

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Sequim Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 650 West Hemlock St Sequim, WA 98382	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45203</p> <p>Based on interview, and record review, the facility failed to ensure services provided met professional standards of practice for 1 of 6 sampled residents (Resident 1) reviewed for quality of care. The facility failed to act timely on a physician order referring the resident for additional diagnostic testing and a spine specialist. This failure placed residents at risk for health complications, prolonged pain, and decreased quality of life.</p> <p>Findings included .</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnosis of spondylosis (a painful condition of the spine resulting from the degeneration of the intervertebral disks) of the lumbar region and low back pain. The Admission Minimum Data Set, an assessment tool, dated 01/04/2024, documented Resident 1 was cognitively intact and required staff assistance for activities of daily living.</p> <p>The care plan, initiated 12/19/2023, documented Resident 1 had potential for acute and chronic pain related to chronic physical disability and chronic back pain.</p> <p>Review of an alert note, dated 12/24/2023 at 6:55pm, documented the resident experienced a fall in the bathroom when attempting to self-transfer, no injuries were noted.</p> <p>Review of an alert charting note, dated 12/27/2023 at 5:14pm, documented the resident was in tears when this nurse assumed care and quoted the resident as saying, I hurt so bad I cannot eat. The provider was notified, and orders were received for additional pain medication.</p> <p>Review of a provider note, dated 01/02/2024, documented staff reported Resident 1's pain was not being controlled. The provider adjusted Resident 1's routine pain management.</p> <p>Review of a thoracic lumbar radiology report (x-ray), dated 01/04/2024, documented Resident 1 had no acute injury noted and concluded the resident had mild-moderate degenerative lumbar spondylosis.</p> <p>Review of a care conference note, dated 01/05/2024, documented the resident's pain was getting worse and impacting her progress in therapy.</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a daily skilled note, dated 01/10/2024 at 8:39pm, documented the resident went to a provider's office to receive spinal injections that could not be provided due to the need for a new MRI (magnetic resonance imaging- a non-invasive imaging technology that produces three dimensional detailed anatomical images). The note documented the resident, family and facility were not aware of the need for the MRI prior to the appointment.</p> <p>Review of a provider note, dated 01/11/2024 documented the provider ordered the routine oral pain medication increased from three times daily to four times daily due to report of severe back pain.</p> <p>Review of a provider note, dated 01/15/2024, documented the resident had been lethargic and difficult to rouse since recent pain medication changes on 1/11/2024, medication was reduced to the previous dose and resident had not been able to participate in physical therapy due to severe back pain. The resident reported they were comfortable as long as they were laying down. The provider ordered an MRI and made a referral to a spine specialist.</p> <p>An IDT (interdisciplinary team) progress note, dated 01/18/2024, documented the resident was severely limited by pain and there was a referral for a spine specialist and the resident needed an MRI scheduled.</p> <p>A provider note, dated 01/23/2024, documented Resident 1 had intractable pain if up, out of bed, they were unable to walk. The resident was receiving a transdermal patch and three oral medications to manage their pain. The provider again noted the MRI and spine referral was ordered.</p> <p>Review of the residents EHR (Electronic Health Record) from 01/15/2024 to 02/08/2024 (a period greater than three weeks) did not show any documentation or record that the facility acted on the provider ordered MRI and spine specialist referral.</p> <p>An IDT progress note, dated 02/08/2023, documented the resident needed a referral to a spine specialist and an MRI and that the scheduler was working on it.</p> <p>A provider note, dated 02/12/2023, documented the resident had not yet received the MRI, had not seen the spine specialist and the resident was not aware of when or if these had been scheduled.</p> <p>An IDT progress note, dated 02/12/2023, documented Resident 1 had a spinal specialist appointment scheduled for 02/28/2028.</p> <p>On 03/13/2024 at 3:13pm, CC1 said Resident 1 went to a provider on 01/10/2024 for spinal injections to help managed their back pain but that provider was not able to do the injection due to Resident 1's recent fall and what they had read on the previous MRI. CC1 informed the facility staff and provider of the need for an MRI, and they ordered it. CC1 said that after a week of not hearing anything about the MRI being scheduled, she asked Staff A and B and was not able to get a status update and did not believe the facility took any steps to schedule the MRI and were minimizing the need for it.</p> <p>On 04/12/2024 at 1:12pm, Resident 1 said she had an MRI scheduled for April 19th.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/26/2024 at 2:51pm, Staff C, Registered Nurse (RN), said when she received an order for an outside referral, she would make a copy and give it to Staff D, receptionist, and they would make the appointments.</p> <p>Review of an email received from Staff D, receptionist, via Staff A, Administrator, included a word document with Staff D's timeline of the referrals for Resident 1. The document showed that Staff D reported she was informed of the MRI on 01/29/2024 but not given the information until 02/05/2024.</p> <p>At 3:25pm, Staff B, RN, Director of Nursing, with Staff A present, said when orders for referrals were received, staff printed out the order and gave it to Staff D. When asked why no action was taken on the 01/10/2024 order for MRI and spine specialist, Staff B said Staff D was trying to reach the MRI department at the local hospital. Staff A said when Staff D called to make the spine specialist appointment, they instructed her if the resident needed an MRI, they would order one. When asked if they would expect the appointments to be made sooner than three weeks after they were ordered, Staff B said yes. Staff A said they had identified this as an issue, and they now had a ward clerk.</p> <p>Reference WAC 388-97-1620 (2)(b)(ii)</p>		