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	08/22/2025

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. .Based on interview and record review, the facility failed to ensure at least eight consecutive hours of Registered Nurse (RN) coverage was provided daily, for 3 of 31 days reviewed (07/27/2025, 08/03/2025 & 08/17/2025) for RN coverage. This failure placed residents at risk for delay in resident assessments, identification of changes in condition, and provision of nursing care and services requiring a RN.Findings included . Review of the Staffing Pattern document completed by Staff B, Director of Nursing Services (DNS), for the 31-day period from 07/19/2025 - 08/18/2025, showed on 07/27/2025, 08/03/2025 and 08/17/2025 no RN coverage was provided. On 08/21/2025 at 2:50 PM, Staff B, DNS, confirmed no RN coverage was provided on the above-referenced dates and said the facility had difficulties finding RN coverage on some weekends, primarily for Sundays. Reference WAC 388-97-1080 (3)(a).

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to ensure Pre-admission Screening and Resident Review (PASRR) assessments were reviewed to ensure they accurately reflected residents' mental health diagnoses and/or selected the requirement for Level 2 PASRR referrals to be made, for 6 of 8 sampled residents (Residents 29, 1, 17, 58, 6, & 8) reviewed for PASRRs. This failure placed residents at risk for not receiving timely and necessary mental health services, and a diminished quality of life.Findings included.1) Resident 29 was admitted to the facility on [DATE], and had diagnoses of major depression disorder (persistent feeling of sadness and loss of interest) and bipolar disorder (mental health condition with severe high and low moods). Review of Resident 29's Level 1 PASRR, dated 10/18/2020, showed it did not have depression selected on the form and did not select that a Level 2 PASRR evaluation was required. No additional Level 1 PASRRs were completed. During an interview on 08/21/2025 at 1:05 PM, Staff C, Social Services Director (SSD), reviewed Resident 29's Level 1 PASRR, and said depression should have been listed on the form and the form should have been redone due to it not selecting that a Level 2 PASRR evaluation was required. 2) Resident 1 was admitted to the facility on [DATE], and had diagnoses of bipolar disorder, major depressive disorder, and anxiety disorder (intense, excessive and persistent worry and/or fear). Review of Resident 1's Level 1 PASRR, dated 08/07/2021, showed it did not have anxiety listed on the form and did not select that a Level 2 PASRR evaluation was required. No additional Level 1 PASRRs were completed. During an interview on 08/21/2025 at 1:05 PM, Staff C reviewed Resident 1's Level 1 PASRR, and said it should have been redone due to it saying Resident 1 did not need a Level 2 PASRR completed. After reviewing Resident 1's diagnosis of anxiety, Staff C said a Level 1 PASRR was not redone with the addition of this diagnosis and should have been. 3) Resident 17 was admitted to the facility on [DATE]. The Annual Minimum Data Set (MDS, an assessment tool), dated 07/16/2025, documented Resident 17 was severely cognitively impaired. Resident 17's Level I PASRR, dated 07/23/2024, included a mood disorder (mental health condition that primarily affects a person's emotional state) diagnosis. Resident 17 was diagnosed with psychosis disorder (state of impaired reality) on 08/12/2025 and delusional disorder (a persona cannot tell what is real from what is imaginary, has delusions) on 11/30/2024. No new PASRR was submitted to include the new diagnoses. 4) Resident 6 was admitted to the facility on [DATE], and had diagnoses of major depressive disorder and anxiety. The Quarterly MDS, dated [DATE], documented Resident 6 was cognitively intact. Resident 6's Level I PASRR, dated 03/13/2024, documented the Level I PASRR was being resubmitted due to a significant change in condition. The Level I PASRR did not document the anxiety disorder diagnosis. 5) Resident 58 was admitted to the facility on [DATE], and had diagnoses of major depressive (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disorder, psychosis, and bipolar disorder. The Quarterly MDS, dated [DATE], documented Resident 58 was severely cognitively impaired. Resident 58's Level I PASRR, dated 01/18/2022, included major depressive disorder and bipolar disorder diagnosis and was resubmitted due to new behaviors. Resident 58's Level I PASRR failed to include psychosis. 6) Resident 8 was admitted to the facility on [DATE], with diagnoses of major depressive disorder and delusional disorder. The Quarterly MDS, dated [DATE], documented Resident 8 was severely cognitively impaired. Resident 8's Level I PASRR, dated 05/05/2025, documented no mental health diagnoses. On 08/21/2025 at 1:05 PM, Staff C said the correct diagnoses should have been included on the Level I PASRR's and they should have all been resubmitted. Reference WAC 388-97-1915 (1)(2)(a-c).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards for 6 of 22 sampled residents (Resident 15, 58, 8, 17, 6 & 5) reviewed unnecessary medication and for 2 of 2 nursing refrigerators (South Hall and North Hall) reviewed. The facility staff failed to label and date open vials and document, follow, or transcribe physician orders when indicated. These failures placed residents at risk for unmet care needs, medical complications, and a diminished quality of life.Findings included.Non-Pharmacological Interventions 1) Resident 15 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS, an assessment tool), dated [DATE], documented Resident 15 was severely cognitively impaired. A physician's order, dated [DATE], documented Resident 15 was to have 5 milligrams (mg) of oxycodone (an opioid) every 4 hours as needed (PRN) for pain. The order was discontinued on [DATE]. Review of the [DATE] Medication Administration Record (MAR), showed the PRN oxycodone was not given during this time frame. A physician's order, dated [DATE], documented Resident 15 was to have 5 milligrams (mg) of oxycodone (an opioid) every 4 hours PRN for pain. The order was discontinued [DATE]. Review of the [DATE] MAR, showed the PRN oxycodone was given 4 times during this time frame. A physician's order, dated [DATE], documented Resident 15 was to have 5 mg of oxycodone every 4 hours PRN for breakout pain. The order was discontinued [DATE]. Review of the [DATE] MAR, showed the PRN oxycodone was given 10 times during this time frame. A physician's order, dated [DATE], documented Resident 15 was to have 5 mg of oxycodone every 4 hours PRN for breakout pain. The order was discontinued [DATE]. Review of the [DATE] MAR, showed the PRN oxycodone was given once during this time frame. A physician's order, dated [DATE], documented for staff to provide non-pharmacological interventions (NPIs, non-medication interventions) to reduce pain, that included what interventions had been used and document the effectiveness of the interventions. Review of Resident 15's [DATE] Treatment Administration Record (TAR), showed no documentation that staff attempted any NPIs. 2) Resident 58 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 58 was severely cognitively impaired. A physician's order, dated [DATE], documented Resident 58 was to have 5 mg of oxycodone every 3 hours PRN for breakthrough pain. Review of the [DATE] MAR, showed the PRN oxycodone was given 11 times during this time frame. A physician's order, dated [DATE], documented for staff to provide NPIs to Resident 58 to reduce pain, that included what interventions had been used and document the effectiveness of the interventions. Review of Resident 58's [DATE] TAR, showed no documentation that staff attempted any NPIs. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Resident 8 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 8 was severely cognitively impaired. A physician's order, dated [DATE], documented Resident 8 was to have .25 milliliters (ml) morphine PRN for comfort care. The order was discontinued [DATE]. Review of Resident 8's [DATE] MAR, showed the PRN morphine was given 10 times during this time frame. A physician's order, dated [DATE], documented Resident 8 was to have .25 ml morphine PRN for comfort care and 0.5 ml morphine PRN for pain. Review of Resident 8's [DATE] MAR, showed the PRN morphine was given 9 times during this time frame. A physician's order, dated [DATE], documented for staff to provide Resident 8 with NPIs to reduce pain, that included what interventions had been used and document the effectiveness of the interventions. Review of Resident 8's [DATE] TAR, showed no documentation that staff attempted any NPIs. On [DATE] at 9:03 AM, Staff D, Resident Care Manager (RCM), confirmed all residents had orders for NPIs and said staff did not document any NPIs. Side Effect Monitoring 1) Resident 17 was admitted to the facility on [DATE]. The Annual MDS, dated [DATE], documented Resident 17 was severely cognitively impaired. Review of the electronic health record (EHR), showed Resident 17 was prescribed Olanzapine (an antipsychotic) for unspecified psychosis (the distortion of reality in which you have difficulty knowing what is real and what is not) and Sertraline (an antidepressant) for depression (a mood or emotional state that is marked by feelings of low self-worth or guilt and a reduced ability to enjoy life). A physician's order, dated [DATE], documented for staff to monitor Resident 17 for antidepressant side effects every shift and document with + if symptoms had been observed and – if symptoms had not been observed. A physician's order, dated [DATE], documented for staff to monitor Resident 17 for antipsychotic side effects every shift and document with + if symptoms had been observed and – if symptoms had not been observed. Review of Resident 17's [DATE] TAR, showed no documentation by staff if side effects had been or had not been observed for either medication. 2) Resident 6 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 6 was cognitively intact. Review of the EHR, showed Resident 6 was prescribed Buspirone (an antianxiety medication) for anxiety (a mental health condition characterized by excessive fear, worry, and anxiety that interfere with daily life). A physician's order, dated [DATE], documented for staff to monitor Resident 6 for antianxiety side (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	effects every shift and document with + if symptoms had been observed and – if symptoms were had not been observed. A review of Resident 6's [DATE] TAR, showed no documentation by staff if side effects had or had not been observed for the antianxiety medication. 3) Resident 58 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 58 was severely cognitively impaired. Review of the EHR, showed Resident 58 was prescribed Venlafaxine (an antidepressant) for depression, Seroquel (an antipsychotic) for bipolar disorder (a mental health condition characterized by extreme mood swings that include emotional highs-mania or hypomania and lows-depression) and Lorazepam (an antianxiety) for anxiety. A physician's order, dated [DATE], documented for staff to monitor Resident 58 for antidepressant side effects every shift and document with + if symptoms had been observed and – if symptoms had not been observed. A physician's order, dated [DATE], documented for staff to monitor Resident 58 for antianxiety side effects every shift and document with + if symptoms had been observed and – if symptoms had not been observed. A physician's order, dated [DATE], documented for staff to monitor Resident 58 for antipsychotic side effects every shift and document with + if symptoms had been observed and – if symptoms had not been observed. Review of Resident 58's [DATE] TAR, showed no documentation by staff if side effects had or had not been observed for any of the psychotropic medications. 4) Resident 8 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 8 was severely cognitively impaired. Review of the EHR, showed Resident 8 was prescribed Risperdal (an antipsychotic) for delusional disorder (mental health condition in which a person cannot tell what is real from what is imagined) and Lorazepam for anxiety. A physician's order, dated [DATE], documented for staff to monitor Resident 8 for antipsychotic side effects every shift and document with + if symptoms had been observed and – if symptoms had not been observed. A physician's order, dated [DATE], documented for staff to monitor Resident 8 for antianxiety side effects every shift and document with + if symptoms had been observed and – if symptoms had not been observed. Review of Resident 8's [DATE] TAR, showed no documentation by staff if side effects had or had not been observed for either medication. On [DATE] at 9:03 AM, Staff D, RCM, said all residents had side effect monitoring in place for all medications. Upon review of each residents [DATE] MAR and TAR, Staff D confirmed staff had not (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented if observations of side effects had been observed, saying the order did not provide space for staff to enter + or -. Nursing Refrigerators During an observation with Staff F, Registered Nurse (RN), on [DATE] at 12:02 PM, North Hall medication room had expired green top lab specimen test tubes, with an expiration date of [DATE], and expired blue top test tubes, with an expiration date of [DATE]. During an observation with Staff G, Licensed Practical Nurse, on [DATE] at 3:47 PM, South Hall medication room had expired green top lab specimen test tubes, with an expiration date of [DATE], and expired blue top test tubes, with an expiration date of [DATE]. During an observation with Staff H, RN, on [DATE] at 1:42 PM, South Hall medication room had expired green top lab specimen test tubes, with the expiration date of [DATE]. When asked if licensed nurses drew blood samples using the test tubes located in the medication room, Staff H said the facility's licensed nurses used the test tubes in the medication room for drawing labs, which were then picked up by the lab courier. On [DATE] at 2:20 PM, when asked about the expired test tubes, Staff I, Assistant Director of Nursing/RN, said it was her expectation for staff to assess the expiration date on the test tubes before using them. Pressure Ulcer Resident 5 was admitted to the facility on [DATE]. Record review showed a [DATE] order for Wound Healing Supplement - Thin Liquids, with instruction to mix in eight ounces of water and administer every morning for 14 days to promote wound healing. The order did not identify what the Wound Healing Supplement was or the dose that was to be administered. Review of Resident 5's [DATE] Medication Administration Record (MAR), showed facility nurses signed, from [DATE] - [DATE], they had administered the unidentified supplement daily as ordered. On [DATE] at 3:19 PM, Staff B, Director of Nursing Services (DNS), said the order was incomplete and needed to be clarified to include the supplement and dose to be administered. Staff B said they believed the order was for Arginaid or Juven (nutritional supplements containing the amino acid L-arginine, plus vitamins C and E, designed to support wound healing). When asked how a nurse would know to administer Arginaid from the current order Staff B said they would not. Resident 5 had a [DATE] order for an alternating low air loss mattress (LAL), with direction to verify the LAL mattress was set to a 10-minute alternating cycle and 170 pounds, every shift. On [DATE] at 12:33 PM, [DATE] at 1:57 PM and [DATE] at 8:38 AM, observation of Resident 5's LAL mattress display panel showed it was set to 340 pounds and had a flashing red light in the top left-hand corner that indicated low pressure. On [DATE] at 8:50 AM, Staff P, RN, confirmed Resident 5's alternating LAL mattress was set to 340 pounds and the low pressure alert light was flashing. Review of Resident 5's [DATE] MAR, showed facility nurses signed twice daily (12-hour shifts) from [DATE] - [DATE] that they verified Resident 5's LAL mattress settings were as ordered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:12 AM, Staff B, DNS, said it was the expectation that facility nurses only sign for tasks they completed and acknowledged if nurses had checked Resident 5's LAL mattress setting each shift as ordered, they would have identified that it was set to 340 pounds, and the low-pressure alarm was flashing and taken corrective action. Reference WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i) .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation, interview, and record review, the facility failed to ensure residents received care and services in accordance with professional standards of practice and their person-centered plan of care, for 5 of 8 residents (Resident 58, 8, 17, 15, &5) reviewed for bowel management, and 1 of 2 residents (Resident 5) reviewed for pressure ulcers. The failure to ensure the provision of bowel care was in accordance with physicians' orders and/or the facility bowel protocol, and that pressure redistribution devices functioned properly, placed residents at risk for delays in treatment, skin breakdown, unmet care needs and a decreased quality of life.Findings included .Bowel Management Review of facility's policy titled, Management of Constipation dated 11/2023, documented When a resident is identified with No/small Bowel Movement [BM] documented for 64hrs, the LN [Licensed Nurse] will assess the resident and determine if the bowel protocol will be initiated. Standard bowel protocol to relieve constipation (in the absence of a bowel obstruction) with a provider order may include the following: Milk of Magnesia 30 ml [milliliters] PO [by mouth] HS [at bedtime] after eight shifts of no BM Bisacodyl Suppository rectally if no results from the Milk of Magnesia Fleets Enema rectally if no results from the Bisacodyl Suppository 1) Resident 58 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 07/11/2025, documented Resident 58 was moderately cognitively impaired. Resident 58's bowel record documented Resident 58 had no BM from 08/11/2025-08/15/2025 (5 days). The electronic health record (EHR) showed no progress notes regarding bowel medication or bowel protocol. The August 2025 Medication Administration Record (MAR) showed the bowel protocol was never attempted. On 08/22/2025 at 9:03 AM, Staff D, Resident Care Manager (RCM), confirmed Resident 58 had no BM from 08/11/2025-08/15/2025. Staff D said the bowel protocol had never been started and should have been. 2) Resident 8 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 8 was moderately cognitively impaired. Resident 8's bowel record documented Resident 8 had no BM from 08/02/2025 - 08/06/2025 (5 days). The August 2025 MAR showed Milk of Magnesia was given on 08/06/2025. On 08/21/2025 at 10:25 AM, Staff I, Assistant Director of Nursing, said her expectation was that Resident 8 should have been assessed by day 3. 3) Resident 17 was admitted to the facility on [DATE]. The Annual MDS, dated [DATE], showed resident 17 was severely cognitively impaired. Resident 17 had a diagnosis of irritable bowel syndrome (IBS, an intestinal disorder causing pain in the belly, gas, diarrhea, and constipation). On 08/18/2025 at 4:02 PM, Resident 17 said they had diarrhea a lot, and did not receive medication for it. Resident 17 said when their brief had been changed yesterday staff reported they had diarrhea. Review of Resident 17's orders, showed they had an active order, for Loperamide (anti diarrhea medication) to be given once every 3-4 days if resident had diarrhea. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 17's MAR and bowel record from 08/01/2025 through 08/18/2025 showed no Loperamide had been administered during that time, and on the following days Resident 17 had loose/diarrhea consistency of bowel movements: 08/01/2025 08/03/2025 08/04/2025 08/05/2025 08/07/2025 08/08/2025 08/09/2025 08/10/2025 08/11/2025 08/12/2025 08/13/2025 08/14/2025 08/15/2025 08/16/2025 08/17/2025 08/18/2025 08/19/2025 On 08/21/2025 at 10:00 AM, Staff O, Certified Nursing Assistant (CNA) when asked what they would do if a resident had loose stools/diarrhea said they would clean the resident up, wash hands, report it to the nurse, then document the loose stool in the electronic health record. When asked if Resident 17 had loose stools, Staff O said yes, just the other day. When asked if they had informed the nurse, Staff O said, I did not tell the nurse. On 08/21/2025 at 10:10 AM, Staff D, RCM, when asked if a resident had loose stools/diarrhea what her expectations of staff were, said If there were loose stools staff could give Imodium (loperamide), that there was a standing order if a resident had diarrhea, and if the diarrhea did not resolve they should notify the provider for further interventions. When reviewing Resident 17's bowel record, Staff D confirmed Resident 17 had frequent loose stools, and that medication had not been administered for (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the month of August 2025. When told that Resident 17 reported they had diarrhea recently, and the CNA had confirmed this but reported they had not told the Nurse, Staff D said this did not meet her expectations, and staff needed education about communicating with the nurses so orders could be implemented. 4) Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's alteration in bowel elimination related to constipation care plan, revised 05/06/2025, showed staff were directed to monitor for constipation and to follow the facility's bowel protocol. Record review of Resident 15's orders, dated 07/31/2025, showed the following bowel care orders:a) Milk of Magnesia (MOM)- administer at bedtime or residents preferred time, as needed, if no BM on the third day.b) Dulcolax suppository- administer per rectum (PR), as needed, if no BM 12 hours after MOM administration.c) Fleet Enema- administer PR, as needed, if no results from Dulcolax suppository in four to six hours. If there are no results, notify the provider. Review of Resident 15's bowel record showed they had no BM from 8/15/25 - 8/18/2025 (4 days). Review of the August 2025 MAR showed Resident 15 was not administered MOM on 08/18/2025 (after three days of no BM) as ordered. 5) Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's alteration in elimination related to constipation care plan, revised 05/06/2025, showed staff were directed to monitor for constipation and to follow the facility's bowel protocol. Record review of Resident 5's orders, dated 05/24/2025, showed the following bowel care orders:a) MOM- administer at bedtime or residents preferred time, as needed, if no BM on the third day.b) Dulcolax suppository- administer PR, as needed, if no BM 12 hours after MOM administration.c) Fleet Enema- administer PR, as needed, if no results from Dulcolax suppository in four to six hours. If there are no results, notify the provider. Review of Resident 5's bowel record showed they had no BM from 08/13/2025 - 08/16/2025 (4 days). Review of Resident 5's August 2025 MAR, showed Resident 5 was not administered MOM 08/16/2025 (after three days of no BM) as ordered. During an interview on 08/21/2025 at 9:37 AM, when asked if Resident 15 and Resident 5 were administered MOM after three days without a BM as ordered, Staff B, Director Nursing Services (DNS), stated, No. <Pressure Redistribution Devices> Resident 5 had a 08/15/2025 order for an alternating low air loss mattress (LAL), with direction to verify every shift the mattress settings were set to a 10-minute alternating cycle and 170 pounds. On 08/18/2025 at 12:33 PM, 08/20/2025 at 1:57 PM and 08/22/2025 at 8:38 AM, observation of Resident 5's low air loss mattress display panel showed it was set to 340 pounds and had a flashing red light in the top left-hand corner that indicated low pressure. On 08/22/2025 at 8:50 AM, Staff P, Registered Nurse, confirmed Resident 5's alternating LAL mattress was set to 340 pounds and the low pressure alert light was flashing. (continued on next page)

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	505128	A. Building B. Wing	08/22/2025

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/22/2025 at 10:12 AM, Staff B, DNS, said Resident 5's LAL mattress should have been set to 170 pounds as ordered and staff should have identified the flashing alarm light that indicated low pressure and notified management or maintenance, but acknowledged that this did not occur. Reference WAC 388-97-1060 (1)

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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 and/or implement comprehensive resident centered care plans for 3 of 20 residents (Residents 45, 70, & 17) reviewed for care planning, and to ensure care conferences occurred for 1 of 2 residents reviewed (Resident 15) for care conferences. This failure placed residents at risk for unmet care needs. Findings included .Care Plans 1) Resident 45 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS, an assessment tool), dated 06/16/2025, documented the resident had a diagnosis of dysphagia (difficulty or inability to swallow) and was moderately cognitively impaired. The MDS documented Resident 45 required set up or clean-up assistance with eating and was on a mechanically altered diet. On 08/20/2025 at 7:46 AM, Resident 45 was observed in the dining room eating breakfast and being assisted by staff. A review of Resident 45's electronic health record (EHR), showed a diet order of: Regular diet Easy to Chew texture, mildly thick consistency, small dining for meals, scoop plate with all meals for diet. A review of Resident 45's care plan, dated 08/20/2025, did not show Resident 45 required feeding assistance. On 08/20/2025 at 2:11 PM, Staff K, Registered Dietitian, said Resident 45's feeding assistance was not in the care plan, and it should have been. 2) Resident 70 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 70 was cognitively intact and had a diagnosis of hemiplegia (the complete or severe loss of voluntary movement on one side of the body) of the left non dominant side. On 08/18/2025 at 11:37 AM, Resident 70 was observed lying in bed, with his left arm across his chest and his fist closed. On 08/21/2025 at 1:15 PM, Staff E, Licensed Vocational Nurse, was observed assessing Resident 70's left upper extremity. Resident 70 was unable to independently open his hand or stretch his arm. On 08/22/2025 at 10:31 AM, Staff B, Director of Nursing Services/Registered Nurse (DNS/RN), said it was the expectation that Resident 70's care plan (CP) would include a focus on his contractures. When asked to review Resident 70's care plan, Staff B confirmed there was no CP focus addressing Resident 70's left upper extremity contracture and said there should have been a contractures CP. 3) Resident 17 was admitted to the facility on [DATE]. The Annual MDS, dated [DATE], showed Resident 17 was severely cognitively impaired. Resident 17 had a diagnosis of irritable bowel syndrome (IBS, an intestinal disorder causing pain in the belly, gas, diarrhea, and constipation). On 08/18/2025 at 4:02 PM, Resident 17 said they had a lot of diarrhea. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 17's care plan, dated 08/19/2025, showed IBS was not on the care plan. On 08/21/2025 at 10:10 AM, Staff D, RN/Resident Care Manager, confirmed that IBS was not on Resident 17's care plan and said it should have been. Care Conference Review of the facility's Care Conferences policy, revised 05/2023, showed care conferences would be held upon admission, following the Baseline Care Plan policy and procedure, quarterly, with significant changes in condition, and as requested by resident/family or other team members. Review of the facility's Baseline Care Plan policy, revised 12/2024, showed a baseline care plan review meeting would be held with the resident/resident representative within 48-72 hours of admission. Resident 15 was admitted to the facility on [DATE]. On 08/18/2025 at 4:01 PM, Resident 15's guardian said they did not believe the resident had a care conference/ care planning meeting since admission. Review of Resident 15's EHR, showed no documentation that the facility had attempted to schedule or had an initial care conference. On 08/22/2025 at 12:17 PM, when asked for documentation of Resident 15's initial care conference or attempts to schedule one, Staff B, DNS, confirmed there was no documentation that showed Resident 15 or their representative, had been offered or participated in a care conference since admission. Reference WAC 388-97-1020(2)(c)(d)(f),(4)(b) .

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review the facility failed to assist with scheduling and/or coordinating notary public services (a public officer whose function it is to administer oaths; to attest and certify, by their hand and official seal, certain classes of documents, in order to give them credit and authenticity) for 2 of 2 residents (Residents 7 & 70) reviewed for advanced directives (written instruction for the provision of health care when the individual is incapacitated, such as a living will or durable power of attorney for health care) who required notarization. This failure placed residents at risk of not having their identified healthcare decisions and preferences honored.Findings included .1) Resident 7 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 08/12/2025, showed the resident was cognitively intact. A Social Services note, dated 08/30/2023, documented Resident 7 had completed an Advanced Directive form, and the Social Services Director was working on scheduling a notary public. Review of Resident 7's Durable Power of Attorney (DPOA) for Healthcare, dated 08/30/2023, showed it was required to be signed by two witnesses, not related by blood or marriage or mentioned in the declarer's will, and not the declarer's attending physician or an employee of a health care facility. In the absence of two qualifying witness signatures, the document had to be notarized by a notary public. Further review showed the document had not been witnessed or notarized. Review of Resident 7's electronic health record (EHR), showed no further documentation was present related to facility staff's attempts to coordinate/schedule a notary public. 2) Resident 70 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact.A Social Services note, dated 08/30/2023, documented Resident 70 had completed an Advanced Directive form, and the next step was to schedule a notary public. Review of Resident 70's DPOA healthcare paperwork, dated 08/21/2023, showed it was required to be signed by two witnesses, not related by blood or marriage or mentioned in the declarer's will, and not the declarer's attending physician or an employee of a health care facility. In the absence of two qualifying witness signatures, the document had to be notarized by a notary public. Further review showed the document had not been witnessed or notarized. Review of Resident 70's EHR, showed no further documentation was present regarding facility staffs' attempts to coordinate/schedule a notary public. On 08/21/2025 at 2:50 PM, when asked if there was any documentation to show facility staff followed up on scheduling a notary public for Residents 7 and 70, Staff B, Director of Nursing Services, stated, No, not that I see.Reference WAC 388-97-0960 (1).

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation, interview, and record review the facility failed to ensure residents received timely specialized rehabilitative services for 1 of 2 residents reviewed for therapy services (Resident 45). This failure to complete a Speech Therapy evaluation and provide services, placed residents at risk for unmet care needs and a diminished quality of life.Findings included .Resident 45 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS, an assessment tool), dated 06/16/2025, documented the resident had a diagnosis of dysphagia (difficulty or inability to swallow) and was moderately cognitively impaired. The MDS documented Resident 45 required set up or clean-up assistance with eating and was on a mechanically altered diet. On 08/20/2025 at 7:46 AM Resident 45 was observed in the dining room eating breakfast and being assisted by staff.A review of Resident 45's electronic health record showed 2 orders dated 06/10/2025: -Speech Therapy to evaluate and treat-Regular diet easy to chew texture, mildly thick consistency, small dining for meals, scoop plate with all mealsOn 08/21/2025 at 9:59 AM, Staff L, Director of Rehabilitation, was asked if Resident 45 was seen by speech therapy, and he said they did not have a speech therapist in June 2025. Staff L said they had recently hired a speech therapist, and they were waiting for their license to be cleared with Washington State before they could start working. On 08/21/2025 at 1:05 PM, when asked if Resident 45 had been evaluated by speech therapy, Staff B, Director of Nursing, said we do not currently have a speech therapist. Staff B was asked if Resident 45 should have been evaluated and she said they were waiting for someone to fill the position. On 08/21/2025 at 1:23 PM, Staff B said she would look to see if there was any documentation that the speech therapy order was addressed and provided to Resident 45.On 08/22/2025 at 11:33 AM, Staff A, Administrator, said the Quality Assurance and Performance Improvement committee was aware the facility did not have speech therapy, and they put together a recruitment plan. Staff A said they had signed a contract with a speech therapist, and they were waiting for their [NAME] license to be approved.On 08/26/2025, no further documentation was provided regarding Resident 45's speech therapy order on 06/10/2025.Reference WAC 388-97-1280 (1)(a-b), (3)(a-b).