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	06/18/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide nail care for 3 of 6 residents (Resident 1, Resident 2, and Resident 3) and failed to provide timely hygiene for 2 of 6 residents (Resident 4 and Resident 5) reviewed for ADLs (activities of daily living). This failure placed residents at risk of pain, infection, and a diminished quality of life.Findings included.Review of a facility policy titled Activities of Daily Living (ADLs), dated 10/01/2021, showed, Each resident shall be given proper daily personal attention and care, including skin, nail, hair, and oral hygiene, in addition to any specific care ordered by the attending physician.NAIL CARERESIDENT 1Resident 1 admitted to the facility on [DATE] with multiple diagnoses. The quarterly minimum data set (MDS), an assessment tool, dated 04/29/2026, showed Resident 1 was cognitively intact. Observation on 06/18/2026 at 11:31 AM, showed that Resident 1 had long fingernails with dark sediment under them. Observation showed Resident 1 had long, thick toenails.During an interview on 06/18/2026 at 11:31 AM, Resident 1 said they were supposed to see a podiatrist, but had not seen one in a long time. Resident 1 said their toenails were uncomfortable because of the length and thickness. Review of the electronic health record (EHR) showed no documentation was able to be found regarding fingernail care for Resident 1. Review of the EHR showed the last documented podiatry visit for Resident 1 was January 2026.Review of the care plan, dated 05/18/2026, showed Resident 1 required assistance with ADLs.RESIDENT 2Resident 2 admitted to the facility on [DATE] with multiple diagnoses. The 5-day Medicare MDS, dated [DATE], showed Resident 2 was moderately cognitively impaired. Observation on 06/18/2026 at 11:16 AM showed Resident 2 had long fingernails with dark sediment under them. During an interview on 06/18/2026 at 11:16 AM, Resident 2 said they had been in the facility for about a month and a half, and the staff had never trimmed their fingernails. Review of the EHR showed no documentation was able to be found regarding fingernail care. Review of the care plan, dated 04/12/2026, showed Resident 2 required assistance with ADLs. RESIDENT 3Resident 3 admitted to the facility on [DATE] with multiple diagnoses. The admission MDS, dated [DATE], showed Resident 3 was cognitively intact. Observation on 06/18/2026 at 02:02 PM showed Resident 3 had long fingernails and very long toenails. During an interview on 06/18/2026 at 02:02 PM, Resident 3 said their nails are not getting trimmed. Resident 3 said they had been in the facility for 10 months and their toenails had never been trimmed by the staff. Resident 3 said they want their fingernails and toenails trimmed. Resident 3 said they asked the facility staff for nail clippers, but the staff told them, there were none available. Review of the EHR showed no documentation was able to be found regarding nail care. Review of the care plan, dated 05/03/2026, showed Resident 3 required assistance with ADLs.HYGIENERESIDENT 4Resident 4 admitted to the facility on [DATE] with multiple diagnoses. The 5-day Medicare MDS, dated [DATE], showed Resident 4 was moderately cognitively impaired. During an interview on 06/12/2026 at 10:52 AM, Resident 4 said they did not receive a shower for two weeks. Resident 4 said the staff had multiple different excuses why a shower was not given. Resident 4 said their hair was getting greasy due to not having a shower for so long. Resident 4 said they finally received a shower on 06/12/2026Review of the May 2026 and June 2026 nursing assistance documentation showed Resident 4 received a shower on 05/30/2026. Review (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

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the documentation showed no showers recorded after that date.Review of the EHR showed no documentation to show why Resident 4 did not receive a shower. Review of the care plan, dated 04/16/2026, showed Resident 4 required assistance for bathing. Review of the care plan showed Resident 4 was supposed to receive a shower every Wednesday and Saturday.RESIDENT 5Resident 5 admitted to the facility on [DATE] with multiple diagnoses. The admission MDS, dated [DATE] showed Resident 5 was cognitively intact. During an interview on 05/28/2026 at 12:24 PM, Resident 5 said they turned on their call light because they had soiled their brief. Resident 5 said they waited over an hour to be cleaned and changed. Review of the care plan dated 05/05/2026 showed Resident 5 was dependent on staff for toileting and changing.During an interview on 06/18/2026 at 01:01 PM, Staff C, Certified Nursing Assistant, (CNA), said their goal was to answer a call light within five minutes. Staff C said sometimes they were with another resident, and it could take some time to get to a resident to change them. Staff C said residents should receive a shower twice a week. Staff C said there was usually a shower aide, but they would sometimes get reassigned if there were call outs. Staff C said documentation is in the EHR and there should have been documentation whether the resident received a shower or not. Staff C said if a resident refused their shower, there would have been an option to document refusals. Staff C said after the resident received a shower, the CNA would document on a shower sheet any skin or nail issues and report to the nurse for follow up.During an interview on 06/18/2026 at 01:50 PM, Staff D, CNA, said they would respond to a residents needs as quickly as possible. Staff D said they would try to respond within five minutes but no longer then 15 minutes. Staff D said a resident should not have had to wait an hour to be changed after soiling themself. Staff D said showers were documented in the EHR under the shower task. Staff D said if a resident refused a shower, they would attempt to do another shower later that day or on the weekend. When asked about nail care, Staff D said some residents would request their nails to be trimmed. Staff D said, if the resident was diabetic, the nurse would trim their nails, otherwise the CNA could trim them. Staff D said they did not document when nails are trimmed. During an interview on 06/18/2026 at 01:56 PM, Staff E, Licensed Practical Nurse, (LPN), said if a resident had not received a shower, the nurse would go to the resident to find out why. Staff E said the staff would try to accommodate resident preferences to try to promote a shower. Staff E said they attempted to provide nail care during their medication pass. Staff E said the facility did not have a structured nail care protocol. Staff E said residents usually told them when they needed their nails trimmed. Staff E said if a resident needed to see a podiatrist, the staff would put them on the list to be seen. Staff E said if they had done nail care, they would document it in a progress note. During an interview on 06/18/2026 at 02:28 PM, Staff B, Registered Nurse/Director of Nursing Services (RN/DNS), said residents typically received a shower twice a week, but it was also based off preferences. Staff B said if a resident refused a shower, it would be reported to the nurse, then there would be an attempt to make the shower up on a different shift or day. Staff B said showers would be documented in the EHR under the shower task, including any attempts at offering a shower. Staff B said the facility did not have a nail care protocol. Staff B said nail care should have been done alongside bathing weekly and as needed. Staff B was unsure how often the podiatrist was in the facility, but residents would be referred by staff to have been seen. Reference WAC 388-97-1060(2)(c).