STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505128	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sequim Bay Post Acute	650 West Hemlock St Sequim, WA 98382

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's representative was notified of significant changes related to the development of a Stage 2 pressure injury (develop when soft tissue is compressed between a bony prominence and an external surface for a prolonged period causing partial-thickness skin loss affecting the epidermis and dermis, but do not expose fat or deeper tissues) for 1 of 3 sample residents (Resident 1) reviewed for notification of changes. This failure placed residents and their representatives at risk of not being able to participate in resident care decisions, delayed medical treatment, and a diminished quality of life. Findings included.Review of the facility policy titled, Change in Condition and Notification Policy, dated 06/01/2025, showed the facility would make notifications regarding the resident's condition, to the resident and resident representative based on the resident's clinical status, decision making capacity and preference. Resident 1 was admitted to the facility on [DATE] for aftercare following a hip fracture and diagnosis including peripheral vascular disease (impaired blood flow to the extremities). The admission Minimum Data Set (MDS) dated [DATE] showed the resident was cognitively intact and felt it was very important to have family and close friends involved in discussions about their care. Review of the Incident report, dated 01/23/2026, showed a clear fluid filled blister to Resident 1's right heel was discovered, the blister measured 4 centimeter (cm) x 5 cm and assessed to be a stage 2 pressure injury. The incident report did not indicate a resident representative was informed of the discovery of the pressure injury. Review of the incident report on 01/28/2026 related to a fall, indicated the Power of Attorney (POA - person who makes decision on resident's behalf)/family would be notified the following shift. Review of the incident report on 02/16/2026 related to a fall, showed the POA/Family was notified via phone call.Review of the incident report on 02/17/2026 related to a fall, showed the POA/family was notified via phone call. Review of the incident report on 02/23/2026 related to a fall, showed the POA/family was notified via phone call. On 04/23/2026 at 1:23 pm, Resident 1 said they would expect the facility to report the wound to her POA.On 04/23/2026 at 1:24 pm, Resident 1 POA said she was not made aware of the wound until she accompanied the resident to their orthopedic appointment on 02/09/2026. On 4/23/2026 at 4:19 pm, Staff C, RCM, RN said resident representatives should be made aware of resident changes such as weight loss, medications, and wounds. Resident representatives should be notified if there was a new stage 2 pressure injury, but they added they might not if the resident was considered alert and oriented. On 04/23/2026 at 5:20 pm, Staff B said they would expect staff to notify the resident representative regarding a new stage 2 pressure injury. Refer to F686Reference WAC 388-97-0320(1)(a) -(d)(2)(a)(b)

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 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 observation, interview, and record review the facility failed to include pressure prevention strategies for a newly admitted resident who was at risk for pressure injury (also known as pressure ulcers, bedsores, or decubitus ulcers, occur when soft tissues are compressed between bony prominences and external surfaces) and failed to consistently implement interventions for 1 of 3 residents (Resident 1) reviewed for care planning. This failure places residents at risk of unmet care needs, development of pressure injuries, and decreased quality of life. Findings included.Review of the facility policy titled, Comprehensive Care Planning Policy, dated 06/01/2025 showed the facility would develop, implement, and maintain a comprehensive care plan for each resident based on needs and clinical condition. The care plan would be developed upon admission and based on clinical assessment, .and identified risk. Resident 1 was admitted to the facility on [DATE] for aftercare following a hip fracture and diagnosis including peripheral vascular disease (impaired blood flow to the extremities). The Clinical admission Skin Assessment, dated 01/08/2026, documented the resident had no pressure injuries present on admission. The admission Minimum Data Set (MDS) dated [DATE] showed the resident was cognitively intact and was at risk for pressure injury. The care plan, initiated on 01/09/2026, showed no focus for risk for pressure injury and no pressure prevention interventions until after the resident was found to have developed a stage 2 pressure injury (partial-thickness skin loss affecting the epidermis and dermis, but do not expose fat or deeper tissues) on 01/23/2026. Review of the physician's order, dated 01/09/2026, showed the resident was to wear bilateral AFO's (ankle-foot-orthotics, used to prevent foot drop) during all transfers and when out of bed. Review of the care plan focus for the stage 2 pressure ulcer initiated on 01/23/2026, included the intervention to keep heels off of the bed. Review of the January 2026 Treatment Administration Record (TAR) showed then between 01/09/2026 and 01/23/2026 staff documented the AFO were not in use for 14 of 38 opportunities charted.Review of the physician's order, dated 01/23/2026, showed the resident was to wear heel booties to both feel whenever she was in bed. Review of the facility wound care provider note, dated 01/28/2026 showed the Stage 2 Pressure Injury to the right heel was a new wound measured 3.3 cm x 6.2 cm and included dressing change orders for three times weekly and recommendations to offload at all times. Review of the January 2026 TAR showed heel protectors documented in place only 7 of 17 opportunities charted. Review of a physician's order dated 02/09/2026 showed the resident was to receive daily dressing changes to the right heel ulcer and the heel was to be floated at all times.Review of Resident 1's February 2026 TAR showed heel protectors documented in place only 17 of 56 opportunities charted. Review of Resident 1's March 2026 TAR showed heel protectors documented in place only 19 of 62 opportunities charted. On 04/09/2026 at 9:16 am, Resident 1's Power of Attorney (POA - person who makes decision on resident's behalf) said they visited the resident three times weekly and nearly every time she saw the resident, they did not have heel protectors in place. The POA said they even posted a sign in the resident's room but was scolded by a nurse after the resident fell while wearing heel protectors. On 04/09/2026 at 12:01 pm, Resident 1 was observed sitting in her wheelchair, the residents' right foot with a dressing in place; the resident was not wearing heel protectors. Two sets of heel protectors were observed on the floor between the dresser and the closet, 1 larger dark blue pair and one smaller light blue pair. Resident 1 said they were under the impression they were supposed to wear the heel protectors at all times. Resident 1 stated, you see I don't have those on, the trouble is one group of people say I am supposed to have them on and the other says I cannot do anything with them on and they take them off, I cannot physically stop them and I need them to help me put them on. That bothers me, it is very stressful, I cannot put them on myself and if they take them off, I cannot put them back on. Resident 1 said she did not have the wound when she got there and although staff were (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	good about placing the heel protectors at night after she reminded them, they did not place them during the day. On 04/16/2026 at 3:20 pm, Staff G, Nursing assistant, said she usually placed the heel protectors on when the resident went to bed. When asked if she recalled if the resident had heel protectors on during the day, prior to going to bed the evening before, Staff G said she recalled she only had socks on because they thought the resident had been working with therapy. On 04/23/2026 at 1:23 pm, Resident 1 was observed sitting in her wheelchair, the residents' right foot with a dressing in place; the resident was not wearing heel protectors. Two sets of heel protectors were observed on the floor between the dresser and the closet, one larger dark blue pair and one smaller light blue pair. On 04/20/2026 at 3:25 pm, Staff F, Registered Nurse (RN) said all residents in the facility are at risk for pressure wounds, they know what intervention are in place by the care plan and or orders in the MAR or TAR. Resident 1 was to wear heel protectors when she was in bed only, due to her being a fall risk and that the resident was out of bed the better part of the day and did not feel that pressure was significant during the day. Staff F said she discouraged the use during the day due to the residents fall risk. On 04/20/2026 at 3:51 pm, Staff E, RN, said that residents were assessed for pressure risk when they are admitted and interventions were put into place on the care plan. Staff know what interventions were in place through the care plan and orders on the MAR/TAR. Resident 1 had an order for heel protectors, but when she attempted to transfer it would increase her fall risk, the resident wanted to wear them all the time, Staff E wanted the resident to be safe, and said Resident 1 was not supposed to wear the heel proctors unless she was in bed. On 4/23/2026 at 4:19 pm, Staff C Resident Care Manager, RN said all residents were at risk for pressure injuries, Residents were assessed on admission and intervention such as repositioning and heel protectors were included on the care plan. Documentation for these interventions were usually found on the TAR. On 04/23/2026 at 5:21 pm, Staff B, Director of Nursing Services, RN, said when residents were admitted they were assessed for pressure risk and care plan interventions were added to the care plan. Staff know what interventions were in place for each resident by the care plan, Kardex or orders in the MAR/TAR. Staff B said they ensured the care plan was being followed while out rounding, and during daily meetings. They educated staff and adjusted the care plan as needed. On 04/23/2026 at 11:56 pm, Staff D, RCM, RN, said newly admitted residents were assessed for pressure injury risk and interventions were placed on the care plan. They said interventions such as frequent repositioning or keeping heels off of the bed would be included and care plans were developed by the nursing staff. Staff D said the first interventions were added to Resident 1 on 01/23/2036 after the discovery of the Stage 2 pressure wound. Staff D said she would not have expected any interventions to be on the care plan, as she did not admit with any wounds; everyone should have their heels floated and weekly skin checks. On 04/28/2026 at 12:20 pm, Staff C, RCM, RN, said Staff H initiates the care plan and nursing staff update them. Staff C said there should be interventions on the care plan if the resident was identified at risk for pressure injuries and some intervention included would be frequent repositioning and floating the heels. Staff C did not see any interventions for risk for pressure injury included on Resident 1's care plan. Staff C confirmed the first interventions were placed on the care plan after the discovery of stage 2 pressure injury. On 04/28/2026 at 12:53 pm, Staff B, DNS, RN, said if a resident was at risk for pressure injury they would expect interventions on the care plan such as skin prep to heels, heel boots, and scheduled off-loading. Staff B said the care plans were initially developed by Staff H, reviewed Resident 1's care plan and did not see interventions placed on the care plan until the pressure wound was noted. Staff B could not identify why there was no intervention for pressure prevention on the care plan prior to the discovery of the Stage 2 pressure injury. See also F686 Reference WAC 388-97-1020 (1)(2)(a)(b)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure pressure offloading interventions were implemented consistently to prevent the development and worsening of pressure injuries (also known as pressure ulcers, that occur when soft tissues are compressed between bony prominences and external services) and that wound care was provided consistently as ordered to promote wound healing for 1 of 3 residents (1) reviewed for pressure injuries. Resident 1 experienced harm when they developed a stage 2 (partial thickness loss of skin with expose dermal tissue) pressure injury on their right heel worsened to an unstageable (full thickness skin and tissue loss in which the extent of tissue damage within ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure injury wound that became infected requiring antibiotic treatment. This failure placed residents at risk for pressure wound development, delayed wound healing and a decreased quality of life. Findings included.Review of the facility policy titled, Pressure Injury Prevention and Management Policy, dated June 01, 2025, showed the facility would assess, monitor, and implement appropriate interventions to reduce the risk of pressure injury development. Resident 1 was admitted to the facility on [DATE] for aftercare following a hip fracture and diagnosis including peripheral vascular disease (impaired blood flow to the extremities). The Clinical admission Skin Assessment, dated 01/08/2026, documented the resident had no pressure injuries present on admission. The admission Minimum Data Set (MDS), an assessment tool, dated 01/14/2026, showed the resident was cognitively intact and was at risk for pressure injury. Review of the physician's order, dated 01/09/2026, showed the resident was to wear bilateral AFO's (ankle-foot-orthotics, used to prevent foot drop) during all transfers and when out of bed.Review of the January 2026 Treatment Administration Record (TAR) showed between 01/08/2026 and 01/23/2026 staff documented the AFOs were not in use for 14 of 38 opportunities charted.Review of the Incident report, dated 01/23/2026, showed a clear fluid filled blister to Resident 1's right heel was discovered, the blister measured 4cm (centimeters) x 5cm and was assessed to be a stage 2 (Partial-thickness loss of skin with exposed dermal tissue) pressure injury. The incident report attributed the development of the blister to the residents' use of bilateral AFO's. Review of the physician's order dated 01/23/2026 showed the resident was to wear heel booties to both feet whenever she was in bed.Review of the January 2026 TAR showed the heel booties as documented in place on 7 of 17 opportunities charted.Review of the facility wound care provider note, dated 01/28/2026, showed the Stage 2 Pressure Injury to the right heel was a new wound measured 3.3 cm x 6.2 cm and included dressing change orders for three times weekly and recommendations to offload at all times.Review of the weekly skin assessment, dated 01/29/2026, documented that the resident had no identified skin concerns. Review of the facility wound care provider note, dated 02/04/2026, documented the right heel wound was deteriorating, and now classified as a Stage 3 (full-thickness loss of skin) pressure ulcer measuring 3.7 cm x 7.1 cm x 0.2 cm with 95% necrotic (dying or dead) tissue. Dressing changes were ordered three times weekly.Review of an outside providers physician's order, dated 02/09/2026, showed the resident was to receive daily dressing changes to the right heel ulcer and the heel was to be floated at all times. The order was noted and agreed to by the facility's provider on 02/10/2026. Review of Resident 1's February 2026 Treatment Administration Record (TAR) showed these orders were not implemented.Review of Resident 1's February 2026 TAR showed heel protectors documented in place with only 17 of 56 opportunities charted. Review of the facility wound care provider note, dated 02/25/2026, showed the wound had deteriorated and measured 2.6 x 6.2 x 0.3 cm with 100% necrotic tissue and macerated (skin that has a white appearance and a very soft, sometimes soggy texture) edges to the wound bed. Review of Resident 1's March 2026 TAR showed heel protectors documented in place only 19 of 62 opportunities charted. Review of the facility wound care provider note, dated 03/04/2026, showed the wound had deteriorated and now classified as (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	unstageable with 100% necrotic tissue. Review of the outside wound clinic provider note, dated 03/17/2026, showed the right heel measured 2.6 x 5.8 x 0.2 cm and was believed to be of mixed etiology . as well as pressure leading to the development of these wounds and orders for patient to offload posterior heel at all times-please float heels while in bed, wear heel protectors if possible.Review of the Care conference note, dated 03/20/2026 at 11:00 am, showed the resident verbalized concern for possible wound infection and nursing was to obtain a wound culture. Review of the wound culture results for the right heel, dated 03/23/2026, showed Resident 1 to have MRSA (methicillin resistant staphylococcus aureus) in the wound. Review of the physician's order, dated 03/23/2026, showed the resident was to receive an antibiotic twice daily for 14 days for a MRSA infection. Review of the physician's order, dated 04/07/2026, showed the resident was to receive an antibiotic twice daily for 30 days for a right heel wound infection. On 04/09/2026 at 9:16 am, Resident 1's Power of Attorney (POA - person who makes decision on resident's behalf) said the resident admitted to the facility on [DATE] and did not have the pressure injury on her right heel, Resident 1 was supposed to always wear heel booties and staff did not assist her with that. Resident 1's POA said they visited three times a week and nearly every visit the resident was not wearing heel protectors. The POA said they inquired about how the wound was doing and was told it was healing; when in fact it was not and they had to request the resident to see a different wound care professional. She also had to request a wound culture to diagnose the wound infection. On 04/09/2026 at 12:01 pm, Resident 1 was observed sitting in her wheelchair, the residents' right foot with a dressing in place; the resident was not wearing heel protectors. Two sets of heel protectors were observed on the floor between the dresser and the closet, one larger dark blue pair and one smaller light blue pair. Resident 1 said she did not have the wound when she got there and although staff were good about placing the heel protectors at night after she reminded them, they did not place them during the day. Resident 1 said they were under the impression they were supposed to wear heel protectors at all times. Resident 1 stated, you see I don't have those on, the trouble is one group of people say I am supposed to have them on and the other says I cannot do anything with them on and they take them off, I cannot physically stop them and I need them to help me put them on. That bothers me, it is very stressful, I cannot put them on myself and if they take them off, I cannot put them back on. On 04/20/2026 at 3:35 pm, Staff F, Registered Nurse (RN), said she never saw Resident 1's wound, it was managed by Staff D and the wound care provider. On 4/20/2026 at 3:51pm, Staff E, RN said they were not sure about the status of Resident 1's wound, they had never seen it and did not know if it was getting better or worse, the dressings were usually changed by Staff D, RN and Resident Care Manager (RCM) or the wound care provider.On 04/23/2026 at 1:23 pm, Resident 1 was observed sitting in her wheelchair, the residents' right foot had a dressing in place; the resident was not wearing heel protectors. Two sets of heel protectors were observed on the floor between the dresser and the closet, one larger dark blue pair and one smaller light blue pair.On 4/23/2026 at 1:23 pm, Resident 1's POA said there was nothing in the AFO to cause the pressure. The left one had an insert in it but not the right one, and said, Besides they didn't use them anyway! On 04/23/2026 at 4:19 pm, Staff C, RCM, RN said Resident 1 acquired an unstageable Pressure wound to her right heel due to her wearing AFOs. Staff C said that determination was made by the IDT team during a discussion, she had not looked at the AFO to determine if that was the cause. Staff C confirmed the 02/09/2026 consultant order was noted and agreed to by the facility provider and did not know why the 02/09/2026 order to increase the dressing change to daily and offload heels at all times was not implemented.On 4/23/2026 at 5:21 pm, Staff B, Director of Nursing, RN, said although they were not in the facility at the time the wound developed, it was her understanding the team thought the AFO's were causing friction and that caused the blister. She believed the POA wanted the resident to wear heel protectors at all times, but the facility staff felt it was unsafe for the resident to do so. Staff B was not aware of the 02/09/2026 order to increase the dressing changes to daily and float heels at all times, that was noted and agreed to by the facility provider, stating I am aware now. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Staff B said the 03/17/2026 outside wound care orders to offload posterior heel pressure at all times was not put in to add the more specific details. After reviewing the February and March 2026 TAR for placement of heel protectors, Staff B said they were not consistently being placed as ordered. On 04/28/2026 at 11:56 am, Staff D, RN, RCM, said they did not look at the AFO when the wound was discovered to determine if it was the cause of the wound. Reference WAC 388-97-1060 (3)(b)