

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2025
NAME OF PROVIDER OR SUPPLIER Orchard Park Health Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4755 South 48th Tacoma, WA 98409	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36854</p> <p>Based on interview and record review, the facility failed to provide necessary activities of daily living care and services for 2 of 3 sample residents (Residents 1 and 2) reviewed for bathing. The failure to bathe residents as per their bathing care plans placed residents at risk for hygiene issues and for diminished quality of life.</p> <p>Findings included .</p> <p><RESIDENT 1></p> <p>Resident 1 was admitted to the facility on [DATE]. According to the quarterly Minimum Data Set (MDS), an assessment tool, dated 04/16/2025, they had no cognitive impairment. Resident 1 needed substantial/maximal assistance with bathing and they were dependent on staff for tub/shower transfers.</p> <p>On 04/23/2025 at 1:05 PM, Resident 1 said their shower/bath days were supposed to be Wednesdays and Saturdays but they usually only get a bed bath. Resident 1 said they had recently gone two weeks without a bath or shower. Resident 1 said they never got a shower or bed bath on Saturdays because the shower aide worked Monday through Friday and the other staff did not do showers on the weekends. Resident 1 said the staff never asked them about showers or bathing. Resident 1 said they had gotten up out of bed that day knowing their choices were that they could have stayed in bed and maybe gotten a bed bath, or got out of bed so they could feel like a human being while knowing they would not get a shower that day.</p> <p>On 04/23/2025 at 2:38 PM, Staff D, a Certified Nurse Assistant and a facility shower aide, said they worked Monday through Friday, from 8:00 AM to 4:30 PM. Staff D said they did about 12 showers/bed baths a day, and they are supposed to do 20. Staff D said they did showers first, then bed baths, then wrote on the assignment sheets the showers that did not get done. Staff D said the floor staff were supposed to do the rest. Staff D said they knew that Resident 1 had shower days of Wednesdays and Saturdays; there was no shower aide on Saturday, so the floor staff were supposed to do it but did not know if that happened.</p> <p>A review of Resident 1's Care plan, dated 01/30/2025, listed a focus of activities of daily living (ADL) self-care performance deficit related to activity intolerance, impaired balance, and limited range of motion, and in the interventions section, the resident was totally dependent on staff to provide a bath, and the resident required total assistance with personal hygiene care.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2025
NAME OF PROVIDER OR SUPPLIER Orchard Park Health Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4755 South 48th Tacoma, WA 98409	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's electronic bathing task record for the period 03/25/2025 to 04/23/2025 showed Resident 1 received a bed bath on 03/26/2025, 04/02/2025, and a shower on 04/22/2025.</p> <p>On 04/23/2025 at 3:35 PM, Staff C, a Licensed Practical Nurse and Resident 1's Resident Care Manager, with Staff D, the shower aide, looked through paper documentation of showers located in a binder, and noted that Resident 1 had received hygiene on 04/11/2025. No other documentation was located.</p> <p>On 04/23/2025 at 3:40 PM, Staff D said they charted on paper and then handed the documents in, which were supposed to be entered into the residents' records.</p> <p><RESIDENT 2></p> <p>Resident 2 was admitted to the facility on [DATE]. According to the MDS, dated [DATE], had moderate cognitive impairment, required assistance from staff for activities of daily living, and was dependent upon staff for showering/bathing.</p> <p>A review of Resident 2's Care plan, dated 04/09/2025, showed the resident had an ADL self-care performance deficit related to dementia and limited mobility, with a goal of improving function in bed mobility, transfers, eating, dressing, toilet use and personal hygiene, and staff was to provide supportive care.</p> <p>A review of Resident 2's electronic bathing task record for 4/09/2025 to 04/23/2025 showed Resident 2 received one shower on 04/22/2025.</p> <p>On 04/23/2025 at 3:40 PM, Staff D said they recalled they gave Resident 2 a shower right after their admission. When asked, Staff D was not able to locate a shower sheet or other documentation.</p> <p>On 04/23/2025 at 4:08 PM, Staff E, a Registered Nurse and the Assistant Director of Nursing, located documentation that Resident 2 received a shower on 04/16/2025.</p> <p>On 04/23/2025, at 04:12 PM, Staff B, a Registered Nurse and the facility Director of Nursing, indicated that residents should receive one to two showers/baths per week, according to their preference.</p> <p>On 05/01/2025, at 01:29 PM, after exit, Staff B provided additional documents to indicate bed baths were given to Resident 1 on 04/03/2025 and 04/16/2025.</p> <p>Reference WAC 388-97-1060 (2)(c)</p>		