STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505436	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gig Harbor Health and Rehabilitation	3309 45th Street Court Northwest Gig Harbor, WA 98335

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40226 Based on interview and record review, the facility failed to ensure care and services were provided timely for one of three residents (Resident 1) reviewed for falls. The facility's failure to obtain immediate medical care placed Resident 1 at risk for distress and delay in evaluation and treatment when the resident sustained a head injury after a fall. Findings included . Facility Policy, Managing Falls and Fall Risk, dated 5/10/2023, documented that after a fall, if there was evidence of injury, appropriate first aid should be provided and/or medical treatment obtained immediately. Resident 1 was admitted to the facility on [DATE] with diagnoses including heart disease. Nursing Progress Note, dated 4/17/2024 at 8:04 AM, documented Resident 1 fell , struck the back of the head and sustained a 3 centimeter (slightly more than 1 inch) vertical wound that, per Progress Note, bled profusely. Progress Note documented that first aid was administered by a Registered Nurse (RN) and that the guardian and provider were notified. Provider offered no new orders but planned to see Resident 1's wound later that day. Progress Note documented that vital signs were within normal limits. Nursing Progress Note, dated 4/17/2024 at 12:19 PM, documented that 4 hours after the fall, Resident 1's family member requested that 911 be called for emergent transfer to the hospital. The Note showed the RN explained to family member that they were monitoring Resident 1 for the past 4 hours, that head wounds bleed a lot, that the bleeding was controlled and there was no indication of an emergency. The RN agreed to send Resident 1 to hospital for non-emergent evaluation. Progress Note documented that when Resident 1 complained of not feeling well inside, the RN agreed to call 911 instead and Resident 1 was transferred to the hospital for emergency evaluation. On 7/17/2024 at 1:03 PM, Staff C, RN, explained that nursing actions when a resident sustained a fall and was bleeding from head were to assess, stop bleeding, obtain vital signs, call physician and send resident to hospital for evaluation via 911. At 1:17 PM, Resident 1 said, I was bleeding from the back of my head .blood was spurting .I was worried that they didn't call 911. (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

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/2024 at 1:41 PM, Staff B, Director of Nursing Services, indicated that the expectation and nursing standard of care was that if a resident fell and sustained a head injury and was bleeding, the nurse should assess, render first aid, notify physician and call 911 to transfer the resident to the emergency department. Staff B said, to me, a head injury is a medical emergency and said there was a risk for a subdural hematoma (condition where blood pools between skull and surface of brain). Reference WAC 388-97-1060 (1).