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	05/23/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation and interview, the facility failed to provide care and services in a manner that maintained and promoted dignity for 1 of 15 sampled residents (32) when staff stood next to her while assisting with eating her meal. This failure placed residents at risk for diminished self-worth, self-esteem, and feelings of embarrassment. Finding included . Resident 32 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, a required assessment tool, dated 02/06/2025, showed Resident 32 was severely cognitively impaired. On 05/19/2025 at 12:43 PM, Staff F, Nursing Assistant (NA), was standing up next to Resident 32 while assisting the resident with eating. At 12:44 PM, Staff F walked away and returned moments later. Staff F stood in front of Resident 32 and assisted her with eating. At 12:48 PM, an unidentified NA brought a chair into the dining room and placed it next to Staff F. Staff F sat down in the chair. On 05/22/2025 at 8:19 AM, Staff F said they were supposed to be sitting next to the resident when assisting a resident with their meals. When asked why she was standing when she assisted Resident 32, Staff F said there were not enough chairs in the dining room that day. Staff F said she tried to get assistance from someone by radio to bring her a chair. At 8:59 AM, Staff B, Director of Nursing and Registered Nurse, stated staff should be ideally at eye level when assisting residents. Reference WAC 388-97-0180 (2) .

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 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 interview and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment was completed accurately to reflect a resident's health status and/or care needs for 1 of 5 sampled residents (31) reviewed for unnecessary medications. This failure placed residents at risk for inaccurate and/or unmet care needs and a diminished quality of life. Findings included . Resident 31 was admitted to the facility on [DATE]. The Annual MDS assessment, dated 04/10/2025, documented Resident 31 was severely cognitively impaired and was taking an antipsychotic (used to manage the symptoms of psychosis, where individuals experience a loss of contact with reality) medication. Record review of Resident 31's Electronic Health Record (EHR) physician orders and medication administration record did not show Resident 31 was prescribed or taking an antipsychotic medication. On 05/22/2025 09:37 AM, Staff C, MDS Nurse and Registered Nurse (RN), said when she completed the MDS, she coded medications in the MDS a resident was taking per the classification of the drug. After looking at Resident 31's Annual MDS, dated [DATE], Staff C said it was coded Resident 31 was taking an antipsychotic medication. After looking at Resident 31's EHR, Staff C said she did not see an antipsychotic medication prescribed or taken by Resident 31. Staff C said the MDS was miscoded. At 10:06 AM, Staff B, Director of Nursing and RN, said it was her expectation the MDS was completed to accurately reflect the resident and medications taken by the residents. Reference WAC 388-97-1000 (2)(n) .

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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 observation, interview and record review, the facility failed to develop a person-centered care plan addressing medication self-administration for 1 of 3 residents (21) reviewed for medication administration. This failure placed residents at risk of un-met care needs and a diminished quality of life. Findings Included . Facility policy entitled, Self Administration of Medications, revised on 05/2016, documented .9. Appropriate notation of these determinations will be placed in the residents care plan. Resident 21 was admitted to the facility on [DATE]. The admission /Medicare - 5 Day Minimum Data Set assessment, dated 04/10/2025, documented Resident 21 was alert and oriented. Review of Resident 21's care plan did not show documentation of self-administration of medications focus and/or interventions. On 05/20/2025 at 8:36 AM, Resident 21 was observed to have a pill organizer container with four compartments with medication in each compartment. Resident 21 said the medications in the pill organizer were his Parkinson's medications. On 05/21/2025 at 9:57 AM, Staff G, Resident Care Manager and Licensed Practical Nurse, said Resident 21 was evaluated for medication self-administration and was deemed appropriate to self-administer his Parkinson's medications. When asked if a care plan was in place for medication self- administration, Staff G said there was no care plan and she had just put in a new care plan addressing medication self-administration. At 2:50 PM, Staff B, Director of Nursing and Registered Nurse, said it was the expectation that there would be a care plan initiated when Resident 21 was assessed and deemed appropriate for medication self-administration. Reference WAC 388-97-1020 (1)(2)(d) .

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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 ensure oxygen and/or nebulizer (a medical device that turns liquid medication into a fine mist that can be inhaled through a mouthpiece or mask) tubing was changed and/or bagged for 1 of 3 residents (14) reviewed for respiratory care. This failure placed residents at risk of respiratory infections, worsening health complications, and a decreased quality of life. Findings Included . Record review of the facility's policy entitled, Oxygen Administration, revised 04/2016, documented . INSTRUCTIONS FOR TUBING AND HUMIDIFIER CHANGES: . 2. Oxygen tubing is to be replaced every seven (7) days or when visible soiled . Resident 14 was admitted to the facility on [DATE] with multiple diagnosis to include chronic obstructive pulmonary disease (COPD, a progressive lung disease that makes it difficult to breathe) and acute and chronic respiratory failure with hypoxia (a low level of oxygen in the blood). The Quarterly Minimum Data Set assessment, dated 02/14/2025, documented Resident 14 was alert and oriented and was on oxygen therapy. A physician's order, dated 08/10/2024, documented Resident 14 was prescribed, CHANGE O2 [oxygen] TUBING WEEKLY every night shift every Wed [Wednesday]. A physician's order, dated 08/10/2024, documented Resident 14 was prescribed, CHANGE O2 AND SVN [small volume nebulizer] TUBING Q [every] WEEK - DATE ALL TUBING AND PLACE IN ZIPLOCK BAG WHEN NOT IN USE every night shift every Wed. Record review of Resident 14's respiratory status care plan, dated 08/23/2024, documented an intervention, NEBULIZER TO BE RINSED WITH COOL WATER AFTER EACH USE & STORED IN A BAG ON NIGHT STAND. On 05/19/2025 at 3:24 PM, Resident 14 was observed lying in bed with oxygen running at 2 lpm (liters per minute) per nc (nasal cannula). The oxygen tubing was observed with tape on it, dated, 5/7, 12 days ago. A nebulizer machine was observed on the nightstand with the nebulizer tubing and mouthpiece propped up against the mattress on the right side of the bed. The nebulizer tubing and mouthpiece were undated and uncovered with no bag observed. Resident 14 said the nebulizer mouthpiece just stayed there. On 05/20/2025 at 10:59 AM, Resident 14 was observed lying in bed with oxygen running at 2 lpm per nc. The oxygen tubing was observed with tape on it, dated, 5/7, 13 days ago. A nebulizer machine was observed on the nightstand with the nebulizer tubing and mouthpiece undated and uncovered with no bag observed. On 05/21/2025 at 10:19 AM, Resident 14 was observed lying in bed with oxygen running per nc. The oxygen tubing was observed with tape on it, dated, 5/7, 14 days ago. A nebulizer machine was observed on the nightstand with the nebulizer tubing and mouthpiece undated and uncovered with no bag observed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 10:22 AM, Staff D, Licensed Practical Nurse (LPN), said oxygen and nebulizer tubing was changed by night shift once a month and as needed. Staff D said the tubing was labeled and dated when it was changed. At 10:30 AM, Staff E, Resident Care Manager and LPN, said oxygen and nebulizer tubing was changed weekly and should be labelled and dated when changed. Staff E said nebulizer tubing was kept in a bag when not in use. Staff E went to Resident 14's room to observe the oxygen and nebulizer tubing. Staff E said the oxygen tubing should have been changed last Wednesday (seven days prior) and it was not. Staff E said the nebulizer tubing should have been dated and kept in a bag, and it was not. At 1:45 PM, Staff B, Director of Nursing Services and Registered Nurse, said it was her expectation oxygen and nebulizer tubing was dated and changed weekly, and kept in a bag when not in use. Reference WAC 388-97-1060 (1)(3)(vi) .