

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505081	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Pacific Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40916</p> <p>Based on interview and record review, the facility failed to ensure residents received timely hearing services to maintain their ability to hear adequately and effectively for 1 of 2 sampled residents (5) reviewed for hearing treatment and services. This failure placed residents at risk for frustrations, decline in communication, and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 5 was admitted to the facility on [DATE]. The quarterly Minimum Data Set, an assessment tool, dated 01/23/2024, documented the resident was cognitively intact, had moderate difficulty hearing, and had no hearing aids.</p> <p>A nursing note, dated 10/19/2023, documented, [Resident 5] is congenial, a little hard of hearing, but loves to visit.</p> <p>A social services summary, dated 10/23/2023, documented, Hearing: none, no devices, denies issues, son would like apt [appointment], will schedule.</p> <p>A social services summary, dated 01/23/2024, documented, Hearing: none, no devices, denies issues, son would like apt, will schedule.</p> <p>On 04/01/2024 at 1:35 PM, Collateral Contact 1, family member, said Resident 5 required hearing aids for communication.</p> <p>On 04/03/2024 at 1:08 PM, Staff D, Social Services Director, said Staff G, Social Services Assistant, usually scheduled resident hearing appointments. Staff D said residents were asked upon admission and quarterly about needing hearing-related services. Staff D said she discussed Resident 5's hearing appointment with Staff G, but Staff D did not see a hearing appointment scheduled on the calendar. Staff D said she expected Staff G to make an appointment for hearing services within a day or two of hearing about the need.</p> <p>(continued on next page)</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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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 1:54 PM, Staff G said she was responsible for scheduling resident hearing appointments in the facility. Staff G said she would hear about hearing needs from nurses on the floor or from reviewing care conference notes. Staff G said residents were offered hearing services upon admission and she would fill out a form and call local hearing places to schedule an appointment. Staff G said Resident 5's hearing appointment was put in today (04/03/2024, 163 days after the 10/23/2023 note indicating the facility was scheduling a hearing appointment). Staff G said the 10/23/2023 appointment was on her follow-up list, but she was not able to follow-up on the appointment. Staff G said she would not consider Resident 5's hearing appointment to be made timely.</p> <p>At 2:06 PM, Staff A, Administrator, said the social services department was responsible for scheduling hearing appointments in the facility. Staff A said hearing needs were assessed upon admission and quarterly thereafter. Staff A said his expectation was for hearing appointments to be scheduled as soon as possible. Staff A said he did not think Resident 5's hearing appointment was made in a timely manner.</p> <p>Reference WAC 388-97-1060 (3)(a)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50488</p> <p>Based on observation, interviews, and record reviews, the facility failed to ensure respiratory care and interventions were provided according to physician's orders for 1 of 2 sampled residents (8) reviewed for respiratory care. This failure placed residents at risk for respiratory distress, discomfort, and unmet care needs.</p> <p>Findings included .</p> <p>Resident 8 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Pneumonia, and Respiratory Failure. The annual Minimum Data Set assessment, dated 01/23/2024, documented the resident was severely cognitively impaired.</p> <p>The physician's (MD) orders, dated 03/30/2024, noted Keep him on 2L (liters) of O2 (oxygen) via NC (nasal cannula) until MD's new orders, every shift for pneumonia.</p> <p>On 04/02/2024 at 10:50 AM, Staff H, Registered Nurse (RN), was observed going into Resident 8's room to administer morning medications except for his Duoneb (medication to open airways) as it was not available in the cart or the Pyxis (an automated medication dispensing system). Resident 8 was sleeping. Resident 8 did not respond to his name or open his eyes when prompted by Staff H. Resident 8's oxygen tubing was observed not in his nose. The oxygen concentrator was about three feet from the bed and was not turned on. Staff H placed an oximeter (reads oxygen saturation levels) on Resident 8's finger. Resident 8's oxygen saturation level read 87% (below normal range). Staff H turned on the concentrator and placed the tubing in Resident 8's nose.</p> <p>At 11:38 AM, Staff H was observed administering Albuterol (opens airways) per doctor's order after the missed Duoneb dose and Resident 8's oxygen not being in place.</p> <p>On 04/03/2024 at 8:32 AM, Staff B, Director of Nursing Services and RN, said she had investigated and found a home care aid had been in the room with Resident 8 and had removed the resident's oxygen and turned off the concentrator per the resident's request.</p> <p>Reference WAC 388-97-1060 (3)(j)(vi)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>50488</p> <p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the facility had a medication error rate of less than five percent when failing to administer 3 of 25 medications at the right time resulting in a medication error rate of 12% and failed to follow administration guidelines for 2 of 6 sampled residents (12 & 56) observed during medication administration. These failure placed residents at risk of not receiving the full therapeutic effect of their medications, possible adverse side effects, and a diminished quality of life.</p> <p>Findings included .</p> <p>According to Drugs.com, Levothyroxine was to be taken on an empty stomach, at least 30 to 60 minutes before breakfast. Levothyroxine should not be given within 4 hours of medications that could affect thyroid hormone levels and decrease effectiveness.</p> <p>1) Resident 12's April 2024 Medication Administration Record (MAR) showed the Papaya was scheduled at 7:00 AM to be given before meals, 3 times per day.</p> <p>On 04/03/2024 at 9:40 AM, Staff C, Registered Nurse (RN), was observed administering Levothyroxine (for hypothyroidism), Papaya (for nausea/vomiting), and Protonix (acid reducer) to Resident 12 by mouth. Staff C said Levothyroxine should be given at least 30 minutes before a meal. Resident 12 was administered Levothyroxine after breakfast along with Protonix (a stomach acid reducer), potentially reducing the absorption rate of Levothyroxine. Staff C said the resident received Papaya prior to meals to prevent nausea and/or vomiting. Staff C said Resident 12 had already consumed her morning meal.</p> <p>2) Resident 56's April 2024 MAR showed Metformin (for diabetes), Omeprazole (acid reducer) and Levothyroxine were to be given at 7:00 AM.</p> <p>On 04/03/2024 at 10:10 AM, Staff C was observed administering Metformin, Omeprazole and Levothyroxine to Resident 56 after breakfast, potentially reducing the absorption rate of Levothyroxine.</p> <p>At 10:35 AM, Staff B, Director of Nursing Services and RN, said Levothyroxine should be scheduled at 5:00 AM.</p> <p>Reference WAC 388-97-1060 (3)(k)(ii)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934</p> <p>Based on observation, interview, and record review, the facility failed to provide prompt dental services for 1 of 2 sampled residents (51) reviewed for dental services. This failure places residents at risk for continued dental problems and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 51 was admitted to the facility on [DATE]. The quarterly Minimum Data Set assessment, dated 02/25/2024, showed the resident was cognitively intact.</p> <p>The Dental Assessment, dated 02/08/2024, documented Resident 51 had top and bottom partials. The assessment showed the bottom partials were ill fitting. The assessment's findings indicated Resident 51 would like to see dentist regarding bottom partial.</p> <p>On 04/01/2024 at 11:37 AM, Resident 51 was observed to have some missing teeth. Resident 51 said her bridge was loose. Resident 51 said she thought the facility was working to get her into seeing someone, but was not sure.</p> <p>On 04/03/2024 at 10:43 AM, Staff G, Social Services Assistant, said she received a list of what residents' needed from nursing staff. Staff G said she was not aware Resident 51 needed to have partials looked at because it had not been communicated to her. Staff G said she did not get a copy Resident 51's Dental Assessment so could only rely on what was provided to her from a list.</p> <p>Reference WAC 388-97-1060 (3)(j)(vii)</p>