STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505016	A. Building B. Wing	05/07/2026

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

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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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the facility's binding arbitration agreements (legal document that required the use of a third party to resolve disputes) was reviewed and explained in a form and/or manner, understood by 2 of 3 sampled residents (Resident 74 & 75) reviewed for binding arbitration agreements. This failure placed residents at risk for lacking understanding of the legal document signed and a diminished quality of life.Findings included.Resident 74 was admitted to the facility on [DATE]. The admission Minimum Data Set, (MDS, assessment tool), dated 04/30/2026, showed Resident 74 was cognitively intact. Record review of Resident 74's electronic health record (EHR) showed Resident 74 signed a Patient and Facility Arbitration Agreement on 04/27/2026. In an interview on 05/07/2026 at 12:30 PM, Resident 74 said they did not recall signing an arbitration agreement or being informed about their right to rescind the agreement within 30 days of signing it.Resident 75 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], showed Resident 75 was cognitively intact. Record review of Resident 75's EHR showed Resident 75 signed a Patient and Facility Arbitration Agreement on 04/30/2026.In an interview on 05/07/2026 at 11:36 AM, Resident 75 said they signed an arbitration agreement but did not recall being informed about their right to rescind the agreement within 30 days of signing it.In an interview and record review on 05/06/2026 at 10:53 AM, Staff E, Business Office Manager, said they reviewed the Patient and Facility Arbitration Agreement with Resident 74 and Resident 75. When asked how Staff E ensured residents understood their right to rescind the arbitration within 30 days, Staff E stated, they can rescind it at any time. When asked if residents could rescind the arbitration agreement 30 days after signing it Staff E stated, yes they can.In an interview on 05/07/2026 at 1:04 PM, Staff A, Administrator, said the facility arbitration agreement was voluntary and after signing it, residents had 30 days to rescind the agreement. No Reference WAC

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)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received information about the risk and benefits and failed to obtain informed consent prior to the administration of psychotropic medications for 1 of 5 sampled residents (Resident 52) reviewed for unnecessary medication use. These failures placed residents and/or their representatives at risk of not being fully informed about the care and treatment related to the risks and benefits associated with psychotropic medications.Findings included . Resident 52 was admitted to the facility on [DATE]. The quarterly Minimum Data Set, an assessment tool, dated 04/08/2026, indicated Resident 52 was severely cognitively impaired.Record review of Resident 52's physician orders, dated 04/08/2026, indicated to give Duloxetine (a prescription medication used to treat depression [a mood disorder]) one capsule by mouth one time a day for depression.Record review of Resident 52's Electronic Health Record (EHR) did not show consent for Duloxetine.During an interview on 05/07/2026 at 9:08 AM, Staff D, Resident Care Manager/Licensed Practical Nurse, said they covered the risk and benefits of psychotropic medications with residents and/or their representatives and then got consent. Staff D said he could not find a consent for Duloxetine.Reference WAC 388-97-0260 (2)(d)

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written Bed-Hold notice to residents and/or residents' representative at the time of transfer to the hospital for 2 of 5 sampled residents (Residents 4 and 8) reviewed for hospitalization and/or discharge. This failure placed residents at risk for lack of knowledge regarding their right to hold their bed while in the hospital.Findings included. Record review of the facility policy, titled, ADMISSION, TRANSFER AND DISCHARGE Notice of Bed Hold Policy Before / Upon Transfer, date revised November 2018, documented, The facility will provide written information to the resident or resident representative specifying the duration of the state bed-hold policy, if any, during which time the resident is permitted to return and resume residence in the facility. 2. Two notifications will be provided. The first one well in advance of any transfer and the second one at the time of transfer. 3. The second notice will be provided to the resident and the representative at the time of transfer or within 24 hours if the transfer was an emergency. 4. In the event the facility is unable to reach the representative, the facility will document the attempts made. Resident 4 was admitted to the facility on [DATE]. The Admission/5-day Minimum Data Set (MDS), an assessment tool, dated 04/14/2026, indicated Resident 4 was alert and oriented. Record review of Resident 4's hospital transfer form, dated 04/30/2026, indicated Resident 4 was transferred to an acute hospital for shortness of breath (bronchitis, pneumonia). Record review of Resident 4's electronic health records (EHR) did not show documentation the bed hold was reviewed with Resident 4 or Resident 4's representative. During an interview on 05/07/2026 at 8:47 AM, Staff D, Resident Care Manager/Licensed Practical Nurse, said the bed hold would be offered prior to the transfer or the following day if it was not done because of an emergency. Staff D said he spoke with Resident 4 at the hospital the following day but did not think it was documented in the EHR. Resident 8 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 8 was moderately cognitively impaired. Review of Resident 8's EHR showed Resident 8 was transferred to the hospital on [DATE]. Further review of Resident 8's EHR did not show documentation of a written bed-hold notice, nor contact was made to the resident and/or representative regarding bed-hold information. In an interview on 05/06/2026 at 3:25 PM, when asked about her transfer to the hospital on [DATE], Resident 8 said the facility did not mention if her bed would be held and did not talk to her about it, stating, I wasn't sure if I'd have my room or not. In an interview on 05/07/2026 at 9:04 AM, Staff F, Licensed Practical Nurse, said when a resident was transferred to the hospital, they would give the resident a copy of the bed hold policy and review it with them. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/07/2026 at 9:13 AM, Staff B, Director of Nursing/Registered Nurse, said Resident 8 was not given information regarding a bed-hold, or offered a bed-hold, and she should have been. Reference WAC 388-97-0120 (4)

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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** Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS, an assessment tool) was completed accurately to reflect a resident's health status and/or care needs for 1 of 4 sampled residents (Resident 8) reviewed for dementia (a decline in mental ability including memory, language, and problem-solving) care. This failure placed residents at risk for unidentified and/or unmet care needs and a diminished quality of life. Findings included. Resident 8 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 8 was moderately cognitively impaired, had Non-Alzheimer's Dementia (a type of dementia), and did not use a wander/elopement alarm (Wander Guard, a security system that uses a wearable tag and/or sensor designed to prevent people with cognitive impairments from leaving secure areas to ensure their safety, by triggering alerts to caregivers). Record review of Resident 8's physician orders, dated 02/06/2026, documented, Wander guard to left ankle check for placement and functioning every shift replace if needed every shift for wandering. Record review of Resident 8's elopement risk/wanderer care plan, date revised 04/09/2026, documented an Intervention/Task area, dated 06/28/2024, .wander guard placed on left ankle check for placement and functioning and change as needed. In an observation and interview on 05/06/2026 at 3:25 PM, Resident 8 was observed sitting in her wheelchair in her room with a Wander Guard alarm bracelet attached to her left ankle. When asked about the Wander Guard alarm on her left ankle, Resident 8 reached down and touched alarm stating, It stays on my ankle 24/7 [24 hours per day, seven days per week] to keep an eye on things. In an interview on 05/07/2026 at 9:17 AM, Staff B, Director of Nursing/Registered Nurse, said the Wander Guard alarm should have been captured on the MDS and it would need to be fixed. Reference WAC 388-97-1000 (1)(b)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for 1 of 3 sampled resident (Resident 36) reviewed for skin conditions, and 1 of 4 sampled residents (Resident 61) reviewed for anticoagulant (blood thinning) unnecessary medications. This failure placed residents at risk for injury, unmet care needs, and a diminished quality of life. Findings included. Resident 36 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS, an assessment tool), dated 04/15/2026, documented Resident 36 was moderately cognitively impaired. In an interview on 05/04/2026 at 2:49 PM, Resident 36 said she had something going on with the bottom of her foot and she didn't know what it was. Record review of Resident 36's physician orders, dated 04/15/2026 and discontinued 04/27/2026, documented an order, apply betadine to left foot bottom of 2nd toe leave ota [open to air]. Record review of Resident 36's physician orders, dated 04/23/2026, documented an order, monitor abrasion to bottom of left foot 2nd [second] toe. Further review of the physician orders, dated 04/23/2026, documented an order, apply skin prep [a film-forming protective barrier wipe applied to skin to create a layer that protects the skin] to scab on bottom side of 2nd toe left foot BID [twice daily]. Review of Resident 36's Electronic Health Record (EHR), May 2026 Monitors, showed Resident 36 was receiving skin prep to scab on bottom of the second toe twice daily for skin care. In a joint observation on 05/07/2026 at 12:20 PM with Staff F, Licensed Practical Nurse (LPN), a scabbed area was observed on the bottom of Resident 36's left foot second toe. Record review of Resident 36's Comprehensive Care Plan, date initiated 04/11/2026, date revised 04/21/2026, did not show a Focus area or Goal for a skin at risk care plan and/or a scab to the bottom of the left foot second toe. In a joint interview on 05/07/2026 at 12:53 PM with Staff D, Resident Care Manager/LPN, and Staff B, Director of Nursing/Registered Nurse, Staff B said Resident 36 should have had a care plan developed for skin at risk and for the area on the bottom of the left second toe and there was not. Resident 61 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 61 was cognitively intact. In an interview on 05/04/2026 at 12:34 PM, Resident 61 said he had a blood clot in his right arm and thought he was on a blood thinner medication. Record review of Resident 61's Nursing Notes, dated 04/20/2026, documented, Results for Ultrasound [a test used to diagnose conditions in soft tissues in the body] as follows: (Occlusive [blockage], likely acute to subacute deep venous thrombosis [DVT, a blood clot in a deep vein causing pain, swelling, and redness] within the right brachial [arm] vein) MD [Medical Doctor] notified and ordered Eliquis [an anticoagulant medication]. Record review of Resident 61's physician orders, dated 04/20/2026, showed Resident 61 was prescribed Eliquis for DVT. Review of Resident 61's Medication Administration Records, dated April and May 2026, showed Resident 61 was receiving Eliquis two times a day for DVT. Review of Resident 61's EHR did not show a comprehensive care plan for a DVT and/or the use of anticoagulant medication. In an interview on 05/06/2026 at 12:31 PM, Staff D said when residents were on anticoagulant medication, it would be put on their care plan they were on anticoagulants. After looking at Resident 61's EHR, Staff D said there was not a care plan for Resident 61 addressing a DVT or anticoagulant medication use and there should have been. In an interview on 05/06/2026 at 12:43 PM, Staff B said Resident 61 should have had anticoagulant medication side effect monitoring and a care plan addressing anticoagulant medication and a DVT. Reference WAC 388-97-1020(1)(2)(a)

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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** Based on interview and record review, the facility failed to ensure resident care plans were revised to accurately reflect care needs for 1 of 3 sampled residents (Resident 36) reviewed for pressure ulcer/injury (damage to the skin and underlying soft tissue caused by prolonged pressure, usually over a bony area), and for 1 of 4 sampled residents (Resident 8) reviewed for anticoagulant (blood thinner) unnecessary medications. This failure placed residents at risk for unmet care needs and a diminished quality of life.Findings included.Resident 36 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS, an assessment tool), dated 04/15/2026, documented Resident 36 was moderately cognitively impaired and did not have a pressure ulcer/injury. Record review of Resident 36's physician orders, dated 04/12/2026 and discontinued 04/21/2026, showed an order for a sacral (the area of the triangular bone at the base of the spine) wound treatment daily and as needed. Record review of Resident 36's Comprehensive Care Plan documented a Focus area, dated 04/11/2026, [Resident 36] has a (specify stage) pressure ulcer of the sacrum. In an interview on 05/07/2026 at 12:17 PM, Staff F, Licensed Practical Nurse, said Resident 36 had a pressure area on her bottom when she was first admitted to the facility and it had been resolved. In an interview on 05/07/2026 at 12:58 PM, Staff B, Director of Nursing/Registered Nurse said Resident 36 did not have a pressure ulcer, stating, The care plan needs to be fixed. Resident 8 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 8 was moderately cognitively impaired and was not taking anticoagulant medication. Review of Resident 8's Electronic Health Record showed Resident 8 was taking Apixaban (an anticoagulant medication) twice daily that was discontinued on 02/09/2026. Record review of Resident 8's anticoagulant care plan, dated 11/03/2023, documented a Focus area, [Resident 8] is on anticoagulant therapy. Further review of the anticoagulant care plan documented Intervention/Tasks areas, dated 11/03/2023, Administer ANTICOAGULANT medications as ordered by physician.Resident is on anticoagulant medication. In an interview on 05/07/2026 at 9:22 AM, Staff B said Resident 8's care plan should have been updated to reflect she wasn't taking anticoagulant medication any longer. Reference WAC 388-97-1020 (2)(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain a physician's order for oxygen use for 1 of 2 sampled residents (Resident 12) reviewed for respiratory care. This failure placed residents at risk for unmet care needs, and a diminished quality of life.Findings Included.Record review of the facility's policy, titled, Quality Of Care Respiratory Care/Tracheostomy Care & Suctioning, dated July 2018, documented . b. There will be a practitioner's order for oxygen therapy to include indication for use. The type of equipment to use, baseline SpO2 [a measurement of how much oxygen a person's blood is carrying] SpO2 levels to initiate and/or discontinue oxygen therapy. Resident 12 was admitted to the facility on [DATE]. The admission Minimum Data Set, an assessment tool, dated 04/04/2026, showed Resident 12 was cognitively intact and was on oxygen therapy.In an observation on 05/04/2026 at 10:51 AM, Resident 12 was observed lying in bed with oxygen on via nasal cannula (a flexible tube with two prongs used to provide oxygen through the nose) via an oxygen concentrator, running at 2 liters per minute (lpm). Resident 12 said she used oxygen at 2 lpm intermittently for shortness of breath. Record review of Resident 12's care plan, dated 03/25/2026, documented a Focus, [Resident 12] has altered respiratory status/difficulty breathing r/t [related to] recent COVID [19] [a respiratory illness] and acute Hypoxic [low oxygen] respiratory failure with oxygen use, asthma. Oxygen per order.Record review of Resident 12's electronic health record did not show a physician's order related to use of oxygen.In an interview on 05/07/2026 at 10:17 AM, Staff B, Director of Nursing/Registered nurse, said it was her expectation that residents using oxygen had physician's orders in place prior to oxygen being administered.Reference WAC 388-97-1060 (1)(3)(vi)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure anticoagulant (blood thinner) medication related side effects were monitored for 1 of 4 sampled residents (Resident 61) reviewed for unnecessary medications. This failure placed residents at risk for adverse side effects from anticoagulant medication use and a diminished quality of life.Findings included. Resident 61 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, an assessment tool, dated 04/11/2026, documented Resident 61 was cognitively intact. In an interview on 05/04/2026 at 12:34 PM, Resident 61 said he had a blood clot in his right arm and thought he was on a blood thinner medication. Record review of Resident 61's Nursing Notes, dated 04/20/2026, documented, Results for Ultrasound [a test used to diagnose conditions in soft tissues in the body] as follows: (Occlusive [blockage], likely acute to subacute deep venous thrombosis [DVT, a blood clot in a deep vein causing pain, swelling, and redness] within the right brachial [arm] vein) MD [Medical Doctor] notified and ordered Eliquis [an anticoagulant medication]. Record review of Resident 61's physician orders, dated 04/20/2026, showed Resident 61 was prescribed Eliquis for DVT. Review of Resident 61's Medication Administration Records, dated April and May 2026, showed Resident 61 was receiving Eliquis two times a day for DVT. Review of Resident 61's Electronic Health Record did not show documentation of monitoring for anticoagulant medication side effects. In an interview on 05/06/2026 at 12:31 PM, Staff D, Resident Care Manager/Licensed Practical Nurse, said when residents were on anticoagulant medication, they would monitor for side effects of the medication, like bleeding and bruising, and it would be put on their care plan they were on anticoagulants. After looking at Resident 61's EHR, Staff D said when Resident 61 was started on anticoagulant medication, it should have been put on his orders to monitor for side effects of the medication every shift, and it was not. In an interview on 05/06/2026 at 12:43 PM, Staff B, Director of Nursing/Registered Nurse, said Resident 61 should have had anticoagulant medication side effect monitoring and a care plan addressing anticoagulant medication and a DVT. Reference WAC 388-97-1060 (3)(k)(i)

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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 observation, interview and record review, the facility failed to ensure staff maintained proper infection control practices for storage of personal care equipment in 1 of 1 resident's room (room [ROOM NUMBER]) reviewed for infection control. This failure placed residents at risk for infection and a diminished quality of life. Findings included.In an observation on 05/04/2026 at 12:20 PM, a specimen hat (container used to collect urine or stool) was observed on the floor near the sink with no protective covering in room [ROOM NUMBER]. In an interview and observation on 05/04/2026 at 3:03 PM, when asked what the specimen hat on the floor near the sink in room [ROOM NUMBER] was used for, Staff H, Certified Nurse Assistant, said It was used for emptying the colostomy bag (a small, waterproof plastic pouch used to collect waste from the body) belonging to the resident in bed 107-3. In an interview and observation on 05/04/2026 at 3:55 PM, Staff I/Registered Nurse (RN), observed the specimen hat on the floor in room [ROOM NUMBER]. Staff I said it was the expectation that the specimen hat was cleaned and kept in a plastic bag off the floor after use. In a joint interview on 05/06/2026 at 9:03 AM, with Staff B, Director of Nursing/RN and Staff G, Infection Control/Staff Development/RN, Staff B said it was the expectation that staff cleaned the specimen hat and bag it after using it. Reference WAC 388-97- 1620(2)(b)(i)(ii)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to ensure nurse staffing information was posted and updated daily at the beginning of each shift for 32 of 32 days reviewed for nurse staff postings. These failures placed residents, resident representatives, and visitors at risk of not being fully informed of the current staffing levels.Findings included.In an observation on 05/04/2026 at 9:28 AM, the posted nurse staffing information located on the first floor (main floor) was dated 04/30/2026. In an observation on 05/06/2025 at 10:26 AM, the posted nurse staffing information located on the first floor was dated 05/05/2026. In an observation, interview and record review on 05/06/2026 at 12:30 PM, Staff C, Staffing Coordinator, observed the posted nurse staffing information located on the first floor and said it was a day behind. Staff C said she usually posted the previous day's nurse staffing information. Staff C said she did not update the staffing numbers and hours for each shift on the Daily Nursing Staff Information postings throughout the day when there were changes but would post the updated information the next day. Staff C said this process was done for staff postings reviewed from 04/04/2026 through 05/04/2026. When asked what the process was when a staff member called out, Staff C said if someone called out, the staff postings were updated the next day.In an interview on 05/07/2026 at 10:07 AM, Staff B, Director of Nursing/Registered Nurse, said it was the expectation that posted nursing staff information showed the current date and that changes to the staffing levels were adjusted every shift. Reference WAC 388-97-1620(2)(b)(i)