STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505081	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Care and Rehabilitation	3035 Cherry Street Hoquiam, WA 98550

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40916 Based on interview and record review, the facility failed to ensure residents had the ability to exercise self-determination related to aspects of life in the facility that were significant to the resident, including health care decisions and accessing outside providers of health care services consistent with their interests, for 1 of 5 sampled residents (Resident 1) reviewed for self determination. This failure placed residents at risk for not being able to choose treatment options outside the facility, decreased autonomy, powerlessness, and a diminished quality of life. Findings included . Resident 1 was admitted to the facility on [DATE]. The 5-day admission Minimum Data Set assessment, dated 05/14/2024, documented the resident was moderately cognitively impaired. A discharge planning note, dated 07/19/2024, documented, ALF LN [Assisted Living Facility Licensed Nurse] in to see [Resident 1] today, though did not complete an eval as [Resident 1] was not feeling well. ALF LN will attempt again next week. On 08/14/2024 at 1:28 PM, Family Member 1 (FM1) said on 07/19/2024 he had a meeting with Resident 1 and Collateral Contact 1 (CC1, Registered Nurse), a nurse from an assisted living facility, in the resident's room. FM1 said Resident 1 had vomiting and diarrhea. FM1 said CC1 told him she thought Resident 1 needed to go to the ER (emergency room). FM1 said he agreed Resident 1 should go to the hospital. FM1 said the nurse on duty, Staff C, Registered Nurse, asked if he wanted Resident 1 to go to the hospital and FM1 told Staff C yes. FM1 said Staff C asked Resident 1 if she wanted to go to the hospital and the resident said yes. At 2:55 PM, Staff C said she contacted the provider on 07/18/2024 to relay Resident 1's complaints of nausea and GI (gastrointestinal) pain. Staff C said the provider told her to give ibuprofen, a pain medication, three times a day for the pain, and send the resident to the ER if the pain persists. Staff C said on 07/19/2024, FM1 was visiting with Resident 1 and she told the resident and FM1 about gallstones that were seen on Resident 1's recent imaging. Staff C said FM1 and Resident 1 talked about treatment options and decided to wait until a provider saw her on Monday, 07/22/2024. Resident 1's electronic medical record did not show documentation of the discussion between Staff C and Resident 1 or FM1. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505081	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Care and Rehabilitation	3035 Cherry Street Hoquiam, WA 98550

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/15/2024 at 9:10 AM, CC1 said she went to the facility on [DATE] to perform an assessment for placing Resident 1 in an assisted living facility. CC1 said Resident 1 was in her room, in a wheelchair, and told CC1 she did not feel well. CC1 said during her assessment Resident 1 could not keep her eyes open. CC1 asked FM1 if this was normal behavior for her and FM1 said it was not. CC1 said she told FM1 that she thought the resident should go to the hospital and FM1 agreed. CC1 said she informed Staff D, Social Services Director, that she could not complete her assessment as Resident 1 was not feeling well. CC1 said at that time she told the facility she thought the resident needed to go to the hospital. Resident 1's electronic medical record did not show documentation of a transfer to the hospital on 07/19/2024. On 08/28/2024 at 11:25 AM, Collateral Contact 2 (CC2), an on-call provider service staff member, said there was a call made from the facility to their on-call provider on 07/19/2024. CC2 said the provider was informed the resident wanted to go to the hospital. CC2 said the provider told the nurse to send the Resident 1 to the hospital. At 11:49 AM, Staff D, Social Services Director, said she recalled the conversation with CC1 regarding Resident 1. Staff D said CC1 told her Resident 1 was not feeling good and CC1 thought Resident 1 needed to go to the hospital. Staff D said she informed either the Resident Care Manager or the floor nurse, but could not remember which one. At 11:52 AM, Staff E, Infection Preventionist and Registered Nurse (RN), said she was the manager of the day as Staff A, Administrator and Staff B, Director of Nursing Services and RN, were out of the facility for the week. Staff E said if there was a change in condition the nurse would assess the resident, call the provider and obtain orders, and tell the resident what they said, then ask the resident if they wanted to go to the hospital. Staff E said the facility could not force a resident to go to the hospital, and the opposite was true, that if the resident wanted to go to the hospital they could go. After reviewing Resident 1's electronic medical record, Staff E could not find documentation the resident was transferred to the hospital on 07/19/2024. Staff E said there should be a progress note if a resident transferred out of the facility. Staff E said the expectation if a resident wished to go to the hospital was to notify the provider and start facilitating the resident transfer. On 08/29/2024, an undated written response provided by the facility, showed the provider on call on 07/19/2024 documented, This letter is in response to an on-call response on the night of 07/19/2024 for patient [Resident 1] at Pacific Care and Rehabilitation facility. Call was received at [12:22 PM] on the secure app from nurse . stating, family is asking to send patient to ER. I responded to the call at [12:35 PM] with instructions but was not recorded on the sign-out for unknown reasons. I always capture responses on the signed out for documentation that will require further follow-up/evaluations, but I cannot recall why it was not captured for this phone call. For this type of call, I would have triaged the patient based on vital signs and current condition, give my recommendations to proceed with family wishes. At the time of this letter, I cannot recall the details of the response to this call. Reference WAC 388-97-0900 (1)-(4)