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	12/09/2025

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to maintain an effective Quality Assurance and Performance Improvement (QAPI) program to correct identified noncompliance and ensure changes were maintained to ensure ongoing compliance. This failure placed residents at risk of lacking quality medical care, abuse/neglect, foodborne illness, preventable infections, and a diminished quality of life. Findings included.Review of the CASPER Report 0003D Provider History Profile, run dated 11/25/2025, showed the facility had the following repeated noncompliance on previous Long-Term Care Surveys/Complaint Investigations and continued to be out of compliance on the current 12/02/2025 Long-Term Care Survey:1. F552 - Right to be Informed/Make Treatment Decisions: 02/2024, 12/2024, and 12/2025.2. F610 - Investigate/Prevent/Correct Alleged Violation: 02/2024, 02/28/2024, 12/2024, 04/24/2025, and 12/2025.3. F641 - Accuracy of Assessments: 12/2024 and 12/2025.4. F645 - PASARR Screening for MD & ID: 02/2024, 12/2024, and 12/2025.5. F656 - Develop/Implement Comprehensive Care Plan: 12/2024 and 12/2025.6. F657 - Care Plan Timing and Revision: 02/2024, 12/2024, and 12/2025.7. F684 - Quality of Care: 02/2024, 07/17/2024, 12/2024, 07/24/2025, and 12/2025.8. F685 - Treatment/Devices to Maintain Hearing/Vision: 02/2024, 12/2024, and 12/2025.9. F688 - Increase/Prevent Decrease in ROM/Mobility: 12/2024 and 12/2025.10. F692 - Nutrition/Hydration Status Maintenance: 02/2024, 12/2024, and 12/2025.11. F745 - Provision of Medically Related Social Service: 12/2024 and 12/2025.12. F757 - Drug Regimen is Free from Unnecessary Drugs: 02/2024, 12/2024, and 12/2025.13. F761 - Label/Store Drugs and Biologicals: 12/2024 and 12/2025.14. F812 - Food Procurement, Store/Prepare/Serve-Sanitary: 10/2019, 01/2023, 02/2024, 12/2024, and 12/2025.15. F865 - QAPI Program/Plan, Disclosure/Good Faith Attempt: 12/2024 and 12/2025.16. F880 - Infection Prevention & Control: 02/2024, 12/2024, 06/18/2025, 08/27/2025, and 12/2025. During an interview on 12/09/2025 at 2:18 PM, Staff A, Administrator, stated the QAPI program met quarterly and followed an agenda which outlined what the QAPI program would review. Staff A stated the facility used corporate provided audit tools to determine problem areas and the QAPI would use this data to develop protocols to track and trend the area to ensure improvement. Staff A stated QAPI ensured compliance was maintained by monitoring problem areas until compliance was maintained and the expectation was when compliance was achieved it would become part of the standard. Staff A stated the facility was aware of the issues identified at F552, F610, F685, F692, F757, and F880 and were continuing to develop methods to ensure compliance. Reference WAC 388-87-1760(1)(2), -1620(2)(b)(i)(ii)

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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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain consent for mental health medications for 4 of 5 sampled residents (Resident 3, 7, 5, and 78) when reviewed for unnecessary medications. This failure placed residents at risk of unwanted side effects, lack of knowledge regarding medication side effects, and a diminished quality of life. Findings included.Resident 5 Review of the EHR showed Resident 5 admitted to the facility on [DATE] with diagnoses to include cerebral palsy (neurological disorders affecting movement, posture, and muscle tone), bipolar disorder, schizoaffective disorder (a chronic mental illness blending symptoms of schizophrenia [like hallucinations, delusions, disorganized thinking] with symptoms of a mood disorder [depression or mania]), and general anxiety disorder (GAD). Resident 5 was able to make needs known. Review of the provider's orders showed Resident 5 had orders for clonazepam (a medication used for seizure disorders and panic disorders), dated 11/07/2025 and 11/28/2025. Review of the EHR showed no consent was obtained for the use of clonazepam. During an interview on 12/08/2025 at 1:56 PM, Staff Y, Registered Nurse/Resident Care Manager, stated the facility provided risks/benefits and obtained resident consent when a psychotropic (affecting the brain) medication was ordered. Staff Y stated Resident 5 used clonazepam, clonazepam required resident consent before use, and Resident 5 did not provide consent for their ordered clonazepam. Staff Y stated this did not meet expectations. During an interview on 12/08/2025 at 2:17 PM, Staff B, DNS, stated residents receiving psychotropic medications should have the risks/benefits explained to them and consent of their use should be obtained. Staff B stated Resident 5's lack of consent for the use of clonazepam did not meet expectations. Resident 3 Review of the electronic health record (EHR) showed Resident 3 was admitted to the facility on [DATE] with diagnoses to include sleep disorder, depression, atrial fibrillation (heart rhythm disorder causing irregular heartbeat) and chronic kidney disease (kidneys cannot filter waste products in the blood). Resident 3 was able to communicate their needs. Review of the EHR showed Resident 3 had medication order for bupropion HCl ER (antidepressant medication with boxed warnings for increased risk of suicidal thoughts) dated 11/01/2025. Review of EHR showed Resident 3 had uncomplete form for informed consent for bupropion. During an interview on 12/09/2025 at 11:25 AM, Staff B, Director of Nursing Services (DNS), stated Resident 3's consent was not filled out correctly and did not meet expectations. Resident 7 Review of EHR showed Resident 7 was admitted to the facility on [DATE] with diagnoses to include bipolar disorder (brain disorder causing extreme mood swings from manic highs to depressive lows), (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	borderline personality (mental condition leading to impulsive actions, intense fear, and unstable mood), anxiety, and post-traumatic stress disorder. Resident 7 was able to communicate their needs. Review of EHR showed Resident 7 had a medication order for Clonazepam (medication with calming chemicals that suppress nerve activities) for anxiety, dated 08/14/2025. Review of EHR showed Resident 7 did not have informed consent for clonazepam. During an interview on 12/09/2025 at 11:30 AM, Staff B, DNS, stated that consent was missing from records and did not meet expectations. Resident 78 Review of the EHR showed Resident 78 readmitted to the facility on [DATE] and was able to make needs known. The annual minimum data set assessment (MDS, a required assessment tool), dated 11/12/2025, showed Resident 78 had diagnoses of dementia (a group of thinking and social symptoms that interfere with daily functioning), anxiety disorder, and diabetes (too much sugar in the blood). Review of Resident 78's December 2025 medication administration records (MAR) from 12/01/2025 - 12/05/2025 showed the resident was prescribed and provided Buspirone HCl (a medication used to treat anxiety). Review of Resident 78's form titled, Informed Consent for Use of Psychotropic Medication, dated 10/07/2025, showed Buspirone documented on the form; however, it showed anti-psychotics were checked for possible side effects instead of possible side effects for an anti-anxiety medication. The statement of consent on the form was left blank showing that no consent was obtained. During an interview on 12/05/2025 at 11:25 AM, Staff D, Resident Care Manager (RCM), stated Resident 78's informed consent dated 10/07/2025 did not meet expectations because side effects for an anti-psychotic was marked and the medication was an anti-anxiety medication. Staff D stated the form did not show if they consented or not because that section of the form was not marked and should have been. During an interview on 12/05/2025 at 11:39 AM, Staff B, DNS, stated Resident 78 received their first dose on Buspirone on 10/07/2025. However, the informed consent for use of psychotropic medication, dated 10/07/2025, actual statement of consent was not completed on the form. Staff B stated anti-psychotics were marked for possible side effects and the medication was not an anti-psychotic. Staff B stated this did not meet their expectations. Reference WAC 388-97-0260

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to address grievances brought by the resident council related to resident care, staff concerns, and dietary for 5 of 5 sampled months of resident council meetings (July, August, September, October, and November 2025) when reviewed for resident council. This failure placed residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the resident council minutes dated July 2025 showed concerns voiced by a member regarding call light wait times and staff not knocking prior to entering resident rooms. Review of the resident council notes dated August 2025 showed staff entering resident rooms was an ongoing concern. Review of the resident council notes dated September 2025 showed ongoing concerns with staff entering resident rooms without knocking, call lights not being answered timely on night shift and when answered, staff would tell the residents they would return but did not come back. Review of the resident council notes dated October 2025, showed staff entering resident rooms without knocking, call lights not being answered timely on night shift and when answered, staff would tell the residents they would return but did not come back were concerns with no improvement. Review of the Grievance Log dated 06/2025 through 11/2025 showed no grievances that corresponded with concerns verbalized at resident council meetings. During an interview on 12/05/2025 at 11:36 AM, Resident 83 stated that management did not follow up with grievances discussed in the resident council meetings. During an interview on 12/09/2025 at 1:18 PM, Staff R, Activities Director, stated, when residents voiced a concern, it was to be documented on a grievance form and provided to the department managers who had until the next resident council meeting (30 days) to respond to the concern. Staff R stated kitchen and nursing staff did not regularly return documentation related to the conclusion of the grievance. During an interview on 12/09/2025 at 10:13 AM, Staff A, Administrator, stated that they were unaware that resident council grievances were not being appropriately addressed. Staff A further stated it did not meet their expectation that specific concerns brought up in resident council had not been followed up on timely. Reference: WAC 388-97-0920

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the minimum data set assessment (MDS) accurately reflected the status for 4 of 22 sampled residents (Residents 45, 7, 5, and 83) when reviewed for accuracy of assessments. This failure placed the residents at risk for unmet care and a diminished quality of life.Findings included. Resident 45 Review of the electronic health record (EHR) showed Resident 45 admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (lung condition caused by damage to the lungs), unsteadiness on feet and major depressive disorder. Resident 45 was able to make needs known. Review of a progress note dated 09/04/2025 showed, MDS summary today resident has some deformity/contracture noted to (R) ankle-foot. Will notify physical therapy of this. Review of the quarterly MDS dated [DATE] showed the Functional limitation in range of motion section marked No. During an interview on 12/08/2025 at 10:23 AM, Staff J, Director of Rehabilitation, stated Resident 45 had limited range of motion in their right ankle. Review of a Physical Therapy evaluation dated 12/09/2025 showed Resident 45's right lower extremity range of motion was evaluated as impaired. During an interview on 10/22/2024 at 2:06 PM, Staff L, MDS Nurse, stated based on their assessment with Resident 45, they believed the coding was accurate. During an interview on 10/22/2024 at 2:30 PM, Staff A, Administrator (ADM), stated the expectation was for residents to be assessed according to the resident assessment instrument (RAI) manual and the MDS assessments were coded accurately. Resident 7 Review of the EHR showed Resident 7 was admitted to the facility on [DATE] with diagnoses to include bipolar disorder (brain disorder causing extreme mood swings from manic highs to depressive lows), borderline personality (mental condition leading to impulsive actions intense fear and unstable mood), anxiety, and post-traumatic stress disorder. Resident 7 was able to communicate their needs. Review of the EHR showed Resident 7 had initial psychiatric evaluation summary related to a preadmission screen and resident review (PASRR, a mental health screening tool) as a level two, and providing certain requirements and recommendation for care and treatment. Review of the annual minimum data set (MDS, an assessment tool), dated 10/17/2025 showed Resident 7 was not marked for post-traumatic stress disorder and level 2 PASRR. During an interview on 12/08/2025 at 12:34 PM, Staff B, Director of Nursing Services (DNS), stated (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the expectations for MDS assessments were to be coded correctly and to include mental health conditions. Staff B stated Resident 7's MDS coding did not meet expectations. Resident 5 Review of the EHR showed Resident 5 admitted to the facility on [DATE] with diagnoses to include cerebral palsy (neurological disorders affecting movement, posture, and muscle tone), bipolar disorder (a brain disorder causing extreme shifts in mood, energy, and activity levels), schizoaffective disorder (a chronic mental illness blending symptoms of schizophrenia [like hallucinations, delusions, disorganized thinking] with symptoms of a mood disorder [depression or mania], and general anxiety disorder (GAD). Resident 5 was able to make needs known. Review of Resident 5's annual MDS, dated [DATE], showed question A1500 - Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? marked as No. Review of the EHR showed Resident 5 had a level II PASRR completed on 04/11/2025. Resident 83 Review of the EHR showed Resident 83 admitted to the facility on [DATE] with diagnoses of panic disorder (an anxiety condition marked by unexpected, recurring panic attacks), post-traumatic stress disorder (a mental health condition triggered by experiencing or witnessing a traumatic event, causing lasting stress and fear even when the danger is gone), and depression. Resident 83 was able to make needs known. Review of Resident 83's annual MDS, dated [DATE], showed question A1500 - Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? marked as No. Review of the EHR showed Resident 83 had a level II PASRR completed on 09/29/2022. During an interview on 12/08/2025 at 11:52 AM, Staff L, Licensed Practical Nurse/Minimum Data Set Coordinator), stated when coding question A1500, they would confer with social services to determine a resident's PASRR status. Staff L stated Resident 5 received a PASRR level 2 on 04/11/2024, their annual MDS dated [DATE] was coded No for A1500, and this was inaccurate. Staff L stated Resident 83 received a PASRR level 2 on 09/29/2022, their annual MDS dated [DATE] was coded No for A1500, and this was inaccurate. During an interview on 12/08/2025 at 12:08 AM, Staff B, Director of Nursing Services, stated the expectation was for the MDS to be accurate. Staff B stated Resident 5 and 83's annual MDS being inaccurate for PASRR status (A1500) did not meet expectations. Reference WAC 388-97-1000(1)(a)(b)(4)(a)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate a baseline care plan for 2 of 19 sampled residents (Residents 8 and 6) when reviewed for baseline care plans. Failure to timely initiate a dental or bathing care plan for resident 8 and/or a skin risk care plan for Resident 6 placed the residents at risk for unmet care needs and a decreased quality of life. Findings included . Resident 8Review of the electronic health record (EHR) showed Resident 8 admitted to the facility on [DATE] with diagnoses of dysphagia (difficulty swallowing) and malnutrition. The resident was able to make needs known. Observation and interview on 12/02/2025 at 2:20 PM showed Resident 8 laid in bed and had no teeth. Resident 8 stated they had dentures but did not wear them often and staff did not assist them to put them in regularly. Resident 8 stated they did not get showers often enough and they had itchy skin because of it. Review of the progress notes dated 09/30/2025 showed an entry by the registered dietitian (RD) which stated, Resident with dentures. Resident reports that [they do] not always put them in for meals. When asked if this can cause difficulty with eating r/t no dentures, resident reported ?sometimes'. RD asked if resident would be open to nursing assisting with denture placement before meals, res agreeable. Review of the plan of care initiated 05/28/2025 showed a care plan entry for denture/dental care dated 09/30/2025 and a care plan entry for showers/bathing initiated on 09/03/2025 (three months after admission). Resident 6Review of the EHR showed Resident 6 admitted to the facility on [DATE] with diagnoses of pressure ulcer and non-pressure ulcer. The resident was able to make needs known. During an interview on 12/02/2025 at 1:01 PM, Resident 6 stated they had a pressure injury on their heel and bottom. The one on their heel had resolved but came back when they started walking on it. Review of the plan of care initiated 03/25/2025 showed an entry for skin impairment with interventions dated 04/02/2025 (eight days after admission). During an interview on 12/05/2025 at 10:28 AM, Staff D, Resident Care Manager (RCM), stated all activity of daily living (ADLs) should be initiated on admission in the baseline care plan. During an interview on 12/05/2025 at 11:00 AM, Staff B, Director of Nursing Services (DNS), stated the baseline care plan should be initiated on admission and include all ADLs. Staff B stated Resident 8 and 6's baseline care plans did not meet expectations. Reference WAC 388-97-1020(3)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review, the facility failed to conduct timely care conferences with the resident/responsible party for 3 of 22 sampled residents (Residents 45, 11, and 6) when reviewed for care planning. This failure placed the residents at risk for unmet needs, not being involved or informed of their plan of care and a diminished quality of life. Findings included .Resident 45 Review of the electronic health record (EHR) showed Resident 45 admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (lung condition caused by damage to the lungs), unsteadiness on feet, and major depressive disorder. Resident 45 was able to make needs known. During an interview on 12/03/2025 at 9:51 AM, Resident 45 stated they could not recall when they last attended a care conference. Review of Resident 45's medical record showed care conferences were conducted on 03/26/2025 and 09/19/2025. Resident 11 Review of the EHR showed Resident 11 readmitted to the facility on [DATE] with diagnoses to include unsteadiness on feet, Alzheimer's disease (a progressive brain disorder causing difficulty with daily activities), anxiety disorder, and bipolar disorder (a brain condition causing extreme mood swings). Review of Resident 11's medical record showed the most recent care conference was conducted 03/10/2025. During an interview on 12/04/2025 at 9:45 AM, Staff F, Social Services Director (SSD), stated that care conferences were offered to residents on admission and then quarterly. Staff F stated they had conducted care conferences late due to a staffing issue. Staff F stated the late care conferences did not meet their expectations. During an interview on 12/09/2025 at 9:00 AM, Staff A, Administrator (ADM), stated that the expectation was for residents to be offered care conferences on admission and then quarterly. Resident 6 Review of the EHR showed Resident 6 admitted to the facility on [DATE] with diagnoses of amputation of the right toe, chronic ulcer of heel and midfoot, and pressure ulcer of the lower back. Resident 6 was able to make needs known. Review of Multidisciplinary Care Conference assessments showed Resident 6 had care conference on 04/03/2025 and 09/29/2025. Review of the minimum data set assessments (MDS) showed Resident 6 had MDS assessments on 03/29/2025, 06/26/2025, 09/25/2025, and 11/15/2025. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/08/2025 at 12:46 PM, Staff F, SSD, stated care conferences were provided following the MDS schedule. Staff F stated Resident 6 should have had a care conference after their 06/26/2025 MDS assessment and the missing care conference did not meet expectations. During an interview on 12/09/2025 at 12:15 PM, Staff A, ADM, stated care conferences should occur quarterly and as needed. Staff A stated Resident 6's lack of care conference between 04/03/2025 and 09/29/2025 did not meet expectations. Reference WAC 388-97-1020(2)(c)(d) (5)(b)

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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 provide care and services in accordance with professional standards of practice and the comprehensive person-centered care plan for 4 of 22 residents (Residents 96, 24, 11, and 14) when reviewed for quality of care and/or Hospice services. Failure to provide bowel management for Resident 14, to obtain and review hospice services notes for Residents 96, 24, and 11, and to develop a collaborative comprehensive care plan involving Hospice service for Residents 24 and 11, placed the residents at risk for unmet needs, clinical complications and a diminished quality of life. Findings included.<Hospice Services Visit Notes> Resident 96 Review of the electronic health record (EHR) showed Resident 96 admitted to the facility on [DATE] with diagnoses to include kidney failure, depression, and dementia (a group of thinking and social symptoms that interfere with daily functioning). Resident 96 received hospice services and was able to make needs known. During an interview on 12/02/2025 at 1:07 PM Resident 96 stated they were not sure if they received hospice services because they did not know what hospice was. Review of Resident 96's provider order dated 07/10/2023 showed do not resuscitate (allow natural death) comfort measure/hospice. Review of the modification of quarterly minimum data set (MDS, a required assessment tool) dated 10/01/2025 showed Resident 96 received hospice care services. Review of the focused care plan for hospice services initiated on 07/10/2023 showed Resident 96 was admitted to hospice services for terminal progressive disease. Review of Resident 96's EHR showed hospice visit notes from January 2025 through May 2025; however, there were not any recent hospice services visit notes. During an interview on 12/09/2025 at 10:57 AM, Staff P, Unit Manager (UM), stated that they have been getting hospice documentation when they came in at times to visit and would give the documentation to Medical Records to scan into the EHR. Staff P stated that if there were any issues or changes hospice would verbally inform them. Staff P stated that there were no current hospice binders with logs located at the nurse's stations. Staff P stated they were unable to locate Resident 96's recent hospice visit notes in their EHR and the Medical Records department did not have the recent documentation. Staff P stated this did not meet expectations. During an interview on 12/09/2025 at 12:11 PM, Staff B, Director of Nursing Services (DNS), stated hospice visit notes were previously located in a binder at the nurse's stations. Staff B stated that Resident 96's recent hospice visit notes were not scanned into their EHR and this did not meet expectations. Resident 24 Review of the electronic health record (EHR) showed Resident 24 admitted to the facility on [DATE] (continued on next page)

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	505436	A. Building B. Wing	12/09/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with diagnoses to include dementia, high blood pressure, and diabetes (too much sugar in the blood). Resident 24 received hospice care services and usually was able to make needs known. Review of Resident 24's provider order dated 11/12/2025 showed to admit to hospice services on 11/03/2025 for advanced dementia. Review of the Significant Change MDS dated [DATE] showed Resident 24 received hospice care services. Review of Resident 24's EHR on 12/05/2025 showed no documentation of hospice services visit notes. During an interview on 12/09/2025 at 11:15 AM, Staff P, UM, stated Resident 24's hospice visit notes should have been scanned into the resident's EHR. Staff P stated that they had requested Resident 24's Hospice visit notes to be provided from hospice last week. Staff P stated there needed to be a system in place to fix this issue. During an interview on 12/09/2025 at 12:31 PM, Staff B, DNS, stated they were unable to locate hospice visit notes in Resident 24's EHR and they should have been obtained, reviewed, and located in the EHR prior to now. Resident 11 Review of the EHR showed Resident 11 readmitted to the facility on [DATE] with diagnoses to include unsteadiness on feet, Alzheimer's disease (a progressive brain disorder causing difficulty with daily activities), anxiety disorder, and bipolar disorder (a brain condition causing extreme mood swings). Resident 11 received hospice care services and was able to make needs known. Observation and interview on 12/02/2025 at 11:55 AM showed Resident 11 being provided care by an unidentified hospice aid who stated they had just finished providing a shower and assisted to dress Resident 11. Resident 11 was now resting in bed and showed no signs and symptoms of pain or discomfort. Review of Resident 11's provider order dated 08/29/2025 showed to admit to hospice with a diagnosis of senile degeneration of the brain. Review of the quarterly MDS dated [DATE] showed Resident 11 received hospice care services. Review of Resident 11's EHR on 12/05/2025 showed no documentation of hospice services visit notes. During an interview on 12/09/2025 at 11:45 AM, Staff P, UM, stated they needed to contact hospice to provide hospice visit notes for Resident 11 and that they should have been located in Resident 11's EHR. Staff P stated this did not meet expectations. During an interview on 12/09/2025 at 12:38 PM, Staff B, DNS, stated Resident 11's hospice visit notes documentation should have been obtained, reviewed, and located in the EHR prior to now, and this did not meet expectations. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	< Collaborative Comprehensive Care Plan Involving Hospice> Resident 24 Review of the focused care plan for hospice services due to terminal progressive disease revised on 11/13/2025 showed Resident 24 had an intervention initiated on 11/13/2025 that Resident 24 was admitted for hospice services. This care plan lacked documentation of hospice services related to who would be visiting and how hospice would be helping with Resident 24's plan of care. During an interview on 12/09/2025 at 11:15 AM, Staff P, UM, stated hospice was only mentioned in Resident 24's focused hospice and nutrition care plans and did not meet expectations for an integrated care plan, and needed to be revised. During an interview on 12/09/2025 at 12:31 PM, Staff B, DNS, stated Resident 24's hospice services were mentioned in the focused hospice and nutrition care plans to inform of hospice status and did not show who was visiting from hospice. Staff B stated this did not meet expectations for an integrated care plan and needed to be revised/updated. Resident 11 Review of the focused care plan for hospice services initiated on 09/03/2025 showed Resident 11 was admitted to hospice services for terminal progressive disease. This care plan lacked documentation of hospice services related to who would be visiting and how hospice would be helping with Resident 11's plan of care. During an interview on 12/09/2025 at 11:45 AM, Staff P, UM, stated Resident 11's care plan did not show who from hospice would be providing care and needed to be revised to be integrated with the hospice plan of care. During an interview on 12/09/2025 at 12:38 PM, Staff B, DNS, stated Resident 11's care plan had mentioned hospice in the focused hospice and falls care plans to inform on hospice status and to notify as needed; however, it did not reflect who from hospice would visit. Staff B stated this did not meet their expectations for an integrated care plan with hospice services and needed to be revised/updated. <Bowel Management> Resident 14 Review of the EHR showed Resident 14 admitted to the facility of 10/14/2025 with diagnoses of hemiplegia (weakness on one side of the body), diabetes (too much sugar in the blood), and kidney failure. The resident was able to make needs known. During an interview on 12/02/2025 at 2:35 PM, Resident 14 stated they had problems with bowel movements, especially when out at appointments. Review of the EHR showed Resident 14 had no documented bowel movements between 11/17/2025 and 11/23/2025 (five days). (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 the medication administration record showed the resident received loperamide (a medication for the treatment of loose bowel movements) as needed for loose stools on 11/17/2025 and 11/19/2025. No documentation was found showing the resident had reported or complained of loose bowels on those dates. Review of the Administration record showed the resident received MiraLAX and a Bisacodyl suppository (Laxatives) for constipation on 11/23/2025, five days after the last documented bowel movement. Review of the plan of care showed Resident 14 had a history of constipation and to follow the bowel protocol Review of the facility policy titled Bowel and Bladder Management dated 08/29/2024 showed: For diarrhea (loose stools) to perform a rectal check for impaction, hold laxative medications for 24 hours and if it continues to notify the provider, test the stool for c-diff toxin (an infection) and administer Loperamide one time. For constipation (lack of bowel movements) to encourage fluids to 2000 ml/day if able, consult nutrition services for recommendations and administer MiraLAX on day 3, day 4 and day 5 with no bowel movements. During an interview on 12/05/2025 at 10:22 AM, Staff D, Resident Care Manager, stated the facility followed the bowel protocol. During an interview on 12/05/2025 at 11:00 AM, Staff B, Director of Nursing Services, stated it was their expectation that the staff follow the bowel protocol for Resident 14. Reference WAC 388-97-1060(1)-3

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain acceptable parameters of nutritional status for 2 of 2 sampled residents (Residents 86 and 14) when reviewed for fluid restrictions. This failure placed the residents at risk for medical complications and a diminished quality of life. Findings included.Findings included. Resident 86 Review of the electronic health record (EHR) showed Resident 86 was admitted to the facility on [DATE] with diagnoses to include end stage renal disease (kidneys cannot filter blood waste), renal dialysis (treatment that filters waste, salt, and fluid from the body), anxiety, depression, and hypertension (elevated blood pressure). Resident 86 was able to communicate needs. During an interview on 12/02/2025 at 1:31 PM, Resident 86 stated they were allowed to consume 1200 milliliters (ml) of fluids a day. Review of medication administration record (MAR) for December 2025 showed Resident 86 had consumed 240 ml of fluids for daytime and 240 ml for nighttime for the first four days in the month. Review of MAR for November 2025 showed Resident 86 had similar documentation. During an interview on 12/08/2025 at 9:19 AM, Staff CC, Certified Nursing Assistant, who was working on Resident 86's hall, stated the residents on fluid restrictions were identified by a symbol on the door, and they were not aware of anyone on fluid restrictions on this hall. Resident 86 did not have symbol on their door. During an interview on 12/08/2025 at 12:36 PM, Staff B, Director of Nursing Services (DNS), stated the staff were to follow the orders and document correctly in the MARs. Staff B stated the documentation of Resident 86's fluid restrictions did not meet expectations. Resident 14 Review of the EHR showed Resident 14 admitted to the facility on [DATE] with diagnoses of diabetes and end stage renal disease. The resident was able to make needs known. Review of the EHR showed a provider order dated 10/22/2025 for 1800 ml fluid restriction, 720 ml from dietary and 1080 ml from nursing. Review of the MAR documentation showed Resident 14 received an average of 794 ml daily in the month of November 2025. The daily total was not documented in the MAR. Observation on 12/02/2025 at 12:44 PM showed Staff Q, Certified Nursing Assistant (CNA), passing meal trays. Staff Q set out seven cups and poured liquids into the cups and placed the cups on each tray without looking at the diet slips. Staff Q, when asked if any residents were on a fluid restriction, stated No. Staff Q then delivered a tray to Resident 14 with one cup of fluids. During an interview and observation on 12/05/2025 at 8:45 AM, Resident 14 stated they were not on a (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fluid restriction because they got constipated. A full glass of clear liquids was noted on the bedside table. During an interview on 12/05/2025 at 8:50 AM, Staff S, Licensed Practical Nurse, stated they were aware Resident 14 was on a fluid restriction. Staff S stated the CNAs recorded the amount each meal and then the nurse records the total at the end of the shift. Review of the EHR showed a point of care task titled nutrition for 11/05/2025 through 12/05/2025, and the amount of fluids consumed was documented as percent of fluids offered and accepted. It did not document the amount in milliliters. During an interview on 12/05/2025 at 8:35 AM, Staff T, Regional Food Service, stated the kitchen did not manage the fluids that were provided. They put out a beverage cart, and the nurses managed any fluid restrictions. During an interview on 12/05/2025 at 8:38 AM, Staff U, CNA, who was passing meal trays on Resident 14's hall, stated the nurses gave them directions on how much fluids to give. They were not aware of any residents on a fluid restriction. During an interview on 12/05/2025 at 8:47 AM, Staff V, CNA, who was assigned to Resident 14 that shift stated no residents on their hall were on a fluid restriction. During an interview on 12/05/2025 at 9:10 AM, Staff D, Resident Care Manager, stated their expectation was for the CNAs to complete a form that calculated the amount of fluids residents on a fluid restriction drank on their shift and give it to the assigned nurse at the end of the shift to enter it into the EHR. Staff D stated the CNAs should look at the meal tickets when pouring fluids to see if a resident was on a fluid restriction. During an interview on 12/05/2025 at 11:08 AM, Staff B, Director of Nursing Services, stated it was their expectation that staff were aware of who was on fluid restrictions and reviewed the diet slips when delivering trays, and document the total at the end of their shifts and daily. Staff B stated Resident 14's fluid restriction did not meet expectations. Reference WAC 399-97-1060(3)(i)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain safe food storage in 3 of 3 resident refrigerators (100 Hall, 300 Hall, and Serenity Unit Refrigerators) and failed to ensure safe food re-heating for 1 of 2 re-heating microwaves (300 Hall Microwave) when reviewed for kitchen. This failure placed residents at risk of eating expired and/or contaminated foods, foodborne illness, and a diminished quality of life. Findings included.RefrigeratorsObservation on 12/03/2025 at 1:21 PM showed the Serenity Unit Refrigerator with a gallon jug of milk with a best by date of 11/27, a plastic container with an unidentifiable yellow food item with white growth on top, and a pitcher of facility made juice without a date label. Observation on 12/03/2025 at 1:26 PM showed the 300 Hall Refrigerator with an unopened bottle of brewed tea labeled as placed in the refrigerator on 11/15 and with a use by date of 11/04/2025. Observation and record review on 12/03/2025 at 1:31 PM showed the 100 Hall Refrigerator with a jar of salsa with a worn off use by date and labeled with a resident's name. Review of the facility's health record system showed the resident discharged from the facility on 10/21/2025. Observation showed a piece of cheesecake labeled as placed in the refrigerator on 11/29/2025. Observation on 12/08/2025 at 10:43 AM showed the Serenity Unit Refrigerator with a bowl of clam chowder dated as placed in the refrigerator on 12/03/2025. MicrowaveReview of a policy titled, Microwave Reheating, dated 10/01/2021, showed, After reheating foods in the microwave, allow standing time (approximately 2 minutes). Then, use a clean food thermometer to check that the food has reached 165 [degrees Fahrenheit]. Observation on 12/08/2025 at 10:33 AM showed the 100 Hall Resident Refrigerator area with a microwave and a temperature log for December 2025 to record the temperature of re-heated food. Review of the temperature log showed six of seven temperatures were more than 15 degrees below 165 F. During an interview on 12/08/2025 at 11:14 AM, Staff AA, Dietary Manager, stated food in the resident refrigerators should be labeled with the date placed into the refrigerator and should be thrown away after three days. Staff AA stated food re-heated using a microwave should reach 165 F to ensure it was safe to eat. Staff AA stated the observations of the resident refrigerators did not meet expectations for safe food storage. Staff AA reviewed the microwave temperature log and stated they were, a bit low and did not meet expectations. During an interview on 12/08/2025 at 11:20 AM, Staff A, Administrator, stated the observations of the resident refrigerators and the temperature log with low temperatures did not meet expectations. Reference WAC 388-97 -1100(3), -2980

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement an infection control program to monitor for and manage infections for 2 of 3 months (September and October 2025) and 2 of 22 residents (Residents 73 and 12) when reviewed for infection control. Failure to collect and analyze the infection control data and implement measures to reduce infections for the months of September and October 2025 and failure to provide infection prevention measures for an indwelling urinary device and abdominal drain for Residents 12 and 73 placed the residents at risk for infections, poor clinical outcomes, and a decreased quality of life. Findings included.Findings included. Review of the facility policy titled Infection Control Surveillance, undated, showed the infection preventionist would collect and analyze the infection control data to identify trends by comparing the rates to previous months in the current year and to the same month in previous years, to identify trends and implement interventions to improve those rates. Review of the infection control log for September 2025 showed no documentation that the collected data was analyzed for trends or interventions were implemented to address trends. Resident 73 Review of the electronic health record showed Resident 73 admitted to the facility on [DATE] with diagnoses of brain cancer and seizures. The resident was able to make needs known. Review of the provider's orders showed an order for cephalexin (an antibiotic) for urinary tract infection (UTI) twice a day for 14 days with a start date of 10/30/2025. Review of the October 2025 infection control log showed this resident's infection was not included in the tracking. During an interview on 12/08/2025 at 12:45 PM, Staff B, Director of Nursing Service (DNS) stated they were the acting Infection Preventionist (IP) for the facility and it was their expectation that the IP collect the infection control data daily and analyze the data at the end of each month to look for trends and then apply changes to help improve infection control. Staff B also stated that all infections should be tracked, and Resident 73 should have been included in the October 2025 data. Resident 12 Review of the electronic health record (EHR) showed Resident 12 was admitted to the facility on [DATE] with diagnoses to include infection and inflammatory reaction due to indwelling urethral catheter (thin, flexible tube inserted into the bladder to continuously drain urine), anemia (condition where blood lacks enough healthy red blood cells or hemoglobin to carry sufficient oxygen to the body's tissue) and malnutrition. Resident 12 was able to communicate needs. Observation and interview on 12/04/2025 at 9:53 AM showed Resident 12 in bed with an abdominal drain (thin, flexible tube inserted into the abdominal wall to continuously drain secretion) bag draining dark red color fluid on the floor. Resident 12 stated the staff opened the bag to drain it and did not close it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/05/2025 at 9:09 AM showed Resident 12 in bed with blood stains on the floor under the abdominal bag and the table leg on top of the drain bag. During an interview on 12/05/2025 at 9:11 AM, Staff H, Licensed Practical Nurse, stated the drain bag should be pinned on the bed and not touching the floor. Observation on 12/08/2025 at 9:20 AM showed Resident 12 in their bed and the catheter bag laying on the floor and draining a large amount of urine on the floor. During an interview on 12/08/2025 at 9:22 AM, Staff Y, Registered Nurse/Resident Care Manager, stated the catheter bag should be closed and not drain on the floor. Staff Y stated that did not meet expectations. During an interview on 12/08/2025 at 12:32 PM, Staff B, Director of Nursing Services, stated the catheter and drainage bags were to be attached securely to the bed and not on the floor. Staff B stated the observations for Resident 12's catheter bag and drainage bag did not meet expectations. Reference WAC 388-97 -1320(1)-(2)(a)(c)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer, educate, and obtain consent for influenza and pneumococcal vaccines for 3 of 5 sampled residents (Residents 6, 15, and 23) when reviewed for influenza and pneumococcal immunizations. These failures denied residents the opportunity to make an informed decision regarding receiving immunizations and/or placed the residents at risk for communicable diseases, complications of other medical conditions, hospitalization, and death. Findings included.Review of the facility policy titled Pneumococcal Vaccine, dated 05/02/2025, showed, Prior to or upon admission, residents would be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, would be offered the vaccine series within thirty days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Review of the facility policy titled Influenza Vaccination, undated, showed the facility would educate, offer and obtain consent for influenza vaccines to residents upon initial admission and administer as appropriate. Resident 6Review of the electronic health record (EHR) showed Resident 6 admitted to the facility on [DATE] with a diagnosis of adult failure to thrive. The resident was able to make needs known. Review of the Vaccine Consent Form dated 03/25/2025 showed the resident had requested any vaccine that is due. Review of the EHR showed no documentation that the facility assessed the resident for appropriate vaccines or administered the influenza or pneumococcal vaccines Resident 15Review of the EHR showed Resident 15 admitted to the facility on [DATE] with a diagnosis of stroke (when blood flow to part of the brain is blocked). The resident was able to make needs known. Review of Resident 15's vaccines information sheet showed the resident was eligible and had not received the influenza or pneumococcal vaccines. Review of the Vaccine Consent Form dated 01/02/2025 showed no documentation that the resident was educated and offered the influenza or pneumococcal vaccines. Resident 23Review of the EHR showed Resident 23 admitted to the facility on [DATE] with diagnoses of pneumonia, adult failure to thrive and history of falls. The resident was able to make needs known. Review of Resident 23's vaccines information sheet showed the resident was eligible and due for but had not received the pneumococcal vaccine. Review of the EHR showed no documentation that the resident was assessed for the need for, educated on and consented to the pneumococcal vaccine. During an interview on 12/08/2025 at 11:18 AM, Staff B, Director of Nursing Services (acting IP), stated it was their expectation that residents were educated and offered the pneumococcal vaccine on admission and residents were offered and educated on the influenza vaccine during the flu season. Staff B stated Residents 6, 15 and 23's vaccinations for influenza and pneumococcal did not meet expectations. Reference WAC 388-97-1340(1)(2)(3)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer, educate, and obtain consent for Covid-19 vaccines for 3 of 5 sampled residents (Residents 6, 15 and 23) when reviewed for immunizations. This failure denied residents the opportunity to make an informed decision regarding receiving immunizations and/or placed the residents at risk for communicable diseases, complications of other medical conditions, hospitalization, and death. Findings included.Review of the facility document titled Clinical Protocol for SARS COV-2, undated, showed All Residents to be offered resources and counseled about receiving the COVID-19 vaccine. Resident 6Review of the electronic health record (EHR) showed Resident 6 admitted to the facility on [DATE] with a diagnosis of adult failure to thrive. The resident was able to make needs known. Review of the Vaccine Consent Form dated 03/25/2025 showed the resident had requested any vaccine that is due. Review of the EHR on 12/08/2025 showed no documentation that the facility assessed the resident for the need for, educated the resident or administered the Covid-19 vaccine. Resident 15Review of the EHR showed Resident 15 admitted to the facility on [DATE] with a diagnosis of stroke (when blood flow to part of the brain is blocked). The resident was able to make needs known. Review of Resident 15's vaccines information sheet showed the resident was eligible, due on 08/22/2025 and had not received the Covid-19 Vaccine. Review of the Vaccine Consent Form dated 01/02/2025 showed no documentation that the resident was educated and offered the Covid-19 vaccine. Resident 23Review of the EHR showed Resident 23 admitted to the facility on [DATE] with diagnoses of pneumonia, adult failure to thrive and history of falls. The resident was able to make needs known. Review of Resident 23's vaccines information sheet showed the resident was eligible, due on 08/22/2025 and had not received the Covid-19 vaccine. Review of the EHR showed no documentation that the resident was assessed for the need for, educated on and/or consented to the Covid-19 vaccine. During an interview on 12/08/2025 at 11:18 AM, Staff B, Director of Nursing Services (acting IP), stated it was their expectation that residents were educated and offered the Covid-19 vaccine. Staff B stated Residents 6, 15 and 23's vaccinations for Covid-19 did not meet expectations. Reference WAC 388-97-1620(2)(b)(i)(ii)

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	505436	A. Building B. Wing	12/09/2025

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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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview and record review, the facility failed to ensure mechanical lifts were in safe working order for 2 of 2 mechanical lifts (Free Spirit and Tenor) when reviewed for activities of daily leaving. This failure placed the residents at risk of avoidable injuries, falls and diminished quality of life. Findings included.Observation on 12/04/2025 at 2:25 PM showed Resident 1 being transferred via mechanical lift from bed to wheelchair. The mechanical lift had no safety pins on the prongs where the resident's sling was attached. Observation on 12/05/2025 at 9:15 AM showed two lifts called Free Spirit and Tenor with missing safety clips. During an interview on 12/05/2025 at 9:50 AM, Staff Z, Maintenance Director, stated the clips were replaced on November 18, 2025, but had disappeared one week after. Staff Z stated they did the monthly maintenance inspecting and were aware of the issue and were looking to order clips. Review of the inspection reports from November and December 2025 showed no safety clips on the two mechanical lifts. During an interview on 12/09/2025 at 11:42 AM, Staff B, Director of Nursing Services, stated the mechanical lifts were to have the safety clips and monitored by maintenance monthly. Staff B stated the mechanical lifts should be taken out of service if there were no safety clips and that practice did not meet expectations. Reference WAC 399-97-2100

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to provide necessary housekeeping in resident rooms for 3 of 4 halls (Halls 100, 200 and 300) reviewed for safe, clean, functional and comfortable environment. These failures placed residents at risk for unsanitary conditions, less than a homelike environment and a diminished quality of life.Findings included . Observation on 12/04/2025 at 2:07 PM showed Resident 95 overhead asking Staff M, Housekeeping Aide, if they were able to clean the resident's bathroom. Staff M stated they had three other rooms to clean and would try to get to the bathroom on their next scheduled shift (three days later). During an interview on 12/05/2025 at 1:34 PM, Resident 95 stated their bathroom had not been cleaned in a week. Observation of the toilet bowl showed brown and orange stains on the toilet seat and in the toilet bowl. During an interview and observation on 12/05/2025 at 11:19 AM, Resident 83 stated, My bathroom hasn't been cleaned since Tuesday. Housekeeping is short staffed. Observation showed dried red matter on the bathroom floor. Review of resident council minutes dated July 2025 showed a concern that rooms were not being cleaned as often as they should have been. Review of resident council minutes dated August 2025 showed a resident complained that they had only seen housekeeping once that month. Review of resident council minutes dated September 2025 showed two residents complained about not receiving housekeeping services for approximately two weeks. During an interview on 12/05/2025 at 12:41 PM, Staff N, Housekeeping Aide, stated they were responsible for cleaning multiple areas due to staffing issues. Staff N stated they cleaned as many rooms as they could daily but were unable to clean all assigned rooms. During an interview on 12/08/2025 at 11:48 AM, Staff M, Housekeeping Aide, stated housekeeping was short staffed and they were unable to clean all their assigned rooms daily. During an observation and interview on 12/08/2025 at 1:42 PM, Staff O, Housekeeping Supervisor, stated they were currently short staffed and the expectation was for housekeeping aides to clean as many rooms as possible. Reference WAC 388-97-0880 (1)(2)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess and provide appropriately sized wheelchairs for 1 of 3 sampled residents (Resident 1) when reviewed for accommodation of needs. This failure placed the Resident at risk for skin breakdown, pain in lower back and hips, inability to use the wheelchair for an extended time, and diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 1 was admitted to the facility on [DATE] with diagnoses to include spondylolisthesis lumbar region (condition when one vertebra [spine bone] slips forward onto vertebra below causing pain and nerve damage), atrial fibrillation (irregular heartbeat), bipolar disorder (brain disorder causing extreme mood swings from manic highs to depressive lows) and heart failure. Resident 1 was able to communicate needs. Observation and interview on 12/02/2025 at 09:01 AM showed Resident 1 in bed. Resident 1 stated they did not get out of bed as often, and the mechanical lift that staff were using to transfer them caused pain. Observation on 12/03/2025 at 1:08 PM showed Resident 1 in bed stating hopefully they would get out of bed and go to their restorative program. Observation on 12/04/2025 at 2:25PM showed Resident 1 being transferred via mechanical lift from bed to wheelchair. Resident 1 was placed into their wheelchair that was constricting and tight for them, two nursing assistants then tried to lift Resident 1 manually to better position Resident 1 in the seat of the wheelchair, and stated the wheelchair was small, leaving Resident 1 leaning to left side and squished into it. During an interview on 12/05/2025 at 8:51 AM, Resident 1 stated they did not participate in the activities on the previous day because they were hurting in the wheelchair and could not tolerate sitting up. Review of EHR showed Resident1's care plan risk for falls focus area with intervention dated 04/01/2025, Assess that wheelchair is of appropriate size. During an interview on 12/05/2025 at 12:22 PM, Staff C, Assistant Director of Nursing, stated review of the records showed Resident 1 had reported the wheelchair problem to the mental health therapist and that was not passed on to the therapy department. During an interview on 12/08/2025 at 10:51 AM, Staff BB, Certified Nursing Assistant, stated Resident 1 has had the same wheelchair for a while now or since they had been in the facility. During an interview on 12/09/2025 at 11:40 AM, Staff B, Director of Nursing Services, stated the residents were assessed for wheelchairs by therapy and they would recommend an appropriate wheelchair. Staff B could not provide information regarding an assessment and therapy evaluation for Resident 1's wheelchair. Reference WAC 399-97-0860(2)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to honor resident choices for 1 of 22 sampled residents (Resident 78) when reviewed for choices. Failure to accommodate Resident 78's choice for ice water when requested placed the resident at risk for decreased quality of life and diminished self-worth.Findings included. Review of the electronic health record (EHR) showed Resident 78 readmitted to the facility on [DATE] and was able to make needs known. The annual minimum data set assessment (MDS, a required assessment tool) dated 11/12/2025 showed Resident 78 had diagnoses of dementia (a group of thinking and social symptoms that interfere with daily functioning), anxiety disorder, and diabetes (too much sugar in the blood). During an interview on 12/02/2025 at 9:43 AM, Resident 78 stated they would like to have ice water with lunch. Resident 78 stated that if they wanted ice water, they would have to ask for it, but, even then, they would just get a glass of water but would prefer ice water. During an interview and observation on 12/02/2025 at 2:17 PM, Resident 78 stated they had asked for ice water at lunch but did not get it. Resident 78 stated they would like to have a water pitcher with ice in their room but were provided with a water bottle instead. There was a plastic water bottle within reach; however, no ice water pitcher in the room. Review of Resident 78's current diet order dated 11/18/2024 showed they were prescribed a carbohydrate-controlled (watching and managing how many carbs one eats to keep energy and blood sugar steady), regular texture, and thin liquid consistency. Review of Residents 78's nutritional status focused care plan initiated on 12/24/2024 showed an intervention to provide therapeutic diet as ordered and honoring preferences as able within diet parameters, initiated on 03/20/2025. Observation in the dining room on 12/03/2025 at 12:59 PM showed Resident 78 asked Staff D, Resident Care Manager (RCM), for ice water. Staff D stated they would provide it in a minute and left the dining room. Observation in the dining room on 12/03/2025 at 1:12 PM showed Resident 78 continued to eat lunch and drank their juice; however, a glass of ice water was not provided. Staff D was assisting to cue residents in the dining room to eat. Observation in the dining room on 12/03/2025 at 1:18 PM showed Resident 78 was provided with a cup of water without ice by another staff member. Observation in the dining room on 12/03/2025 at 1:19 PM showed Resident 78 finished eating and drinking, their meal tray was removed from the table, and ice water was never provided. During an interview on 12/08/2025 at 12:17 PM, Resident 78 stated they would be provided with ice water most of the time if they requested it, but sometimes they would forget to ask for it. Resident 78 stated they preferred to get their water with ice. During an interview on 12/08/2025 at 12:27 PM, Staff E, Certified Nursing Assistant (CNA), stated Resident 78 often asked for a cup of ice water during lunch and they would ensure to provide it to them. Staff E stated Resident 78 loves ice water. Staff E stated they did not recall Resident 78 ever asking for a pitcher of ice water for their room. During an interview on 12/08/2025 at 1:05 PM, Staff A, Administrator, stated they were not aware that Resident 78 was not consistently being provided with ice water when requested and this did not meet their expectations. Staff A Stated Resident 78 should have been provided with ice water when requested. Staff A stated that if Resident 78's preference was to have ice water with meals then it should be care planned and it could be added to their dietary meal slip. Reference WAC 388-97-0180(2)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to periodically review a residents advanced directive for 1 of 4 sampled residents (Resident 96) when reviewed for advanced directive. This failure placed the residents at risk of not being able to designate a healthcare designee and a diminished quality of life. Findings included.Review of the electronic health record showed Resident 96 admitted to the facility on [DATE] with diagnoses of end stage renal disease (kidneys permanently fail), dementia (severe cognitive decline affecting memory, thinking, language, and problem-solving), and encounter for palliative care (specialized medical support for people with serious illnesses). Resident 96 was unable to make needs known. Review of a Multidisciplinary Care Conference assessment, dated 07/28/2025, showed the Advanced Directives Reviewed/Offered was blank. Review of a Multidisciplinary Care Conference assessment, dated 10/16/2025, showed the Advanced Directives Reviewed/Offered was blank. During an interview on 12/05/2025 at 10:29 AM, Staff F, Director of Social Services, stated residents' advanced directives (AD, a legal document naming a healthcare agent, e.g. living will, power of attorney) were reviewed on admission and quarterly with care conferences. During an interview on 12/08/2025 at 12:40 PM, Staff F, Director of Social Services, stated Resident 96 had not had an AD review at the previous two care conferences (07/28/2025 and 10/16/2025) and this did not meet expectations. During an interview on 12/09/2025 at 12:13 PM, Staff A, Administrator, stated AD should be reviewed quarterly and Resident 96's lack of AD review with the two most recent care conferences did not meet expectations. Reference WAC 388-97-0280(3)(c)(i)(ii), -0300(1)(b)(3)(a)-(c)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete and/or implement thorough investigations to rule out abuse or neglect related to falls for 1 of 3 sampled residents (Resident 11) when reviewed for accidents/falls. These failures placed Resident 11 at risk for unidentified abuse or neglect, continued exposure to abuse and/or neglect, and a diminished quality of life.Findings included. According to the Nursing Home Guidelines also known as the Purple Book, sixth edition, dated October 2015, All alleged incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown source, personal and/or financial exploitation, or misappropriation of resident property must be thoroughly investigated . A thorough investigation is a systematic collection and review of evidence/information that describes and explains an event or a series of events. It seeks to determine if abuse, neglect, abandonment, personal and/or financial exploitation or misappropriation of resident property occurred, and how to prevent further occurrences. Review of the electronic health record (EHR) showed Resident 11 readmitted to the facility on [DATE] with diagnoses to include unsteadiness on feet, Alzheimer's disease (a progressive brain disorder causing difficulty with daily activities), anxiety disorder, and bipolar disorder (a brain condition causing extreme mood swings). Review of the quarterly minimum data set assessment (MDS), dated [DATE], showed Resident 11 had two or more falls since admission or prior assessment, received hospice care services (end of life care), and was able to make needs known. Review of the incident report investigation dated 09/13/2025 showed Resident 11 was found lying on their belly with a dry incontinent garment on, just outside the bathroom door in their room at 4:04 PM and told staff they wanted to use the bathroom. It showed Resident 11 was unable to use a call light related cognitive deficits and was frequently incontinent of bowel and bladder. This report did not show that hospice was informed of Resident 11's fall and it was not clear what the root cause of the fall was. During an interview on 12/09/2025 at 2:09 PM, Staff B, Director of Nursing Services (DNS), stated Resident 11 was on urine retention medication and had a diagnosis of benign prostatic hyperplasia (BPH, non-cancerous enlargement of the prostate gland just below the bladder causing problems with urinating), and should have been checked to see if they were retaining urine and completed a post void residual (PVR, checking the urine that remains in the bladder after urinating). Staff B stated hospice was not informed of this fall and should have been. Staff B stated Resident 11's fall investigation dated 09/13/2025 did not meet their expectations for a thorough investigation. Review of the incident report investigation dated 09/14/2025 showed Resident 11 was found on the floor crawling towards outside of their room at 5:28 AM and stated they were getting out of bed. Attached to the incident report was a fall witness interview dated 09/14/2025 that showed there was another witness; however, there was no other witness statement attached to the incident report. It showed an intervention was to be put into place to wake Resident 11 up prior to breakfast and offer resident to get up rather than waiting for them to wake up. Review of the focused fall care plan showed Resident 11's intervention to wake resident up prior to breakfast and offer to get resident up in their wheelchair was initiated on 09/22/2025 (eight days after Resident 11's fall on 09/14/2025). During a joint interview on 12/09/2025 at 2:27 PM with Staff B, DNS, and Staff D, Residential Care Manager (RCM), both stated that an investigation was to be completed within five days. Staff D stated Resident 11's intervention for their fall on 09/14/2025 was initiated on 09/22/2025 which was not done timely and the DNS agreed. Staff D stated that there should have been another witness statement attached to Resident 11's 09/14/2025 incident report investigation and that did not happen. Both Staff B and Staff D stated due to the late intervention and lack of a witness or missing witness statement the 09/14/2025 fall investigation was not thorough and did not meet expectations. Review of the incident report investigation dated 10/05/2025 showed Resident 11 was observed crawling on the floor from their bed at around midnight, and Resident 11 stated they were hungry. Attached to the incident report was a blank fall witness interview form and the incident (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report showed No Statements found. It did not show that the provider or responsible party were notified of the fall. This report showed new interventions included to update care plan to keep their wheelchair close to bed and locked so Resident 11 could get from bed to their wheelchair safely, and nighttime snack. It showed place on alert for pain and anxiety, as needed (PRN) pain medication would be reviewed for appropriateness, therapy to screen for appropriateness of bed height for transfers, and to speak with hospice related to therapy screen. Attached to the incident report was a therapy referral dated 10/16 2025 (11 days after Resident 11's 10/05/2025 fall) that showed it was signed and completed by therapy on 10/20/2025 (15 days after Resident 11's 10/05/2025 fall). Review of Resident 11's progress notes on 12/05/2025 showed no progress note created on 10/05/2025 to reflect Resident 11 had a fall. The first mention of a fall was a progress note dated 10/07/2025 at 7:05 PM that showed, No recent incident noted or reported od [sic] resident of [sic] crawling of bed. (two days after fall on 10/05/2025). Unable to locate a progress note that showed to show PRN pain medications were reviewed for appropriateness or that hospice was informed of a therapy screen. Review of Resident 11's focused fall care plan revised on 10/13/2025 showed an intervention to make sure their wheelchair was close to the bed and locked so Resident 11 could get from bed to their wheelchair safely initiated on 06/10/2025 and revised on 10/14/2025 and intervention for Nighttime snack initiated on 10/14/2025 (both revised or initiated nine days after Resident 11's fall on 10/05/2025). During an interview on 12/09/2025 at 2:38 PM, Staff B, DNS, stated they were unable to locate Resident 11's progress notes for the date of 10/05/2025 related to the fall or that notification to the provider or responsible party were done. Staff B stated the aid assigned to Resident 11 on 10/05/2025 did not complete a witness statement and it was unclear if they were interviewed. Staff B stated the new interventions related to the fall of 10/05/2025 were not initiated timely in Resident 11's care plan. Staff B stated Resident 11's therapy referral dated 10/16/2025 was late and should have been completed within five days of the fall. Staff B stated they were unable to locate documentation that hospice had input related to Resident 11's fall on 10/05/2025 and it should have been documented and attached to the incident report. Staff B stated Resident 11's 10/05/2025 incident report investigation did not meet expectations. Review of the progress note dated 10/13/2025 showed Resident 11 was found sitting on the floor between the bed and the door. Resident 11 stated that they crawled out of bed. Review of the facility's October 2025 incident report log showed no fall logged related to Resident 11 being found sitting on the floor on 10/13/2025. During an interview on 12/09/2025 at 2:38 PM, Staff B, DNS, stated Resident 11's fall on 10/13/2025 should have been logged in the October 2025 incident reporting log and an investigation should have been conducted to rule out neglect. Staff B stated this did not meet their expectations. Review of the incident report investigation dated 10/21/2025 showed Resident 11 was witnessed on 10/21/2025 at 4:30 PM to stand up from their wheelchair, started walking and slipped down on their buttocks after a bingo activity in the dining room. Resident 11 was unable to give a description related to the fall. It showed interventions to be put in place after fall included therapy referral and to assist Resident 11 back to nursing station for opportunity to lay down or use the bathroom. Attached to this report included a therapy referral dated 10/22/2025 and signed by therapy on 10/26/2025, which showed that Resident 11 was on hospice and not appropriate for skilled physical therapy services on this date. During a joint interview on 12/09/2025 at 2:57 PM with Staff B, DNS, and Staff D, RCM, Staff D stated Resident 11's referral dated 10/22/2025 for fall on 10/21/2025 showed a screen was not completed for the resident. Staff B stated a referral for therapy should not have been an intervention and instead it should have been for a therapy screen. Both Staff B and Staff D stated that Resident 11's intervention to assist Resident 11 back to nursing station for opportunity to lay down or use the bathroom was initiated on 10/27/2025 which was not initiated within five days of the fall. Both Staff B and Staff D stated Resident 11's 10/21/2025 incident report investigation did not meet their expectations. Review of the incident report investigation dated 11/07/2025 showed Resident 11 was found on 11/07/2025 at around 8:00 AM sitting on the floor outside the door to their room. When (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked what they were doing, Resident 11 stated, I don't know. When asked if slid out of bed, Resident 11 responded, Yes. When asked if they fell, Resident 11 stated, Yes. The incident report showed Certified Nursing Assistants (CNAs) had reported that Resident 11 had been putting themselves on the floor for the past week. It showed new interventions included, Therapy Referral and encourage resident to get up out of bed for meals. The fall witness interview form dated 11/07/2025 was not completely filled out and did not show the last time the resident was toileted or when Resident 11 was changed or assisted to the bathroom. Review of Resident 11's therapy referral dated 11/11/2025 showed Resident 11 would be screened; however, the screen was not attached to the 11/07/2025 incident report investigation. Review of Resident 11's focused fall care plan attached to the 11/07/2025 incident report showed to wake Resident 11 up prior to breakfast, and offer to get them up in wheelchair, initiated on 11/07/2025 and revised on 11/11/2025. However, this exact intervention was also attached the focused care plan to Resident 11's fall on 10/05/2025; however, it showed it was initiated on 09/22/2025. Review of the fall follow up progress note dated 11/07/2025 showed/included, CNA's reported that [Resident 11] has been sliding out of bed and scooting' on the floor for the past week. Review of Resident 11's progress notes from 10/21/2025 through 11/24/2024 showed no documentation other than on 11/07/2025 that showed Resident 11 was sliding out of bed and scooting on the floor. Review of the facility's November 2025 incident reporting log showed Resident 11 had one fall on 11/07/2025 and no other falls were logged for Resident 11. During a joint interview on 12/09/2025 at 3:08 PM with Staff B, DNS, and Staff D, RCM, Staff D stated the therapy referral dated 11/11/2025 showed Resident 11 would be screened; however, unable to provide that document at this time and would contact therapy. Staff D stated the fall witness statement dated 11/07/2025 should have shown the last time Resident 11 was toileted. Staff D stated that there should have been a new intervention revised on Resident 11's care plan and not use one already used before. Staff B stated each time Resident 11 was found scooting on the floor as reported by the CNAs would be considered a fall and should have been investigated. Staff D stated the CNAs statement was not clear and should have been interviewed each time and this should have been reported each time if it was true that Resident 11 had been scooting on the floor for the past week. Staff B stated Resident 11's 11/07/2025 fall investigation did not meet their expectations. Reference WAC 388-97-0640 (6)(a)(b)(c)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 follow up on a Preadmission Screening and Resident Review (PASRR, a mental health screening tool) for 1 of 7 sampled residents (Resident 4) when reviewed for PASRR. This failure placed residents at risk for unmet needs and a decreased quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 14 admitted to the facility of 05/30/2025 with diagnoses of anxiety and depression. The resident was able to make needs known. Review of the EHR showed Resident 4 was screened for PASRR on 04/17/2025 and determined to require a level 2 PASRR for mood disorders. No level 2 PASRR was found in the EHR. During an interview on 12/04/2025 at 11:21 AM, Staff F, Social Services Director, stated Resident 4 transferred from another skilled nursing facility and they were told it was sent for review but on 12/02/2025 they reached out to the PASRR review team and learned it was never sent/received. Staff W stated they should have followed up sooner. Reference WAC [PHONE NUMBER](1)(2)(a)-(c)

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Gig Harbor Health and Rehabilitation	3309 45th Street Court Northwest Gig Harbor, WA 98335

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to initiate comprehensive care plans for 2 of 22 sampled residents (Residents 4 and 78) when reviewed for comprehensive care plans. Failure to initiate a plan of care for epilepsy for Resident 4 and ensure the care plan was accurate and included monitoring behaviors and side effects for use of antidepressant and antianxiety medication use for Resident 78 placed the residents at risk for unmet needs and a decreased quality of life. Findings included .Resident 78 Review of the electronic health record (EHR) showed Resident 78 readmitted to the facility on [DATE] with diagnoses to include dementia (a group of thinking and social symptoms that interferes with daily functioning), anxiety disorder, and depression. Resident 78 was able to make needs known. Review of the medication administration record (MAR) dated December 2025 showed Resident 78 was prescribed and received an antidepressant and antianxiety medication and was not prescribed nor receive an antipsychotic medication. Review of Resident 78's focused care plan for Antipsychotics initiated on 12/05/2024 showed the resident used an antipsychotic medication. Review of Resident 78's focused care plan for psychoactive medications initiated on 11/16/2025 showed it was initiated 41 days after antianxiety medication was ordered on 10/06/2025 and 301 days after antianxiety medication was ordered on 01/19/2025, showing it was not timely initiated. This focused care plan did not show/list target behaviors or side effects for staff to monitor for the use of antidepressant and antianxiety medications. During an interview on 12/08/2025 at 9:52 AM, Staff D, Resident Care Manager (RCM), stated a resident's care plan should be revised with a change in condition and as needed. Staff D stated when a problem/issue was identified it should be care planned immediately or as soon as possible. Staff D stated that Resident 78 had a focused care plan for antipsychotics; however, the resident was not receiving an antipsychotic medication. Staff D stated Resident 78's care plan should have included to monitor for behaviors and side effects for the use of antidepressant and antianxiety medications, and this did not meet expectations. During an interview on 12/08/2025 at 10:04 AM, Staff B, Director of Nursing Services (DNS), stated care plans were to be revised quarterly, annually, and with a change in condition. Staff B stated Resident 78's care plan should not have included antipsychotic medication use because the resident did not receive an antipsychotic medication. Staff B stated Resident 78's care plan should have had behaviors and side effects listed to monitor for the use of antidepressant and antianxiety medications. Staff B stated Resident 78's comprehensive care plan did not meet their expectations. Resident 4 Review of the EHR showed Resident 4 admitted to the facility on [DATE] with diagnoses of diabetes (too much sugar in the blood) and epilepsy (when the body has episodes of uncontrolled jerking movements). The resident was able to make needs known. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident plan of care initiated on 05/30/2025 showed no care plan entry with interventions for the diagnosis of epilepsy. During an interview on 12/05/2025 at 10:28 AM, Staff D, RCM, stated Resident 4's diagnosis of epilepsy should have been included in the plan of care. During an interview on 12/05/2025 at 11:00 AM, Staff B, DNS, stated it was their expectation that the care plans be comprehensive and Resident 4's diagnosis of epilepsy should have been addressed in the care plan. Reference WAC 388-97-1020(1)(2)(a)(b)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure provider's orders to monitor orthostatic blood pressure was followed for 1 of 5 sampled residents (Resident 5) when reviewed for unnecessary medications. This failure placed the resident at risk for dizziness when laying and sitting, avoidable falls, and a diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 5 admitted to the facility on [DATE] with diagnoses to include cerebral palsy (neurological disorders affecting movement, posture, and muscle tone), bipolar disorder (a brain disorder causing extreme shifts in mood, energy, and activity levels), schizoaffective disorder (a chronic mental illness blending symptoms of schizophrenia [like hallucinations, delusions, disorganized thinking] with symptoms of a mood disorder [depression or mania], and general anxiety disorder (GAD). Resident 5 was able to make needs known. Review of the provider's orders showed Resident 5 was to have orthostatic blood pressure (blood pressure reading taken in different positions) monthly, dated 02/01/2025. Review of the EHR showed no orthostatic blood pressure readings recorded. During an interview on 12/08/2025 at 1:56 PM, Staff Y, Registered Nurse/Resident Care Manager, stated the facility ensured a resident was not at risk of falling due to medications by monitoring orthostatic blood pressure. Staff Y stated Resident 5 had a provider's order to monitor orthostatic blood pressure, but the resident did not have orthostatic blood pressure readings in their EHR. Staff Y stated this did not meet expectations. During an interview on 12/08/2025 at 2:17 PM, Staff B, Director of Nursing Services, stated residents' orthostatic blood pressure was monitored to ensure they were not a fall risk due to medications. Staff B stated Resident 5 had orders for orthostatic blood pressure monitoring, but there was no documented monitoring. Staff B stated this did not meet expectations. Reference WAC 388-97-1620(2)(b)(i)(ii)(6)(b)(i)

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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 provide the necessary care and services to maintain physical and psychosocial well-being for 1 of 22 sampled residents (Resident 14) when reviewed for quality of life. Failure to provide an escort/caregiver for a dependent resident when going to a doctor's appointment placed the resident at risk for unmet care needs, diminished self-worth, and decreased quality of life. Findings included. Review of the electronic health record (EHR) showed Resident 14 admitted to the facility on [DATE] with diagnoses of hemiplegia (weakness on one side of the body), anxiety, and cognitive deficit. The resident was able to make needs known. During an interview on 12/02/2025 at 2:40 PM, Resident 14 stated they had gone out to a doctor's appointment that morning and did not have an escort. Resident 14 stated the driver dropped them off and left them there. Resident 14 was not able to navigate the doctor's office and missed their appointment. They then had a bowel movement in their wheelchair and had to navigate back to the facility alone. Review of the care plan initiated on 10/21/2025 showed Resident 14 was dependent on staff for toileting and transferring. During an interview on 12/03/2025 at 11:15 AM, Staff D, Resident Care Manager, stated that Resident 14 did not have an escort to the doctor's appointment but should have. During an interview on 12/03/2025 at 11:23 AM, Staff C, Assistant Director of Nursing, stated it was their expectation that a resident who was dependent on staff and was incontinent of bowel would need an escort for doctor appointments. During an interview on 12/03/2025 at 11:26 AM, Staff B, Director of Nursing Services, stated Resident 14 should have had an escort for the doctor's appointment on 12/02/2025. Reference WAC 388-97 -1060(1)-1620(a)-1020(2)(a)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and services to ensure a resident's ability to participate in activities of daily living did not diminish for 1 of 22 sampled resident (Resident 45) reviewed for activities of daily living (ADLs) and therapy services. Residents 45 experienced harm when they had a decline in mobility in the areas of sit to stand, toilet transfers and ambulation. This failure placed residents at risk of decreased mobility and a diminished quality of life.Findings included .Review of a facility policy titled, Activities of Daily Living (ADLs), dated 10/01/2021, showed Residents will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable.Resident 45 admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (lung condition caused by damage to the lungs), unsteadiness on feet and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). Resident 45 was able to make needs known.Observation and interview, on 12/02/2025 at 10:55 AM, showed Resident 45 lying in bed, their right ankle was elevated on a pillow and turned inward. Resident 45 stated their ankle was not inverted when they admitted to the facility and they were no longer able to stand due to the pain and the position of their ankle.Review of form titled Physical Therapy PT Evaluation, dated 04/04/2025, showed functional mobility assessment as follows:1. Transfers: Sit to stand= Partial/Moderate assistance.Chair/bed to chair transfer=Partial/Moderate assistanceToilet transfer=Partial/Moderate assistance.2. Ambulation: Walk 10 feet=Substantial/maximal assistance. Review of form titled Physical Therapy PT Evaluation, dated 06/03/2025, showed functional mobility assessment as follows:1. Transfers: Sit to stand= DependentChair/bed to chair transfer=DependentToilet transfer=Not attempted due to medical condition or safety concerns.2. Ambulation: Walk 10 feet=Patient refusedContracture: Functional limitations present due to contracture: NoReview of a progress note, dated 09/04/2025, showed an interview was conducted with Resident 45 for a quarterly assessment. Resident 45 had some deformity/contracture noted to right ankle-foot, will notify physical therapy.Review of the quarterly minimum data set assessment, dated 09/04/2025, showed the Functional limitation in range of motion section marked No.Review of a progress note, dated 11/12/2025, showed Resident 45 was seen by a therapist for evaluation. Included was a statement from Resident 45, The only reason you are seeing me is because I threatened to sue because of my foot. Therapy educated resident that therapy cannot address foot contracture as it requires surgical intervention. Resident 45 reported they were unable to stand due to right foot contracture.Review of Resident 45's Care plan, initiated 03/14/2025, showed no interventions related to a right ankle contracture.Review of form titled Physical Therapy PT Evaluation, dated 12/09/2025, showed functional mobility assessment as follows:1. Transfers: Sit to stand= Not attempted due to medical condition or safety concerns.Chair/bed to chair transfer=DependentToilet transfer= Not attempted due to medical condition or safety concerns.2. Ambulation: Not attempted due to medical condition or safety concerns.Contracture: Functional limitations present due to contracture: Yes Patient has bony deformity with inability to correct or achieve any range of motion (ROM). Nursing is managing patient's contracture impairment (Will discuss options with nursing and physician, recommend consult with orthopedic physician due to inability to attain any ROM with hard end-feel).During an interview on 12/08/2025 at 10:53 AM, Collateral Contact (CC), stated Resident 45's ankle had gotten progressively worse since admission and they didn't know what the facility had been doing about it. CC stated prior to admission Resident 45 was not fully walking but was able to shuffle around with their walker. During an interview on 12/04/2025 at 12:42 PM, Staff K, Physical Therapist, stated therapy ordered a brace for Resident (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45's ankle in April 2025 but it was not useful since the ankle was not a ligament issue. Staff K stated Resident 45 was upset that nothing was being done about the ankle. Staff K informed Resident 45 they would need to see an orthopedic provider to determine if there were alternative interventions. Staff K stated they informed the former nurse unit manager that Resident 45 needed a referral for orthopedic consultation but is unaware if there was any follow-up.During an interview on 12/09/2025 at 9:28 AM, Staff B, Director of Nursing Services (DNS)/ADON, stated when residents require possible surgical intervention nursing reports to the provider and the medical provider makes the decision to complete the referral. Staff B stated Resident 45's provider was made aware of the situation and there was nothing further the facility could have done.During an interview on 12/09/2025 11:00 AM, Staff X, Nurse Practitioner, stated the facility requested an orthopedic referral for Resident 45 that day (12/09/2025) which Staff X agreed to. Staff X stated they don't decline specialty requests for a referral if it is medically necessary and will help the resident's quality of life. Staff X stated they were unaware of a referral being previously discussed for Resident 45.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide treatment and services to maintain vision for 1 of 3 sampled residents (Resident 15) when reviewed for communication/sensory. This failure placed the resident at risk for unmet needs, continued visual impairment, and a diminished quality of life.Findings included . Review of the electronic health record (EHR) showed Resident 15 readmitted to the facility on [DATE] with diagnoses to include high blood pressure, stroke (blood flow to a part of the brain is blocked causing brain cells to die), and anemia (lack of healthy red blood cells). Resident 15 was able to make needs known. During an interview on 12/02/2025 at 12:18 PM, Resident 15 stated they had asked to see an eye doctor because their vision had declined and when they tried to read it was blurry. During a follow-up interview on 12/04/2025 at 11:05 AM, Resident 15 stated they had told a social worker that they wanted to see an eye doctor but that social worker no longer worked at the facility and no one else has followed up with them. Review of the quarterly minimum data set (MDS, a required assessment tool) dated 10/02/2025 showed Resident 15 had adequate vision with no corrective lenses. Review of Resident 15's current care plan on 12/04/2025 showed no focused care plan for vision. Review of Resident 15's care conference progress note dated 04/05/2025 showed ancillaries (providing support or activity) needed, included optometry (healthcare profession focused primary on eye and vision care). Review of the provider/encounter progress note dated 04/07/2025 showed Resident 15 was working with the social worker to schedule an optometry appointment. During an interview on 12/05/2025 at 10:55 AM, Staff F, Social Services Director (SSD), stated another social worker was responsible for working on the long-term care (LTC) caseload and that social worker was no longer employed as of 08/13/2025. Staff F stated Resident 15 should have been placed on the list to be seen by an optometrist, should have been seen prior to now, and this did not meet expectations. During an interview on 12/05/2025 at 11:57 AM, Staff A, Administrator, stated the social worker that should have followed up with Resident 15's vision concerns was terminated due to a pattern of failure to follow up. Staff A stated this did not meet their expectations. Reference WAC 388-97-1060 (3)(a)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to investigate the root cause of a fall, ensure new interventions were developed or timely initiated, and/or referrals/screenings were completed to minimize falls for 1 of 3 sampled residents (Resident 11) when reviewed for accidents/falls. This failure placed Resident 11 at risk for falls, injuries, medical complications and a diminished quality of life.Findings included. Review of the electronic health record (EHR) showed Resident 11 readmitted to the facility on [DATE] with diagnoses to include unsteadiness on feet, Alzheimer's disease (a progressive brain disorder causing difficulty with daily activities), anxiety disorder, and bipolar disorder (a brain condition causing extreme mood swings). Review of the quarterly minimum data set assessment (MDS) dated [DATE] showed Resident 11 had two or more falls since admission or prior assessment, received hospice care services (end of life care), and was able to make needs known. Review of the incident report investigation dated 09/13/2025 showed Resident 11 was found lying on their belly with a dry incontinent garment on, just outside the bathroom door in their room at 4:04 PM and told staff they wanted to use the bathroom. However, it did not clearly show the root cause of the fall. During an interview on 12/09/2025 at 2:09 PM, Staff B, Director of Nursing Services (DNS), stated Resident 11 was on urine retention medication and had a diagnosis of benign prostatic hyperplasia (BPH, non-cancerous enlargement of the prostate gland just below the bladder causing problems with urinating), and should have been checked to see if they were retaining urine and a post void residual (PVR, checking the urine that remains in the bladder after urinating) should have been completed. Staff B stated Resident 11's fall investigation dated 09/13/2025 did not meet their expectations for thorough investigation. Review of the incident report investigation dated 09/14/2025 showed Resident 11 was found on the floor crawling heading outside of their room at 5:28 AM and stated they were getting out of bed. It showed an intervention was to be put into place to wake Resident 11 up prior to breakfast and offer resident to get up rather than waiting for them to wake up. Review of the focused fall care plan showed Resident 11's intervention to wake the resident up prior to breakfast and offer to get resident up in their wheelchair was initiated on 09/22/2025 (eight days after Resident 11's fall on 09/14/2025). During a joint interview on 12/09/2025 at 2:27 PM with Staff B, DNS and Staff D, Residential Care Manager (RCM), both stated that an investigation was to be completed within five days. Staff D stated Resident 11's intervention for their fall on 09/14/2025 was initiated on 09/22/2025 which was not done timely and Staff B agreed. Review of the incident report investigation dated 10/05/2025 showed Resident 11 was observed crawling on the floor from their bed at around midnight, and Resident 11 stated they were hungry. This report showed new interventions included to update care plan for to keep wheelchair close to bed and locked so Resident 11 could get from bed to their wheelchair safely, and nighttime snack, and therapy to screen for appropriateness of bed height for transfers, and to speak with hospice related to therapy screen. Attached to the incident report was a therapy referral dated 10/16/2025 (11 days after Resident 11's 10/05/2025 fall) that showed it was signed and completed by therapy on 10/20/2025 (15 days after Resident 11's 10/05/2025 fall). Review of Resident 11's focused fall care plan revised on 10/13/2025 showed an intervention to make sure the wheelchair was close to the bed and locked so Resident 11 could get from bed to their wheelchair safely initiated on 06/10/2025 and revised on 10/14/2025 and intervention for Nighttime snack initiated on 10/14/2025 (both revised or initiated nine days after Resident 11's fall on 10/05/2025). Review of the progress note dated 10/13/2025 showed Resident 11 was found sitting on the floor between the bed and the door. Resident 11 stated that they crawled out of bed. This showed a subsequent fall occurred prior to interventions or therapy referral/screen from the 10/05/2025 were initiated. During an interview on 12/09/2025 at 2:38 PM, Staff B, DNS, stated the new interventions related to the fall of 10/05/2025 were not initiated timely in Resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11's care plan. Staff B stated Resident 11's therapy referral dated 10/16/2025 was late and should have been completed within five days of the fall. Staff B stated they were unable to locate documentation that hospice had input related to Resident 11's fall on 10/05/2025 and it should have been documented and attached to the incident report. Staff B stated Resident 11's 10/05/2025 incident report investigation did not meet expectations. Staff B stated Resident 11's fall on 10/13/2025 should have been logged in the October 2025 incident reporting log. Staff B stated this did not meet their expectations. Review of the incident report investigation dated 10/21/2025 showed Resident 11 was witnessed on 10/21/2025 at 4:30 PM to stand up from their wheelchair, started walking and slipped down on their buttocks after a bingo activity in the dining room. It showed interventions to be put in place after fall included therapy referral and to assist Resident 11 back to nursing station for opportunity to lay down or use the bathroom. Attached to this report included a therapy referral dated 10/22/2025 and signed by therapy on 10/26/2025, which showed that Resident 11 was on hospice and not appropriate for skilled physical therapy services on this date. During a joint interview on 12/09/2025 at 2:57 PM with Staff B, DNS, and Staff D, RCM, Staff D stated Resident 11's referral dated 10/22/2025 for fall on 10/21/2025 showed a screen was not completed for the resident. Staff B stated a referral for therapy should not have been an intervention and instead it should have been for a therapy screen. Both Staff B and Staff D stated that Resident 11's intervention to assist Resident 11 back to nursing station for opportunity to lay down or use the bathroom was initiated on 10/27/2025 which was not initiated within five days of the fall. Review of the incident report investigation dated 11/07/2025 showed Resident 11 was found on 11/07/2025 at around 8:00 AM sitting on the floor outside the door to their room. It showed new interventions included, Therapy Referral and encourage resident to get up out of bed for meals. Review of Resident 11's focused fall care plan attached to the 11/07/2025 incident report showed to wake Resident 11 up prior to breakfast, and offer to get them up in wheelchair, initiated on 11/07/2025 and revised on 11/11/2025. However, this exact intervention was also attached to the focused care plan of Resident 11's fall on 10/05/2025; however, it showed it was initiated on 09/22/2025. During a joint interview on 12/09/2025 at 3:08 PM with Staff B, DNS, and Staff D, RCM, Staff D stated the therapy referral dated 11/11/2025 showed Resident 11 would be screened; however, they were unable to provide that document at this time. Staff D stated that there should have been a new intervention revised on Resident 11's care plan and not use one already used before. Reference WAC 388-97- -1060(3)(g)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a behavioral health provider's recommendations for changes in mental health medications were considered/implemented for 1 of 5 sampled residents (Resident 5) when reviewed for unnecessary medications. This failure placed the resident at risk of ineffective mental health medication regimen, increase of avoidable behaviors, and a diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 5 admitted to the facility on [DATE] with diagnoses to include cerebral palsy (neurological disorders affecting movement, posture, and muscle tone), bipolar disorder (a brain disorder causing extreme shifts in mood, energy, and activity levels), schizoaffective disorder (a chronic mental illness blending symptoms of schizophrenia [like hallucinations, delusions, disorganized thinking] with symptoms of a mood disorder [depression or mania], and general anxiety disorder (GAD). Resident 5 was able to make needs known. Review of the provider's orders showed Resident 5 received clonazepam (a medication used for seizure disorders and panic disorders). Review showed Resident 5 received clonazepam one tablet every 12 hours as needed (PRN) from 05/13/2025 through 10/30/2025. Review showed Resident 5 received clonazepam one tablet every 12 hours PRN from 10/30/2025 through 11/07/2025. Review showed Resident 5 received clonazepam one tablet twice a day scheduled starting 11/07/2025 through 12/02/2025. Review showed Resident 5 received clonazepam twice daily PRN from 11/28/2025 through 12/02/2025. Review of a Psyche Follow-up progress note, dated 09/15/2025, showed a recommendation for facility staff to increase Resident 5's clonazepam to three times a day PRN. Review of a Psyche Follow-up progress note, dated 09/29/2025, showed Resident 5 reported difficulty remembering to request PRN clonazepam and requested the PRN order be changed to scheduled. Review showed a recommendation for facility staff to change Resident 5's clonazepam to scheduled two times daily for improved symptoms control. Review of a Psyche Follow-up progress note, dated 10/06/2025, showed Resident 5's behavioral health provider had recommended clonazepam be changed from PRN to scheduled, but this had not occurred. Review of a Psyche Follow-up progress note, dated 10/27/2025, showed Resident 5 had difficulty remembering to request PRN clonazepam and requested the order be changed to scheduled, but this change had not been implemented. During an interview on 12/08/2025 at 1:56 PM, Staff Y, Registered Nurse/Resident Care Manager, stated the facility had a behavioral health provider who would meet with residents to make recommendations for medication changes. Staff Y stated Resident 5's behavioral health provider had recommended clonazepam to be increased to three times daily on 09/15/2025 and recommended clonazepam be scheduled rather than PRN on 09/29/2025. Staff Y stated Resident 5's recommendations for clonazepam usage were not changed until 11/07/2025, and this did not meet expectations. During an interview on 12/08/2025 at 2:17 PM, Staff B, Director of Nursing Services, stated the facility had a behavioral health provider who would provide recommendations for changes to mental health medications. Staff B stated medication change recommendation provided by the behavioral health provider should be acted upon immediately. During an interview on 12/09/2025 at 9:17 AM, Staff B stated there had been an issue with communication between the behavioral health provider and the facility and Resident 5's clonazepam recommendations had not been addressed timely. Staff B stated this did not meet expectations. Reference WAC 388-97-1000(2)(f)(g)

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	505436	A. Building B. Wing	12/09/2025

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 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 ensure medically related social services, including follow up, monitoring and assessment of intervention effectiveness, were provided for a resident with a mental health diagnosis and a history of making negative statements for 1 of 22 sampled residents (Resident 30) when reviewed for medically related social services. This failure placed residents at risk for unwanted behaviors, unmet care needs, and a diminished quality of life.Findings included . Review of the electronic health record showed Resident 30 admitted to the facility on [DATE] with diagnoses of bipolar disorder (mental illness causing extreme shifts in mood alternating between high and low periods), depression, and chronic pain. Resident 30 was able to make needs known. Review of a progress note dated 11/29/2025 showed nursing staff documented Resident 30 stated they were so sad that their family did not come to visit they felt like dying. Review of Resident 30's mental health care plan, initiated 11/14/2025, documented interventions, If presents as a danger to self/suicidal, contact crisis hotline (988). If they present as a danger to others contact local law enforcement. Review of the medial record showed no documented follow up related to Resident 30's comment. During an interview on 12/04/2025 at 9:50 AM, Staff F, Social Services Director, stated social services should have followed up with Resident 30 after their comment related to dying to conduct an interview, put them on alert, and contact the crisis line if necessary. During an interview on 12/04/2025 at 9:58 AM, Staff D, Resident Care Manager, stated nursing staff should have coordinated with social services to make sure Resident 30 was interviewed, the provider was contacted, and the care plan was updated. Staff D stated the lack of follow-up did not meet their expectations. During an interview on 12/09/2025 at 9:28 AM, Staff B, Director of Nursing Services, stated Resident 30 should have been placed on alert and social services should have conducted an interview to determine level of distress. Staff B stated the lack of communication and intervention did not meet their expectations. Reference WAC 388-97-0960(1)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including providing medication without a dosage and not following a prescribed order) to meet the needs of 2 out of 3 sampled residents (Residents 51 and 37) when reviewed for medication administration. Failure to timely remove a medicated topical patch for Resident 51 and to provide medication without a dosage to Resident 37, placed residents at risk for medical complications and a poor quality of life.Findings included. Resident 51Review of the electronic health record (EHR) showed Resident 51 admitted to the facility on [DATE] with diagnoses to include dementia (a group of thinking and social symptoms that interfere with daily functioning), gout (painful inflammation/swelling of the joints), and diabetes (too much sugar in the blood). Resident 51 was able to make needs known. Observation and interview on 12/05/2025 at 9:15 AM showed Staff G, Licensed Practical Nurse (LPN), pulled off a lidocaine external patch (used to treat minor aches and pain in muscles and joints) from the left shoulder that was dated 12/04/2025. Staff G stated that the patch was to be applied for 12 hours and then removed and it should have been removed last night as prescribed. Review of the December 2025 medication administration record (MAR) from 12/01/2025 - 12/05/2025 showed Resident 51 had a start date of 12/03/2025 for Lidocaine External Patch 4% applied to the left should topically one time a day for pain, leave on for a maximum of 12 hours and remove per schedule. This MAR showed Resident 51 was administered the patch per provider's order; however, it did not have a place to document when the patch was removed. During an interview on 12/08/2025 at 9:25 AM, Staff B, Director of Nursing Services (DNS), stated Resident 15's December 2025 MAR had the order to apply the lidocaine patch to the left shoulder but there was not a removal attached to the order, and this did not meet expectations. Staff B stated this was a medication error. Resident 37Review of the EHR showed Resident 37 readmitted to the facility on [DATE] with diagnoses that included diabetes, heart failure, and depression. Resident 37 was able to make needs known. Observation and interview on 12/05/2025 at 7:25 AM showed Staff H, LPN, put docusate sodium (a laxative used to treat constipation) 100 mg in a med cup and then proceeded to provide it to Resident 37 along with other prescribed medications. Review of the December 2025 MAR from 12/01/2025 - 12/05/2025 showed Resident 37 had a start date of 09/26/2025 for docusate sodium tablet to be provided two times a day for constipation and to hold for loose stools. Documentation showed Resident 37 received the medication twice a day; however, the order did not indicate the dosage to be provided. During an interview on 12/05/2025 at 7:42 AM, Staff H, LPN, stated all medication orders should include a dosage. Staff H stated they should have clarified Resident 37's docusate order prior to giving the medication, but usually the order has a dosage for 100 mg. During an interview on 12/08/2025 at 9:30 AM, Staff B, DNS, stated Resident 37's December 2025 MAR order for docusate sodium being provided twice a day did not include a dosage and there should have been one. Staff B stated the provider should have been called and the order verified/clarified to include the dosage, and this did not meet their expectations. Reference WAC 388-97-1300(1)(a)(b)(i)(ii)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently provide non-pharmacological interventions (NPI, health interventions/approaches used instead of medication) for 2 of 5 sampled residents (Residents 5 and 78) when reviewed for unnecessary medications. This failure placed the residents at risk of receiving unnecessary medications, avoidable medication side effects, and a diminished quality of life. Findings included.Resident 5 Review of the electronic health record (EHR) showed Resident 5 admitted to the facility on [DATE] with diagnoses to include cerebral palsy (neurological disorders affecting movement, posture, and muscle tone), bipolar disorder (a brain disorder causing extreme shifts in mood, energy, and activity levels), schizoaffective disorder (a chronic mental illness blending symptoms of schizophrenia [like hallucinations, delusions, disorganized thinking] with symptoms of a mood disorder [depression or mania], and general anxiety disorder (GAD). Resident 5 was able to make needs known. Review of provider's orders showed Resident 5 received tramadol (opioid pain medication used for moderate to severe pain) as needed (PRN), dated 01/19/2025. Review showed Resident 5 should receive NPI before the use of tramadol. Review of the September 2025 medication administration record (MAR) showed Resident 5 received PRN tramadol without NPI on 6 of 14 opportunities. Review of the October 2025 MAR showed Resident 5 received PRN tramadol without NPI on 6 of 11 opportunities. Review of the November 2025 MAR showed Resident 5 received PRN tramadol without NPI on 4 of 15 opportunities. During an interview on 12/08/2025 at 1:56 PM, Staff Y, Registered Nurse/Resident Care Manager (RN/RCM), stated the facility used other interventions, like breathing exercises or stretching, before providing PRN pain medications to ensure the medications were necessary. Staff Y stated the expectation was to provide these NPI prior to PRN pain medication usage. Staff Y stated Resident 5 not consistently receiving NPI prior to PRN pain medication usage did not meet expectations. During an interview on 12/08/2025 at 2:17 PM, Staff B, Director of Nursing Services (DNS), stated the facility used NPI prior to providing PRN pain medications to ensure the medications were necessary. Staff B stated Resident 5's lack of consistent NPI use prior to PRN pain medications did not meet expectations. Resident 78 Review of the EHR showed Resident 78 readmitted to the facility on [DATE] with diagnoses to include dementia (a group of thinking and social symptoms that interfere with daily functioning), anxiety disorder, and diabetes (too much sugar in the blood). Resident 78 was able to make needs known. Review of the November 2025 MAR showed Resident 78 had orders for acetaminophen (used to treat minor aches and pain) prescribed as needed for pain and orders to monitor pain and document NPI (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with a code number. Documentation showed acetaminophen was provided on 11/16/2025; however, instead of an NPI code, NA was documented. Review of Resident 78's progress notes for 11/16/2025 showed no documentation that NPI were provided prior to the as needed acetaminophen was administered. During an interview on 12/08/2025 at 9:44 AM, Staff D, RCM, stated Resident 78's MAR showed they were provided as needed acetaminophen on 11/16/2025; however, it was documented NA for the NPI intervention instead of an NPI code. Staff D stated they were unable to locate a progress note to show that an NPI was provided prior to Resident 78 being given the as needed pian medication on 11/16/2025. During an interview on 12/08/2025 at 10:51 AM, Staff B, DNS, stated that the expectation was that nurses provided NPI prior to giving as needed pain medication and it should be documented in the MAR and/or a progress note. Staff B stated Resident 78's documentation on 11/16/2025 related to NPI and as needed pain medication provided did not meet their expectations. Reference WAC 388-97-1060(3)(k)(i)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure proper storage and labeling of medications in 1 of 3 medication carts (Run Four Medication Cart) and 1 of 2 medication rooms (Peak Medication Room) when reviewed for medication storage. This failure placed residents at risk of receiving expired medications, ineffective treatment, and diminished quality of life. Findings included.Observation on 12/05/2025 at 12:35 PM, with Staff C, Assistant Director of Nursing, showed Peak Medication Room refrigerator with missing temperature logs for the evening time on 12/03/2025 and 12/04/2025. The medication refrigerator stored medications and tuberculin testing supplies (a skin test to help diagnose tuberculosis [TB] infection). Staff C stated the expectation was for Licensed Nurses to document the temperature twice a day, morning and evening. Staff C could not provide temperature logs for November 2025. Observation and interview on 12/08/2025 at 10:56 AM showed the Run Four Medication cart with expired medication slow magnesium chloride with calcium tablets dated expiration of October 2025, and an insulin pen opened and used without date or name. Staff DD, Registered Nurse, stated the insulin and tablets with slow magnesium chloride and calcium were expired. During an interview on 12/08/2025 at 12:26 PM, Staff B, Director of Nursing Services, stated the medications stored in refrigerator were to have twice a day documentation of the temperature, and the medications on the carts were to be dated when opened and discarded when expired. Staff B stated the refrigerator temperature monitoring, and the expired medications did not meet expectations. Reference WAC 399-97-1300(2)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide dental services for 1 of 2 sampled residents (Resident 1) reviewed for dental needs. This failure placed the resident at risk of having discomfort, difficulties eating, and diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 1 was admitted to the facility on [DATE] with diagnoses to include spondylolisthesis lumbar region (condition when one vertebra [spine bone] slips forward onto vertebra below causing pain and nerve damage), atrial fibrillation (irregular heartbeat), bipolar disorder (brain disorder causing extreme mood swings from manic highs to depressive lows) and heart failure. Resident 1 was able to communicate needs. Observation and interview on 12/02/2025 at 11:59 AM showed Resident 1 in bed with missing upper teeth. Resident 1 stated they had problems with their teeth and need a denture. Review of the EHR showed Resident 1 was seen by a dental hygienist on 08/21/2025 with a recommendation for a dentist. Review of the EHR showed no referral or follow up information about a dentist. During an interview on 12/09/2025 at 11:32 AM, Staff B, Director of Nursing Services, stated the process was to obtain an order and social services would set up the appointment, and that should be documented in the record. Staff B stated Resident 1's dental services did not meet expectations. Reference WAC 399-97-1060(3)(j)(vii)