| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505016 | A. Building<br>B. Wing | 09/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Grays Harbor Health & Rehabilitation Center | 920 Anderson Drive<br>Aberdeen, WA 98520 |

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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident oxygen administration orders were completed per physician order for 1 of 4 sampled residents (Resident 1) reviewed for oxygen administration. This failure placed residents at risk of low oxygen levels and a diminished quality of life. Findings included. Resident 1 admitted to the facility on [DATE]. The 5-day admission Minimum Data Set, an assessment tool, documented the resident was on oxygen therapy and was severely cognitively impaired. Record review of Resident 1's oxygen care plan, initiated 07/14/2025, documented, Administer oxygen @ 2L/min [at two liters per minute] via nasal cannula; Continuous for dyspnea [trouble breathing]. Record review of a physician order, dated 07/11/2025, documented, Administer oxygen @ 2L/min via nasal cannula; Continuous for dyspnea. In an observation on 09/03/2025 at 9:30 AM, Resident 1 was observed in her room, in bed, under covers, eyes closed. Resident presented confused and asked where she was. An oxygen concentrator was near the resident bed, turned off, with the nasal cannula wrapped on top of the machine. Near the bed was the resident's wheelchair, and on the back of the wheelchair was an oxygen tank that was empty. In an interview on 09/03/2025 at 9:34 AM, Staff C, Licensed Practical Nurse, said she thought Resident 1's oxygen orders had been changed, but reviewed the orders and said Resident 1 had orders for continuous oxygen therapy. In an observation on 09/03/2025 at 9:37 AM, Staff B, Director of Nursing/Registered Nurse, observed Resident 1 in her room and confirmed the resident was not on oxygen while in the room, and the oxygen tank on the back of the wheelchair was empty. In an interview on 09/03/2025 at 9:46 AM, Staff B said Resident 1's orders state continuous oxygen therapy, and the order had not been changed since the resident admitted to the facility on [DATE]. Staff B said with orders for continuous oxygen orders she would expect Resident 1 to have oxygen applied at all times. Reference WAC 388-97-1060 (3)(j)(vi). |

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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