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	08/23/2024

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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47518 Based on interview and record review, the facility failed to obtain and/or maintain Advance Directives (AD) for 1 of 11 sampled residents (157) reviewed for AD. This failure placed residents at risk for losing their right to have their healthcare preferences and/or decisions honored. Findings included . Resident 157 was admitted to the facility on [DATE]. The Admission/Medicare - 5 day Minimum Data Set assessment, dated 08/15/2024, documented Resident 157 was alert and oriented. Record review of Resident 157's Social Service Initial Evaluation, dated 08/12/2024, documented, 18a .POA [Power of Attorney] is [Proper Name]. Record review of Resident 157's Multidisciplinary Care Conference, dated 08/12/2024, documented, K.1 . Son is POA. Record review of Resident 157's Electronic Health Record (EHR) did not show AD paperwork documentation, or that AD documents were requested. On 08/22/2024 at 2:01 PM, Staff C, Director of Social Services, said when a resident was admitted , if they had an AD or Power of Attorney, social services would ask them to bring copies in. At 2:05 PM, Staff D, Social Worker, said she would ask during the care conference for AD copies to be brought in or emailed if they had one. When asked if Resident 157's AD documentation paperwork was requested during the care conference, Staff D said she did not have copies of the AD. Staff D stated, I do not have that documented. On 08/23/2024 at 9:48 AM, Staff B, Director of Nursing Services and Registered Nurse, said during the care conference, the social worker would establish if there was an AD. Staff B said the social worker would request a copy of the AD and document the request in the EHR. At 9:55 AM, Staff A, Administrator, said it was her expectation a copy of the AD was requested and staff documented it was requested. Staff A stated, If it wasn't documented, it wasn't done. Reference WAC 388-97-0240 (3)(a)(b)(i-iii)

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 37934 Based on interview and record review, the facility failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) for 1 of 3 sampled residents (42) reviewed for Beneficiary Notices. This failure placed residents and/or their representatives at risk for not having adequate information to make financial decisions related to the residents' stay in the facility. Findings included . The Notice of Medicare Non-Coverage, dated 04/10/2024, documented Resident 42's representative was contacted on 04/09/2024 and informed Resident 42's services were ending on 04/11/2024. The SNF ABN was not provided to inform the representative of the potential financial liability. On 08/23/2024 at 11:25 AM, Staff N, Business Office Manager, said the SNF ABN for Resident 42 was not completed. At 11:40 AM, Staff C, Social Services Director, said she had a conversation with Staff N and she was not sure who was supposed to cover the SNF ABN with residents or their representatives. Staff C said Resident 42 should have had the SNF ABN because he remained in the facility. Reference WAC 388-97-0300 (4)(a-c)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47518 Based on interview and record review, the facility failed to provide a written Bed-Hold notice to the resident or resident's representative at the time of transfer to the hospital for 1 of 1 sampled resident (105) reviewed for bed hold notification. This failure placed residents at risk for lack of knowledge regarding their right to hold their bed while in the hospital. Findings included . Resident 105 was admitted to the facility on [DATE]. The admission Minimum Data Set assessment, dated 06/14/2024, documented Resident 105 was moderately cognitively impaired. The Electronic Health Record (EHR) showed Resident 105 was hospitalized on [DATE]. The EHR did not show documentation of a written Bed-Hold notice, nor that contact was made to the resident or resident's representative regarding a Bed-Hold. On 08/22/2024 at 10:06 AM, Staff E, Admissions Liaison, said when a resident was transferred to the hospital, admissions contacted the resident or the resident representative and offered a bed-hold. Staff E said she did not have a form she filled out. Staff E said if a resident transferred to a hospital directly from a doctor's appointment while a resident, the resident was still offered a Bed-Hold. Staff E said she could not locate a written Bed-Hold notice nor documentation offering a Bed-Hold for Resident 105. At 10:14 AM, Staff A, Administrator, said it was her expectation a Bed-Hold was offered and documented when a resident transferred to the hospital. Reference WAC 388-97-0120 (4)(a-c)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50846 Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment was completed accurately to reflect a resident's condition at the time of assessment for 1 of 27 sampled residents (75) reviewed for assessment accuracy. This failure placed residents at risk for unidentified and/or unmet care needs. Findings included . Resident 75 was admitted to the facility on [DATE] with diagnoses including history of strokes (when the brain's blood supply is cut off, which can damage or kill brain tissue). The MDS, dated [DATE], documented the resident was alert and oriented and was able to make care needs known. The MDS did not reflect the resident's visual deficit. On 08/08/09/2024 at 2:47 PM, Resident 75 stated, Strokes have taken a big chunk of my vision. It is very difficult for me to see. It is difficult to read the activity calendar and get into the bathroom. Resident 75 said she needed assistance with most Activities of Daily Living (ADLs) related to her poor vision. On 08/21/2024 at 10:30 AM, Staff W, Activity Director, said Resident 75 was visually impaired. The resident can not see the activity newsletter daily, so activity staff read it to her. Staff W said Resident 75 had a cell phone and uses listens to books. Staff W said the staff encourage participation in activity programs and provide assistance to get to activity programs. At 11:30 AM, Resident 75 was observed in the dining room, eating independently. Resident 75 asked staff to tell her what was on the plate in front of her and where the food item was. At 2:45 PM, Staff X and Staff Y, MDS Coordinators, said the MDS assessments for residents were completed by resident interview, resident observation, and asking all staff for input. Staff X and Staff Y said all staff included the nurses, nursing assistants, social work, activities and therapies. When asked questions about the process for gathering information for resident MDS assessments, Staff X stated, We follow CMS (Centers for Medicare and Medicaid) guidance. On 08/23/24 at 10:07 AM, Staff Z, Certified Nursing Assistant, said, Resident 75 was visually impaired and required assistance with set- up of eating, bathing, toileting. Staff J, Charge Nurse and Licensed Practical Nurse, stated, [Resident 75] has been at the facility in the past and staff know this resident and understand she is visually impaired. At 10:45 AM, Staff Q, Charge Nurse, said Resident 75 was legally blind. Reference WAC 388-97-1000 (1)(a)(b)(d)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51254 Based on observations, interview and record review, the facility failed to follow the recommendations of the Preadmission Screen and Resident Review (PASARR) Level II for 1 of 7 sampled residents (14) reviewed for PASARR. This failure placed residents at risk for not receiving necessary mental health services and a diminished quality of life. Findings included . Resident 14 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease (chronic, long-term brain disorder that affects the nervous system and causes involuntary movements) and Depression. The quarterly Minimum Data Set (MDS) assessment, dated 08/07/2024, indicated Resident 14 experienced hallucinate and experience delusions, and was severely cognitively impaired. The PASARR, dated 06/25/2024, indicated Level II services were appropriate for new behaviors of a psychotic disorder. The Notice of Determination, dated 07/16/2024, documented Resident 14 had been identified as having a mental health condition that required specialized behavioral health services. Review of the PASARR Level II, Initial Psychiatric Evaluation Summary, dated 07/25/2024, indicated specialized services could be provided in a skilled nursing facility by a licensed mental health professional or mental health agency for individual services. The assessment indicated Resident 14 may most benefit from an environment that provides a low level of stimulation as well as a sense of routine and predictability. Resident 14 would likely benefit from a calm, reassuring approach. Provide resident reorientation and redirection as needed. Provide empathic listening and validation of feelings [Resident 14] is experiencing, then redirect her to topics or activities that prove to be distracting and engaging for her. Keep communication simple and short. Provide slow transitions between topics or cares and allow rest breaks in between. Try to anticipate her basic needs and wants. Review of Resident 14's impaired cognition care plan, dated 07/28/2024, did not include PASARR level II recommendations for behavioral health interventions. On 08/19/2024 at 9:50 AM, Resident 14 was observed calling out and lying in bed. Resident 14 was tearful and making disorganized statements I have been murdered once . the government brought me back to life once . so they could steal my [NAME] benefits . Resident was able to engage in conversation briefly, then called out for help again. At 11:00 AM, Resident 14 was observed calling out sporadically for help from her friends and nursing staff. On 08/20/2024 at 8:38 AM, Resident 14 was observed talking to herself in their room, while looking through items in their purse. Resident 14 said she was anxious because she did not know what was going on. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/21/2024 at 9:09 AM, Staff F, Certified Nursing Assistant, said she would look in [the electronic medical records (PCC) for information on how to help calm a confused resident. Staff F was unable to locate interventions for behaviors in PCC. When asked how she would approach a resident that was calling out or scared, Staff F said she would just go into the resident's room and see what she could do to help. Staff F said it would be helpful if there was information in PCC to direct the care. At 11:14 AM, Staff G, Licensed Practical Nurse, said if a resident had behavior interventions, she would look at the Medication Administration Record (MAR) for information. When asked to pull up interventions in the MAR, Staff G was unable to locate specific interventions to assist in behavior management for Resident 14. On 08/22/2024 at 8:35 AM, Staff C, Social Service Director, said PASARR Level II recommendations were usually listed on the care plan. Staff C said the facility should use the recommendations from the PASARR evaluator for resident mental health care in the facility. Staff C said behavioral health care plan interventions should then transfer onto the Kardex [resident's individualized care directives for nursing assistants]. Staff C was unable to locate the PASARR Level II evaluator recommendations on Resident 14's care plan. At 9:35 AM, Staff A, Administrator, said PASARR Level II recommendations should be integrated into the care plan to direct staff on behavioral health interventions. Reference WAC 388-97-1060 (1)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934 Based on interview and record review, the facility failed to ensure the Pre-Admission and Resident Review (PASARR) assessment was completed correctly for 2 of 9 sampled residents (38 & 100) reviewed for PASARR. This failure placed residents at risk for not receiving the necessary mental health services and a diminished quality of life. Findings included . 1) Resident 38 was admitted to the facility on [DATE] with diagnoses including depression. The admissions Minimum Data Set (MDS) assessment, dated 07/22/2024, indicated Resident 38 was alert and oriented. The PASARR, dated 07/12/2024, indicated Resident 38 had a Mood Disorder. The recommendation was No Level II evaluation indicated at this time due to exempted hospital discharge: Level II must be completed if scheduled discharge does not occur. On 08/21/2024 at 2:20 PM, Staff A, Administrator, said they should review the PASARR for accuracy for new admits. Staff A said she did not understand the exemption issue and would reach out to the PASARR. At 3:17 PM, Staff A, said she spoke with the PASARR Coordinator, and the exemption needed a doctor's signature and was for 30 days. 2) Resident 100 was admitted to the facility on [DATE] with diagnoses including Depression and Anxiety Disorders. The 5-Day MDS, dated [DATE], indicated Resident 100 was severely cognitively impaired. The PASARR, dated 07/29/2024, from the local hospital, did not document Resident 100 had any serious mental illness indicators. The local hospital discharge summary, dated 08/02/2024, documented Resident 100 was to continue these medications which have changed: lorazepam [antianxiety medication]. The discharge summary indicated to continue these medications which have not changed: Seroquel [antipsychotic medication], Zoloft and Trazodone [antidepressant medications]. The Physician Discharge Summary, dated 08/02/2024, indicated Dementia, and noted, Will maintain delirium precautions with day night cycling. Continue melatonin as needed insomnia. Not needed low-dose Zyprexa for extreme agitation. Maintain other meds Seroquel, Zoloft, Trazadone, and Lorazepam. On 08/21/2024 at 2:08 PM, Staff C, Social Services Director, said Social Services reviewed PASARRs to ensure accuracy for new admissions. Staff C said they needed a better system to review for accuracy. Reference WAC 388-97-1915 (1)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50846 Based on observation, interview, and record review, the facility failed to ensure a care plan was updated to reflect changing needs for 1 of 27 sampled residents (67) reviewed for care plans. This failure placed residents at risk for unmet care needs and a diminished quality of care. Findings included . Resident 67 was admitted to the facility on [DATE] with diagnoses including falls with a fracture of one rib right side, fracture of T5-T6 vertebra, Dysphagia (difficulty swallowing), Aphasia (a language disorder that affects a person's ability to communicate, caused by damage to the parts of the brain that control language) and Dementia. The 5- day Minimum Data Set (MDS) assessment, dated 08/07/2024, documented Resident 76 was moderately cognitively impaired and required moderate assistance with toileting. The MDS showed the resident was at risk of injury from falls due to new admission and deconditioning with resulting lack of balance and endurance; and Resident 67 had an indwelling foley catheter (a thin, flexible tube that's inserted into the urethra and bladder to collect and drain urine). Review of Resident 67's care plan, initiated 07/31/2024, showed it did not document what assistance the resident required for toileting, eating, and grooming. Review of Nursing Progress Notes, dated 08/08/2024, showed Resident 67 pulled out his urinary catheter and it was not replaced. A review of facility falls investigations showed Resident 67 had falls on 08/01/2024, 08/03/2024, 08/08/2024, 08/09/2024, 08/11/2024 and 08/15/2024. On 08/19/2024 at 11:30 AM, Resident 67 was observed in the dining room eating. The resident had difficulty getting the food from the plate to his mouth, as food was falling from his fork onto his lap as he tried to take bites. Resident 67 received assistance with opening his drinks and information about what he was eating and where on the plate the food was located. Resident 67 was unshaven and his hair was matted to the back of his head. On 08/20/2024 at 10:00 AM, Resident 67 was observed sitting in a wheelchair outside of his room sleeping. At 11:30 AM, Resident 67 was observed being wheeled to the dining room for lunch. The resident was not offered to use the bathroom. The Kardex (care instructions for caregivers), reviewed on 08/21/2024, did not specify what assistance Resident 67 required for toileting, grooming or eating. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/21/2024 at 3:00 PM, when asked how information was communicated to the caregivers and charge nurses regarding Resident 67's ADL care needs, Staff J, Unit Manager, stated, Admission assessment, shift to shift report, and nursing assistants review the Kardex. As we update care plans for specific care needs, we attach it to the Kardex. The aides look at the Kardex every day and it gives them the information they need to follow. After reviewing the Kardex and care plan with no directives for assistance with toileting, grooming and eating for Resident 67, Staff J said the care plan was being updated today. Reference WAC 388-97-1020 (2)(d)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50846 Based on observation, interview, and record review, the facility failed to ensure toilet assistance was provided consistently, in accordance with the resident's preferences and current abilities for 1 of 6 sampled residents (67) reviewed for activities of daily living (ADLs) for dependent residents. This failure placed residents at risk for embarrassment, poor hygiene, potential falls, and a diminished quality of life. Findings included . Resident 67 was admitted to the facility on [DATE] with diagnoses including falls and Aphasia (a language disorder that affects a person's ability to communicate, caused by damage to the parts of the brain that control language). The 5-Day Minimum Data Set (MDS)assessment, dated 08/07/2024, documented Resident 67 had moderate cognitive impairment, was able to make care needs known and required moderate assistance with toileting. The MDS documented Resident 67 was at risk of injury from falls due to new admission and deconditioning with resulting lack of balance and endurance; and Resident 67 had an indwelling Foley catheter (a thin, flexible tube that's inserted into the urethra and bladder to collect and drain urine). The care plan, initiated 07/31/2024, did not document what assistance Resident 67 required for toileting. A review of facility fall investigations, showed Resident 67 had falls on 08/01/2024, 08/03/2024, 08/08/2024, 08/09/2024, 08/11/2024 and 08/15/2024. On 08/20/2024 at 10:00 AM, Resident 67 was observed sitting in a wheel chair outside of his room sleeping. At 11:30 AM, the resident was observed being wheeled to the dining room for lunch. No assistance to use the bathroom was offered. At 12:22 PM, Resident 67's representative said Resident 67 never had any incontinent issues at home and did not know why the resident wore a brief for incontinence at the facility. The representative said the resident had a Foley catheter but he pulled it out earlier in the month. The representative said Resident 67 had several falls at the facility within a few days of admission. Resident 67's representative said prior to hospitalization and nursing home placement, Resident 67 was continent of bowel and bladder. The Kardex (care instructions for caregivers), reviewed on 08/21/2024, did not specify what assistance Resident 67 required for toileting. On 08/21/2024 at 10:15 AM, when asked about the assistance Resident 67 required for toileting, Staff P, Certified Nursing Assistant, stated, It depends. Some days he will be able to tell us. Some days he is incontinent of bowel and bladder. Most of the days he is incontinent. Staff P indicated she did not know of any toileting schedule for Resident 67. Staff P said she had not taken Resident 67 to use the bathroom, and had only assisted with personal care after incontinent episodes. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 10:30 AM, Resident 67 was observed laying in bed in his room. At 11:30 AM, Resident was wheeled to the dining room for lunch, with no assistance to use the bathroom being offered. At 1:20 PM, Staff Q, Charge Nurse and Registered Nurse, said Resident 67 received total care for incontinence of bowel and bladder. Staff Q stated, He wants to take himself to the bathroom. That is when he falls. At 2:30 PM, Staff R, Physical Therapist (PT), said Resident 67 had balance concerns and many falls, but was able to walk 100 feet with one person assist. Staff R stated, When I got him out of bed he requested to use the bathroom. Staff R indicated a toileting program had not been discussed with nursing, but stated, That would be a good intervention for him. At 3:00 PM, when asked how information was communicated to caregivers and charge nurses regarding Resident 67's ADL care needs, Staff J, Unit Manager, stated, Admission assessment, shift to shift report, and nursing assistants review the Kardex. As we update care plans [about specific care to be provided], we attach it to the Kardex. The aides look at the Kardex every day and it gives them the information they need to follow. After reviewing the Kardex and care plan for Resident 67 without directives for assistance with toileting, Staff J stated, Toileting was added to the care plan today. At 3:30 PM, after reviewing the documentation of falls at the facility and the interventions added to Resident 67's care plan to mitigate falls, Staff B, Director of Nursing Services, and Staff A, Administrator, said toileting the resident routinely and updating the care plan would be a good interventions to mitigate falls. At 9:05 PM, Staff S, Certified Nursing Assistant, stated, Yes, [Resident 67] does ask to go to the bathroom quite often. I do try to help him a lot. [The resident is] one person assist to the bathroom. I have not assisted him to the bathroom, but I have helped change him in bed. When [Resident 67] is sitting out here, he will ask to go to the bathroom a lot. At 9:26 PM, Staff U, Charge Nurse, said Resident 67 was not continent of bowel and bladder and required total assistance with toileting. At 10:29 PM, Staff V, Certified Nursing Assistant, stated, This evening, [Resident 67] used the bathroom, and he asked us to help him go to bed. He was able to say he wanted to use the bathroom. [Resident 67] wants to take himself to the bathroom. That is when he falls. Reference WAC 388-97-1020 (2)(d)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51254 . Based on observation, interview, and record review, the facility failed to ensure the necessary care and services were provided to maintain residents' abilities in range of motion and activities of daily living, and provide preventative range of motion (ROM) services for 4 of 5 sampled residents (64, 82,15 & 67) reviewed ROM services. This failure placed residents at risk for an avoidable decline and diminished quality of life. Findings included . 1) Resident 64 was admitted to the facility on [DATE] with diagnoses including Hemiplegia, unspecified affecting left non-dominant side (Partial paralysis on one side of the body). The quarterly Minimum Data Set (MDS) assessment, dated 07/31/2024, showed Resident 64 was severely cognitively impaired, and no restorative therapy services were completed. The care plan, dated 01/06/2024, indicated resident required extensive assistance x2 for bed mobility, and repositioning. No restorative services was noted in the care plan. On 08/20/2024 at 10:00 AM, Resident 64 was observed lying in bed with left arm down to side of body and using right arm to drink from container on bed side table. When asked if she could use her left arm/hand, Resident 64 stated her arm and hand did not move on their own. Resident 64 was able to lift left hand using her right hand and demonstrated limited mobility of hand. 2) Resident 82 was admitted to the facility on [DATE] with diagnoses including Hemiplegia and Hemiparesis (partial paralysis or weakness on one side of the body) following cerebral infarction (a stroke) affecting left non-dominant side. The 5-day MDS, dated [DATE], indicated Resident 82 was alert and oriented, and no restorative therapy services were completed. The care plan, dated 06/21/2024, indicated Resident 82 required one person assist with bed mobility and transfers. No restorative services was noted in the care plan. On 08/21/2024 at 11:06 AM, Resident 82 was observed sitting on the side of bed with his left arm dangling to side. Resident 82 said he did exercises to prevent his hand from getting more paralyzed. Resident 82 said staff did not address his left-hand function. Resident 82 said he had downloaded videos from online to help keep his hand from further decline. 3) Resident 15 was admitted to the facility on [DATE]. The resident was discharged to the hospital on 01/10/2024 after a fall with fractures to the right humerus and right hip. Resident 15 was readmitted to the facility on [DATE]. The annual MDS, dated [DATE], indicated the resident was alert and oriented, and no restorative therapy services were completed. (continued on next page)

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	505525	A. Building B. Wing	08/23/2024

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan, dated 07/26/2024, indicated Resident 15 required 2 person assist with bed mobility and transfers. No restorative services were found in the care plan and the Electronic Health Record (EHR). On 08/19/2024 at 9:50 AM, Resident 15 was observed eating with her left hand and tray table to left side of bed. Resident 15 said she had learned to eat with her left hand because her right shoulder was weak. Resident 15 said she did not get any type of therapy for the right shoulder, and was barely able to use the right arm. On 08/20/2024 at 12:24 PM, Resident 15 was observed using her left arm to eat lunch. Resident 15 said she broke her right shoulder which was her dominant arm, and now does the best she could with the left arm to eat and drink. Resident 15 said she worked with physical therapy for a while to help strengthen her leg but had not done anything to keep the right shoulder from getting stiff. On 08/22/2024 at 8:07 AM, Staff J, Unit Manager and Licensed Practical Nurse, said the restorative program was overseen by the activities department. Staff J said she did not know what residents were in the restorative program. At 9:43 AM, Staff H, Activities Assistant and Certified Nursing Assistant, said there was no schedule for residents to receive restorative services. Staff H said any resident that would like to participate were able to go to the gym to exercise. Staff H said residents that were not able to go to the program did not receive restorative services. When asked if a bed bound resident who chose not to go to the gym was able to receive restorative services, Staff H stated, No. Staff H said there was no task assignment for restorative services so they would not be aware of residents that needed restorative services. At 10:21 AM, Staff I, Director of Rehab and Occupational Therapist, said when residents came off rehab services, they were given recommendations for restorative programs to maintain their highest level of function. Staff I said the activity assistant was the person that worked with the residents that choose to participate in restorative services. Staff I said therapy did not oversee the program but would make recommendations. Staff I was not aware if residents that were recommended for restorative services were included into the restorative program. 4) Resident 67 was admitted to the facility on [DATE] with diagnoses including falls with a fracture of one rib right side, fracture of T5-T6 vertebra, Dysphagia (difficulty swallowing), Aphasia (a language disorder that affects a person's ability to communicate, caused by damage to the parts of the brain that control language) and Dementia. The MDS, dated [DATE], showed the resident had moderate cognitive impairment and was able to make care needs known. Resident 67 was at risk of injury from falls due to new admission, deconditioning with resulting lack of balance and endurance. Resident 67 had an indwelling foley catheter (a thin, flexible tube that's inserted into the urethra and bladder to collect and drain urine.) A review of facility fall investigations showed Resident 67 had falls on 08/01/24, 08/03/2024, 08/08/2024, 08/09/2024, 08/11/2024 and 08/15/2024. The facility Investigative Report, dated 08/09/2024, showed interventions included .Encourage patient to attend restorative nursing in the morning in an effort to correct his sleep pattern. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/22/2024 at 9:48 AM, Staff J, Unit Manager, stated, There is no restorative nursing program. Staff J said the activities department led the restorative program and activities staff were in charge of the restorative nursing program, as they are all certified nursing assistants. Staff J said she had no documentation of what was included in the restorative program, and did not know what the goals or interventions were for Resident 67's participation in restorative care. At 10:15 AM, Staff W, Activity Director, stated, The restorative program at the facility included residents participating in physical activities with the activity director, or one of the activities folks. Usually, we do it in the morning in the physical therapy gym. Review of documentation of what was included in Resident 67's restorative program showed there was no plan, interventions or goals. The only documentation activities had was in regards to the restorative program for Resident 67 was attendance. The intervention to participate in restorative nursing services to mitigate falls was initiated on 08/09/2024. Resident 67 had participated twice on 08/12/2024 and 08/18/2024. Staff W stated, Resident 67 Often refuses to participate. However, restorative services are part of his care so, we should be documenting that. On 08/23/2024 at 10:00 AM, Staff A, Administrator, said restorative programs should be documented in EHR. No restorative documentation was found in resident records. Staff A said they were putting a restorative program back in place. Staff A said currently some residents did go down for exercise, and these activities should have been documented. Staff A said residents should have programs to help them maintain their highest level of function. Reference WAC 388-97-1060 (3)(d)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934 Based on interview and record review, the facility administered Tuberculin (TB) Solution to a resident allergic to the TB solution for 1 of 5 sampled residents (100) reviewed for Tuberculin testing. This failure placed residents at risk for medical complications and a diminished quality of life. Findings included . Resident 100 was admitted to the facility on [DATE]. The 5-Day Minimum Data Set assessment, dated 08/08/2024, indicated Resident 100 was severely cognitively impaired. The local hospital H&P (history & physical) Note, dated 07/26/2024, indicated Resident 100 had an allergy to Tuberculin. A progress note, dated 08/03/2024 at 7:19 PM, documented, chest x-ray done r/t (related to) unable to take the TB solution, results came back negative . The August 2024 Medication Administration Record (MAR) documented Resident 100 was administered the first step Tuberculin on 08/08/2024. The MAR documented Resident 100 was administered the second step on 08/16/2024. On 08/22/2024 at 2:54 PM, Staff O, Infection Preventionist, said Resident 100 was administered the first step on 08/08/2024 and the second step on 08/16/2024. At 3:20 PM, after reviewing Resident 100 was ordered a chest x-ray documented in the electronic health record, Staff O said it looked as if Resident 100 had an allergy to Tuberculin. Staff O said she would have to check to see if in fact Resident 100 was administered the Tuberculin. At 3:49 PM, Staff O and Staff A, Administrator, said Resident 100 was administered the Tuberculin and Resident 100 should not have been given Tuberculin because she had an allergy to Tuberculin. Reference WAC 388-97-1060 (3)(k)(iii)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50416 Based on interview and observation, the facility failed to ensure medication was secured in 1 of 4 medication carts (100 hall medication cart) reviewed for medication administration. This failure placed resident at risk for medications being accessible to unauthorized staff and residents. Findings included . On 08/22/2024 at 9:08 AM, Staff K, Licensed Practical Nurse, was observed standing near the 100 hall medication cart. When asked if they were available to be observed for medication administration, Staff K said they had completed their morning medication pass. Staff K went into room [ROOM NUMBER] and was speaking to the resident in bed one. A medication cup with clear yellow liquid was observed on the 100 medication cart when Staff K walked away. At 9:12 AM, Staff K came out of room [ROOM NUMBER] and proceeded to answer the call light in room [ROOM NUMBER]. She returned to the medication cart and then walked back into room [ROOM NUMBER]. At 9:14 AM, Staff K walked back to the medication cart and discarded the yellow liquid that was on the cart into the trash can. When asked the name of the yellow liquid discarded, Staff K stated, It is lactulose (a medication used to prevent constipation). The resident refused it. At 2:08 PM, Staff B, Director of Nursing Services and Registered Nurse, said it was her expectation the nurse administering medication would keep all medications locked in the medication cart before walking away from the cart. Reference WAC 388-97-1300 (2)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 50416 Based on interview and observation, the facility failed to ensure patient care equipment was maintained in safe operating condition for 1 of 1 suction machines (2nd Floor Crash Cart Suction Machine) reviewed for equipment in safe operating condition. This failure placed residents at risk for not having their care needs met. Findings included . On 08/20/2024 at 12:18 PM, while reviewing the 2nd Floor crash cart, Staff L, Licensed Practical Nurse, said the crash cart was checked every night shift. Staff L was asked to turn on the suction machine on the crash cart. When the suction machine was turned on, the suction machine had no suction to it. When asked what the sign off forms on the cart were for, Staff L said they were not sure what the staff were checking, and the crash cart was checked by the night shift nurse every evening. At 12:24 PM, Staff B, Director of Nursing Services and Registered Nurse (RN), said staff checked the crash cart every night. At 3:20 PM, Staff M, RN, said the suction machine on the crash cart was used to clear a resident's airway in the event they have excessive secretions in the mouth. Staff M said if the suction machine on the crash cart was not working, they would designate someone to get another suction machine from the supply room. Staff M said the night shift nurse checks the suction machine on the crash cart every night. At 3:29 PM, Staff B said the sign off list on the crash cart was acknowledging the staff have checked the items on the cart and checked that they were functioning. Staff B stated, We turn it on and make sure that it has suction. I know that did not happen this time. I would expect them to turn it on and check the suctioning not just the motor is running. Reference WAC 388-97-2100 (1)