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 02/24/2026
NAME OF PROVIDER OR SUPPLIER: Sequim Bay Post Acute		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)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to follow up on reports of lost items for 1 of 3 residents (Resident 1) reviewed for grievances. This failure places all residents at risk of unmet needs, a diminished quality of life, and potential financial burden. Findings included .Resident 1 was admitted to the facility on [DATE], The admission Minimum data set (MDS), an assessment tool, dated 10/08/2025, showed the resident had moderate cognitive impairment, was dependent on staff for ADLs, medically complex and required the use of corrective lenses. Review of the Resident's Demographics page which included a photo, showed the resident wearing eyeglasses. The care plan focus for Activities, initiated on 10/09/2025 documented the resident wore glasses. The resident discharged from the facility on 12/29/2025. On 02/11/2026 at 10:11 am, CC 1, resident's caregiver, said they reported the resident's glasses missing to facility staff on multiple occasions. The initial occasion was earlier in December, and the nurse referred her to Staff H, Social Services, and they looked through a drawer, and the glasses were not there. At the time of discharge the glasses were still not found and said the discharging nurse told her the glasses were not on Resident 1's inventory list so, then it didn't happen.On 02/11/2025 at 1:58 pm, review of the facility's grievance logs for 10/01/2025 through 01/31/2026 showed no entry for Resident 1's missing glasses. On 02/12/2026 at 1:45 pm, Staff E, Nursing Assistant, said if a resident or family reported something missing, he would tell Social Services, in addition to looking for the item and filling out a grievance form. On 02/12/2026 at 1:51 pm, in a joint interview with Staff C, Social Services Director, and Staff H, Social Services Assistant, Staff H said if someone reported something missing, they would fill out a stop loss form. Staff H said he did not recall anything about Resident 1's missing glasses. Staff C said she did recall hearing they were missing and looking for them but thought they had been found. Staff C said they did not fill out a stop loss form. On 02/12/2025 at 2:06 pm, Staff J, Registered Nurse (RN), said If something was reported to be missing, they would look for it and if it wasn't found they would fill out a grievance form and forward it to Staff A and B. Staff J said they recalled Resident 1 wore glasses but did not recall that they were reported missing. On 02/12/2026 at 4:51 pm, CC2, Case Manager, said they reported to the nursing staff that the residents' glasses were missing on December 4th and again on December 16th. They were never found or replaced. They were able to order another pair of glasses for Resident 1, but he had to pay a Co-pay of $20.On 02/24/2026 at 1:47 pm, Staff D, LPN, said if something was reported missing, they try to look for it and report it to Social Services. Staff D, who was identified as the discharging nurse on Resident 1's Discharge summary, dated [DATE], recalled going over the inventory list specifically but did not recall being made aware of missing glasses or making a statement that they were not on the inventory list. Staff D said Resident 1 did wear glasses and was not aware they were missing, stating Staff C usually handles that. On 02/24/2025 at 2:20 pm, Staff B RN, Director (continued on next page)

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Nursing, said, if items are reported missing, staff were to fill out a grievance form and they take it from there, trying to find the lost item, or replace it. Staff B was not aware of Resident 1's missing glasses. On 02/24/2026 at 3:20 pm, Staff G, RN, said via phone said, it sounds familiar when asked she if recalled anyone reporting Resident 1's glasses were missing. Staff G did not recall if they were found or a grievance form was filled out. Reference WAC 388-97-0460

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to promptly update and consistently implement care planned interventions for 1 of 3 residents (Resident 1) reviewed for care planning) to maintain the resident's ability and function in preparation for discharge home. This failure places residents at risk of unmet care needs, decreased quality of life, and decline in functional ability. Findings included . Resident 1 was admitted to the facility on [DATE], The admission Minimum data set (MDS), an assessment tool, dated 10/08/2025, showed the resident had moderate cognitive impairment, was dependent on staff for ADLs, medically complex, had no previous use of a mechanical lift (a machine used to transfer/assist non weight bearing person from bed to chair or other surfaces), and no refusals of care. The resident discharged the facility on 12/29/2025. Review of Resident 1's Care plan, initiated 10/07/2026, included goals the resident would improve current level of function including transfers and included interventions of two-person dependent assist using a Hoyer mechanical lift, revised to a sit to stand lift on 12/19/2025. Review of the Social Services Meeting Care Conference Follow Up note, dated 10/29/2025 at 1:00pm showed resident one had progressed with transfers from the Hoyer lift to the sit to stand lift. Review of Resident 1's Physical Therapy Discharge note, dated 11/06/2025, showed the resident had reached max potential and had completed sit to stand training, and the resident required the assistance of two staff members and the sit to stand mechanical lift for transfers.On 02/11/2025 at 10:11am, CC1, resident's caregiver, said they had visited Resident 1 several times during the month of December and was concerned as they observed staff using a Hoyer lift with the resident despite being upgraded to the sit to stand lift. They never observed staff using the sit to stand lift with the resident. They were concerned because Resident 1 would be returning to the care home and would need to be able to use the sit to stand lift. CC1 said they reported their concerns to Staff C. On the day of discharge CC1 said they observed facility staff transfer the resident with a Hoyer. When the resident discharged to home the resident reportedly, had no idea how to use the sit to stand and he really struggled the first few days at home. CC1 said the facility did provide training on the sit to stand, but the resident was not included in the training.On 2/12/2026 at 1:45pm Staff E, Nursing Assistant (NA), said staff know how a resident transfers by what is on the care plan, they recalled Resident 1 was usually transferred via the Hoyer lift. Staff D said he wasn't assigned Resident 1 necessarily but was usually assigned their roommate and assisted with transfers. Staff D said, he may have gotten better and used a sit to stand, but I am pretty sure he was still a Hoyer lift' On 02/12/2026 at 1:51pm Staff C, Social Services Director, in a joint interview with Staff H, Social Services Assistant, said she did recall the reported concern, it was about two weeks prior to the resident's discharge, and she connected with therapy and nursing to see which lift was more appropriate; therapy worked with the resident prior to discharge and cleared him to use the sit to stand. Staff C said they communicated with staff and they were to use the sit to stand lift in preparation for discharge home but said they thought, possibly staff had been using the Hoyer lift because it was easier. Staff H said he recalled observing Resident 1 not want to get up with the sit to stand lift and the staff would have to use the Hoyer.On 02/12/2026 at 4:51pm CC2, Case Manager, said they visited Resident 1 multiple times and observed staff using a Hoyer lift to transfer the resident. CC2 was included in the care conference prior to discharge and questioned why staff were using Hoyer if they were supposed to be using the sit to stand, especially in preparation to discharge home. If he had to be transferred via a Hoyer lift, he would not be able to discharge to home. CC2 specifically recalled on December 16th, they requested staff to assist resident to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	get up for an appointment that was scheduled and observed staff transfer him out of bed using the Hoyer lift. On 02/24/2026 at 12:44pm Staff F, Physical Therapist (PT) said they worked with the residents to determine the appropriate lift necessary for transfer, when Resident 1 admitted they required a Hoyer lift and when therapy discharged services, he had made progress and was able to use a sit to stand for transfers. Their recommendations at the time of therapy discharge (11/06/2025) was the use of a sit to stand lift for transfers, her expectation would be for staff to use that lift. Staff F was not aware staff were still using a Hoyer or that the resident was refusing to get up. The resident was getting up six out of seven days when therapy was working with him and if there was a decline or reason for using the Hoyer, she would expect a referral for another PT evaluation to reassess. On 02/24/2026 at 1:47pm Staff D. Licenses Practical Nurse (LPN), said staff know how a resident transfers by what's in the care plan, she would expect the residents to be transferred out of bed at least once, preferably twice a day. Staff D said they recalled that Resident 1 was a Hoyer lift, he preferred to eat breakfast in bed and would frequently decline to get out of bed, agency staff would leave it at that but if the LN was informed, they could usually persuade the resident to get up. She would expect staff to document refusals and let her know. Staff D said they did not recall any specific lift required to be used prior to discharge, nor any reported concerns regarding the use of the Hoyer lift. Review of Resident 1's Task Record for 12/01/2025 through 12/28/2025 for mobility, including transfers, showed the resident was only transferred 16 times during the 28 days, only six of those times included the mobility item for sit to stand, meaning the resident may have possibly been transferred with the sit to stand as it documented the mobility action. On 02/24/2026 at 2:20pm, Staff B, Director of Nursing, Registered Nurse, said staff know how to transfer residents via the Kardex (bedside visual report derived from the care plan) in the electronic health record and they have run sheets that tell them about any changes in the residents' status. Staff B said they would expect staff to assist residents out of bed several times a day, but staff cannot make residents get up if they don't want to. Staff B said she believed staff were using the sit to stand on Resident 1 and that he was fairly unmotivated and did not like the lift or getting out of bed; and the days the resident was not transferred out of bed on the Task list were actual refusals. Staff B said they would expect refusals to be documented and followed up on. Staff B said they did not feel getting out of bed only 16 times in the last 28 days prior to discharge would have a negative impact on the resident's ability to use the sit to stand lift at home. On 02/24/2026 at 3:20pm Staff G, RN, Resident Care manager said, via phone call, Resident 1 transferred via a Hoyer lift, when he would let you transfer him, he did not like to get out of bed. Review of Resident 1's progress notes for 10/07/2025 through 12/31/2025 showed only one progress note related to refusals; on 10/12/2025 at 11:30am the resident declined a shower. Review of the Discharge MDS, dated [DATE], showed the resident was dependent on staff for transfers, and did not display rejection of care. Reference WAC 388-97-1020(1)(2)(a)(b)