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	08/27/2025

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 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to consistently provide necessary supplies for toileting needs for 2 of 3 residents (Residents 5 and 6) reviewed for Activities of Daily Living. This failure placed residents at risk for increased discomfort and a diminished quality of life. RESIDENT 5Resident 5 admitted to the facility on [DATE] with multiple diagnoses. The admission minimum data set (MDS, an assessment tool), dated 06/17/2025 showed Resident 5 had moderate cognitive impairment, but was able to make their needs known and was moderately dependent on staff for toileting hygiene. During an interview on 07/24/2025 at 2:02 PM, Resident 5 said the facility had run out of briefs three times since their admission to the facility. Resident 5 said it could take the facility between 3-5 days to get their size of brief in the building. Resident 5 said when the facility ran out of briefs, the staff would put a smaller size brief on them until they were able to get the right size. Resident 5 said the smaller size would feel uncomfortable and would not hold urine. Resident 5 said they had urine leak down their leg because of the wrong size of brief. RESIDENT 6Resident 6 admitted to the facility on [DATE] with multiple diagnoses. The admission MDS, dated [DATE] showed Resident 6 had moderate cognitive impairment, but was able to make needs known and was totally dependent on staff for toileting hygiene. During an interview on 08/05/2025 at 1:50 PM, Resident 6 said the facility sometimes ran out of briefs. Resident 6 said the staff would always be looking for briefs. Resident 6 said when the facility ran out of briefs, the staff would put a bigger size brief on them. Resident 6 said the larger brief did not always catch all the urine and they would feel wet.During an interview on 08/06/2025 at 10:59 AM Staff I, Certified Nursing Assistant (CNA), said the facility did sometimes run out of briefs for the residents. Staff I said when they did run out of briefs, the staff would use a different sized brief.During an interview on 08/06/2025 at 12:42 PM Staff H, Central Supply, said when they placed the order for necessary supplies, multiple people would have to approve it. Staff H said there had been times they had ran out of briefs. Staff H said when that happened, they would contact their sister facility and pick up briefs. Staff H said the briefs could usually be obtained on the same day but there could have been a delay of up to 12 hours. During an interview on 08/07/2025 at 11:33 AM, Staff A, Administrator, said they had not been aware they needed to approve orders for supplies every day. Staff A said the facility should not have been running out of briefs. Reference WAC 388-97-1060 (1).

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
	505436	A. Building B. Wing	08/27/2025

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

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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 - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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	505436	A. Building B. Wing	08/27/2025

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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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure quality of care was provided by timely obtaining emergency services and thoroughly documenting alert charting for 3 of 3 sampled residents (Resident 1, 2, and 3) reviewed for falls. Resident 1, who was on a blood thinning medication, experienced harm when the facility failed to obtain immediate medical care after an unwitnessed fall with a head injury; the resident developed a latent post fall subdural hematoma (a brain bleed that can happen after a head injury) that required emergency room transfer, surgery, and hospitalization. This failure placed the residents at risk for medical complications, delay in care and services, potential death, and a diminished quality of life. Findings included . Review of a facility policy titled, Fall Protocols,, undated, showed, after a fall, the resident will be monitored for change in condition every shift for 72 hours. Monitoring may include physical assessment of the resident, vital signs, neurological checks, assessment for pain, swelling, redness, or impaired skin. Review of a document titled, Head Injury in Anticoagulated Patients Guideline, published by the Washington State Department of Health, dated 12/16/2024 showed any adult person (18 years or older) who are using anticoagulant (blood thinning) medication that have a mechanism of injury which places them at risk for intracranial (brain) injury (including any signs of external injury to the head or neck), should have a rapid triage(an assessment to determine the urgency of the need for care), labs to assess coagulation levels, emergent ordering of a head CT scan (medical imaging that uses a series of x-rays), and immediate interpretation of the CT scan by a radiologist (a doctor specializing in medical imaging.)Review of the Lippincott Manual of Nursing Practice, Eleventh Edition showed head injuries can include fractures to the skull and face, direct injuries to the brain (as from a bullet), and indirect injuries to the brain (such as concussion, contusion, or intracranial hemorrhage). Head injuries commonly occur from motor vehicle accidents, assaults, or falls. Intracranial hemorrhage is defined as a significant bleeding into a space or a potential space between the skull and the brain. This is a serious complication of a head injury with a high mortality (risk of death) because of rising intracranial pressure (ICP) and the potential for brain herniation. Intracranial hemorrhages can be classified as epidural hematomas, subdural hematomas, or subarachnoid hemorrhages depending on the site of the bleed. Review of the manual showed a head injury is a triage level 2: imminently life-threatening or emergent.DELAY IN EMERGENT CARERESIDENT 1Resident 1 admitted to the facility on [DATE] with multiple diagnoses that included acute embolism and thrombosis of deep veins of the right lower extremity (blood clots in the right leg), unsteadiness on feet, and muscle weakness. The admission minimum data set (MDS, an assessment tool), dated 07/17/2025, showed Resident 1 was moderately cognitively impaired, but was able to make their needs known. Review of the provider orders showed Resident 1 was receiving Apixaban 5 milligrams (mg) twice daily (a blood thinning medication)Review of the progress notes dated 07/25/2025 at 4:35 PM showed Resident 1 had a fall on 07/25/2025. Review of the progress notes showed Staff D, Infection Preventionist (IP) heard a crash then observed Resident 1 on the floor. Resident 1 was noted to have a laceration above the right eye which required steri strips (thin bandages applied to skin to help small cuts stay closed). The Nurse Practitioner (NP) was notified. New orders were received to monitor and to send to the Emergency Department (ED) if their condition worsened.During an interview on 08/04/2025 at 2:44 PM, Staff D, said they found Resident 1 on the floor with a small laceration (cut) above the left eye. Staff D said they assessed Resident 1, placed them back in bed, started neurological checks, and asked staff to do more frequent visual checks. Staff D said once they finished the incident report, they gave care over to the floor staff. Review of SBAR Communication Form, dated 07/25/2025, showed Resident 1 had a fall with a laceration to the head. The form showed Resident 1 was taking a blood thinner.During an interview on 08/04/2025 at 2:30 PM, Staff C, Resident Care Manager/Registered Nurse, (RCM/RN) said on 07/26/2025, the spouse called them into the room, Staff C said they assessed Resident 1, noted they had a delayed response and different sized pupils, notified the NP, and sent Resident 1 to the ED.During an interview on 08/04/2025 at 2:40 PM, Collateral Contact (CC) AA, said they were notified of the fall on 07/25/2025 and was told Resident 1 was ok. CC AA said they went to the facility to visit Resident 1 in the afternoon of 07/26/2025, noticed Resident 1 was not acting normally and had slurred speech, so they turned on the call light. CC AA said it took the staff at least 25 minutes to respond to the call light until Staff C entered the room to answer the call light. CC AA said Staff C said an ambulance needed to be called. CC AA said once Resident 1 arrived at the local hospital, they