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	04/22/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect resident's right to be free from physical abuse for 2 of 4 sampled residents (Residents 1 and 3) reviewed for resident-to-resident altercations. This failure placed residents at risk for abuse, psychosocial harm, and a diminished quality of life.Findings included .Review of a facility policy titled abuse dated 10/20/2022 showed, the organization recognizes and respects that each resident has the right to be free from abuse . RESIDENT 1Resident 1 admitted to the facility on [DATE] with multiple diagnoses including dementia (a decline in cognitive function). The Medicare 5-day Minimum Data Set, (MDS-an assessment tool), dated 03/27/2026, showed Resident 1 was severely cognitively impaired.RESIDENT 2Resident 2 admitted to the facility on [DATE] with multiple diagnoses including dementia with agitation. The quarterly MDS, dated [DATE] showed Resident 1 was severely cognitively impaired.Review of the progress note, dated 03/27/2026 at 08:53 PM, showed Resident 1 was offered a marker by Resident 2. Review showed when Resident 1 attempted to take the marker, Resident 2 grabbed Resident 1 by the arm and pulled on it. Review showed Resident 1 and Resident 2 were immediately separated and Resident 2 was placed on a one-to-one observation for safety.During an interview on 04/22/2026 at 02:09 PM, Staff G, Certified Nursing Assistant (CNA), said Resident 2 was self-propelling their wheelchair in the hallway. Staff G said as Resident 2 passed by Resident 1, they grabbed Resident 1 by the arm. Staff G said they separated the residents, notified the nurse, and began every 15-minute checks on Resident 2.During a joint interview on 04/22/2026 at 02:30 PM Staff A, Administrator, and Staff B, Registered Nurse/Director of Nursing Services (RN/DNS), said Resident 1 was moved to a room at the end of the hall on the opposite side of the hall from Resident 2 to increase physical space between them. Staff A and Staff B said Resident 2 was discharged to an assisted living memory care facility on 03/30/2026.RESIDENT 3Resident 3 admitted to the facility on [DATE] with multiple diagnoses, including dementia. The quarterly MDS dated [DATE] showed Resident 3 was severely cognitively impaired.RESIDENT 4Resident 4 admitted to the facility on [DATE] with multiple diagnoses, including dementia. The quarterly MDS, dated [DATE], showed Resident 4 was severely cognitively impaired. Review of the progress note, dated 04/13/2026 at 5:13 PM, showed Resident 3 was witnessed being hit in the head by Resident 4.During an interview on 04/22/2026 at 11:16 AM, Staff C, Licensed Practical Nurse (LPN), said Resident 3 was returned to the unit during meal time by the restorative aide. Staff C said it was reported to them that Resident 3 had been hit in the head by Resident 4. Staff C said they assessed Resident 3 for injuries after the residents were separated. During an interview on 04/22/2026 at 01:30 PM, Staff H, Restorative Aide, said Resident 3 self-propelled themself to the table Resident 4 was sitting at. Staff H said they saw Resident 4 hit Resident 3 on the head. Staff H said they immediately separated the residents and reported the incident to the nurse. During a joint interview on 04/22/2026 at 02:30 PM, Staff A and Staff B said Resident 3 and Resident 4 were separated after the incident. Staff A and Staff B said ongoing interventions include having Resident 3 and Resident 4 eating at separate tables in the dining room and facing opposite directions to avoid further conflict. Reference WAC: 388-97-0640 (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

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to thoroughly and accurately document incidents for 2 of 5 sampled residents (Resident 3 and Resident 5) reviewed for professional standards in quality of care. This failure placed residents at risk for unmet care needs, medical complications, and decision makers having an incomplete picture of resident progress. Findings included .RESIDENT 3Review of Resident 4's progress note, dated [DATE] at 05:13 PM, showed Resident 4 hit another resident in the head.During an interview on [DATE] at 11:16 AM, Staff C, Licensed Practical Nurse (LPN), said Resident 4 hit Resident 3 in the head while in the dining room.During an interview on [DATE] at 01:30 PM, Staff H, Restorative Aide, said they witnessed Resident 4 hit Resident 3 while in the dining room.Review of Resident 3's progress notes did not show documentation of the incident between Resident 3 and Resident 4.During a joint interview on [DATE] at 02:30 PM Staff A, Administrator and Staff B, Registered Nurse/Director of Nursing Services (RN/DNS), said documentation for Resident 3 should have been completed in the progress notes about the resident-to-resident altercation. RESIDENT 5Resident 5 admitted to the facility on [DATE] with multiple diagnoses. The annual Minimum Data Set, dated [DATE], showed Resident 5 was cognitively intact.Review of the progress note dated [DATE] at 07:36 PM showed Resident 5 began choking during lunch. The progress note read, Resident was in her bed throughout the day until this incident happened. I gave the resident her morning medication around 9am. During lunch time, the CNA [certified nursing assistant] called me saying that resident was choking. I was coming from room [ROOM NUMBER], I rushed in there, I found another nurse who had been called by the CNA when he couldn't see me (I was in room [ROOM NUMBER]). Resident was sitting at 90 degrees; Me and the CNA pulled her forward While the other nurse did hemlock maneuver x2. Resident said she feels something has moved down her throat. Within a minute, resident became unresponsive. Review of the progress noted did not show documentation of provider notification or what happened after Resident 5 became unresponsive. During an interview on [DATE] at 10:30 AM, Staff D, LPN, said on [DATE], during lunch time, they were coming out of a different room when the CNA told them that Resident 5 was choking. Staff D said Resident 5 was holding their neck, making sounds like they were trying to clear their throat, then they pulled Resident 5 forward in the bed. Staff D said Resident 5 told them something moved down in their throat, then became unresponsive. Staff D said they contacted another nurse for assistance, got the crash cart, put oxygen on Resident 5, called the family, and then started chest compressions. Staff D said another staff called 911 and the resident was taken to the hospital. During an interview on [DATE] at 01:21 PM Staff E, LPN, said on [DATE] during lunch time, Staff D had called them for assistance with Resident 5. Staff E said when they arrived, Resident 5 was sitting up in their bed at a 90-degree angle. Staff E said Staff D, LPN and Staff F, CNA were in the room. Staff E said they were told Resident 5 choked on their lunch and the Heimlich was attempted unsuccessfully. Staff E said they checked Resident 5 for a carotid pulse, which was absent. Staff E said CPR (Cardiopulmonary Resuscitation, an emergency lifesaving procedure performed when the heart stops beating or breathing is inadequate). Staff E said another staff called 911 and then the Emergency Medical Technicians (EMT, a person that provides out-of-hospital emergency medical care) arrived and took over care of Resident 5. Staff E said Resident 5 was transported to the hospital. During an interview on [DATE] at 10:37 AM, Staff F, CNA, said on [DATE] Resident 5 was eating lunch in their room when they noticed the call light on. Staff F said when they entered the room, they found Resident 5 coughing and making noise. Staff F said they notified Staff D, LPN that Resident 5 was choking on their lunch.During a joint interview on [DATE] at 02:30 PM, Staff A, Administrator, and Staff B, RN/DNS, said the progress note should have included information about provider notification, initiation of CPR, and transfer of Resident 5 to the hospital. Reference WAC 388-97--1720(1)(a)(i)-(iv)(b).