialysis center that will reflect ongoing communication, coordination, and collaboration. Resident 2 was admitted to the facility on [DATE], with multiple diagnoses to include dialysis The 5-day Minimum data set, an assessment tool, indicated Resident 2 was unable or unwilling to complete the assessment. Record review of Resident 2's electronic health record (EHR) showed Resident 2 had an AV fistula (connection between an artery and vein frequently used for dialysis) to her left upper extremity. Record review of Resident 2's EHR, dated March 2026 showed assessments completed for Resident 2 that documented that Resident 2 did not have an AV fistula or dialysis access site for the following dates: 03/05/2026 03/07/2026 03/10/2026 03/12/2026 03/13/2026 03/14/2026 03/15/2026 03/17/2026 Record review of Resident 2's medication administration record, dated March 2026, showed no assessments for Resident 2's AV fistula upon return from dialysis on dates 03/04/2026 to 03/10/2026. In an interview with Collateral Contact (CC 1) on 04/14/2026 at 4:22 PM, said Resident 2 arrived at the dialysis center on 03/16/2026 without the appropriate sling under the patient to assist with a safe transfer into the dialysis chair. CC 1 said Resident 2 was unable to receive dialysis services on that day. CC 1 said the facility was made aware of the incident and asked to reschedule for the missed dialysis on 03/17/2026. CC 1 said the facility was unable to arrange transportation for Resident 2 on 03/17/2026 and would receive her next scheduled dialysis on 03/18/2026. CC 1 said on the morning of 03/18/2026 she called the facility to remind them to place Resident 2 on the appropriate sling. CC 1 said Resident 2 showed up again to the dialysis center without the transfer sling under Resident 2 to safely transfer her into the dialysis chair, and dialysis center staff did a 4 man lift to ensure Resident 2 received dialysis that day. Record review of Resident 2's care plan showed no interventions listed for the specialty transfer sling to be used for dialysis until 03/17/2026. In an interview and record review on 04/21/2026 at 11:59 AM, Staff A, Administrator and Registered Nurse said the nurses should be doing assessments on return from dialysis services. Staff A was unable to find assessments in the EHR. Staff A also said she would expect the assessments completed in the record to be accurate. Staff A said the facility should have made sure the sling was under Resident 2 to ensure safe transfer into dialysis chair. Reference WAC: 388-97-1900 (1)(6)(a-c)</p>		