STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505507	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shelton Health and Rehabilitation	153 Johns Court Shelton, WA 98584

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat residents with respect and honor privacy while having private conversations for 1 of 1 sampled resident (1) reviewed for privacy. This failure placed residents at risk for diminished self-worth, self-esteem, and feelings of embarrassment.Findings included. Resident 1 was admitted to the facility on [DATE] with diagnoses of dementia, post-traumatic stress syndrome (a mental health condition that's caused by an extremely stressful or terrifying event), and diabetes mellitus. The quarterly minimum data set, an assessment tool, dated 06/30/2025, documented Resident 1 had moderate cognitive impairment and required substantial assistance with activities of daily living.The care plan, dated 12/08/2024, documented Resident 1 was dependent on staff to meet emotional, intellectual, physical, and social needs. Staff will converse with the resident while providing care and will anticipate the residents' needs.On 08/18/2025 at 2:08 pm, Resident 1 reported that sometimes staff would hang out in their room when they have company. Resident 1 motioned towards the entry of their room and pointed out Staff J, Housekeeping, was doing this during our conversation. Resident 1 said they felt like staff did this intentionally to overhear conversations. At this time, Resident 1 asked Staff J if someone could address the toilet bowl as it was still soiled after housekeeping had cleaned their room earlier. Staff J went and got Staff K, Housekeeping, to address the residents' concerns. While Resident 1 and this writer continued to speak about the resident's care, Staff K proceeded to dust the area around resident's bed, where the resident was laying. Staff K leaned over the bedside table, directly between the resident and this writer, and dusted the light fixture above the bed. Next, Staff K dusted the light fixture in an unoccupied space next to Resident 1's bed. Then, Staff K dusted the bottom of the bedside table directly next to this writer's feet. Staff K proceeded to clean and dust other areas in Resident 1's main room, where we were talking. Resident 1 then asked Staff K to go and clean the bathroom, where the original concern was, while we were talking. Staff K went to the bathroom and cleaned the area of concern. Staff J remained at the entrance of the room during the entire conversation. Resident 1 said see, this is what I was talking about. Resident 1 explained how uncaring it is to intrude on the residents' privacy and how staff lacked empathy. After Staff K was done cleaning the bathroom, Staff K came out into the room and asked if we were done talking. We concluded our conversation at that time.On 09/12/2025 at 3:00 pm, Staff I, Housekeeping, said housekeeping staff should respect the resident's privacy when they have guests. If privacy were required, Staff I would do another task instead.On 09/18/2025 at 2:15 pm, Staff B, Registered Nurse and Director of Nursing Services, said there was a privacy issue where housekeeping staff were cleaning in Resident 1's room. Staff B said staff should not have been cleaning near Resident 1 and this writer while having a conversation. Staff B said she would be talking with housekeeping about the issue.Reference WAC 388-97-0180(1-4)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure sufficient staffing levels were met to follow the plan of care and services for 5 of 10 residents (1, 2, 4, 5 & 6) reviewed for staffing. This failure placed residents at risk for unmet physical, mental and psychosocial needs, a decline in health status and a diminished quality of life.Findings included.Resident interviews, observations & record review1) Resident 1 was admitted to the facility on [DATE] with diagnoses of dementia, post-traumatic stress syndrome (a mental health condition that's caused by an extremely stressful or terrifying event), and diabetes mellitus. The quarterly minimum data set (MDS), an assessment tool, dated 06/30/2025, documented Resident 1 had moderate cognitive impairment and required supervision with bathing.Record review of the care plan, dated 02/26/2025, showed Resident 1 will have a shower on Sunday and Wednesday.On 08/18/2025 at 2:08 pm, Resident 1 said the facility had staffing problems. Resident 1 said medications were late, there were long waits to answer the call light, and staff rush when assisting the resident. The resident said staff did not spend time with the residents. Resident 1 said showers did not always happen or did not happen on their preferred day. Resident 1 said they preferred to shower on Sundays, so they were clean for church. The resident said it was annoying when they did not get their shower when they preferred.Record Review of bathing documentation, dated 08/13/20025 to 09/12/2025, showed Resident 1 received 3 of 8 bathing opportunities. One shower was not given on the planned day.2) Resident 2 was admitted to the facility on [DATE] with diagnoses of asthma, and chronic pain syndrome. The quarterly MDS, dated [DATE], documented Resident 2 had no cognitive impairment and was dependent on staff with many activities of daily living (ADLs).Record review of the care plan, dated 10/08/2024, showed Resident 2 will have baths on Tuesdays and Saturdays.On 09/18/2025, at 12:22 pm, Resident 2 said the facility had staffing issues. Resident 2 said baths were not consistently getting done. The resident said the facility pulled the bath aides (BA) to the floor when they must cover a shift or someone calls in sick. Then, it was the nursing assistants (NA) responsibility to get the baths while being responsible for all their other duties. So, baths did not always happen. The facility would make temporary fixes to the staffing issues, but nothing would stick and eventually, it goes back to how it was.Record review of bathing documentation, dated 08/13/20025 to 09/12/2025, showed Resident 2 received 3 of 8 bathing opportunities.3) Resident 3 was admitted to the facility on [DATE] with diagnoses of major depressive syndrome and spinal stenosis (narrowing of the spine, which puts pressure on the spinal cord and nerves causing pain). The quarterly MDS, dated [DATE], documented Resident 3 had moderate cognitive impairment and required substantial assistance with ADLs.On 09/12/2025 at 2:19 pm, Resident 3 said there was a problem with staffing. Resident 3 said there were not enough staff to answer the call light promptly. Often, the resident waited for 20 minutes or longer to have the call light answered. Resident 3 said they were often waiting to use the bathroom and the resident needed two people to assist them. Resident 3 said weekends and lunch time were the worst times.4) Resident 4 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (lung and airway diseases that restrict your breathing) and a cerebral vascular accident (a stroke). The admission MDS, dated [DATE], documented Resident 4 had no cognitive impairment and required moderate assistance with ADLs.Record review of the care plan, dated 05/23/2025, showed Resident 4 required an assist of one staff, using a slide board, to use the bath.On 07/22/2025 2:04 pm, Resident 4 appeared disheveled and in a gown. Resident 4 had many sores and scabs visible along their arms and legs.Record review of bathing documentation, dated 08/13/20025 to 09/12/2025, showed Resident 4 would receive showers every Monday, Thursday, and Saturday at noon. Resident 4 received 8 of 12 bathing opportunities.5) Resident 5 was admitted to the facility on [DATE] with diagnoses of dementia and major depressive disorder. The quarterly MDS, dated [DATE], documented Resident 5 had severe cognitive impairment and required moderate assistance with ADLs.Record review of the care plan, dated 04/25/2025, documented Resident 5 would receive showers every Tuesday and Friday.Record review of bathing documentation, dated 08/13/20025 to 09/12/2025, showed Resident 5 received 4 of 8 bathing opportunities.6) Resident 6 was admitted to the facility on [DATE] with diagnoses of left tibia fracture (lower leg break) and pressure ulcer (injuries to the skin and the tissue below the skin that are due to pressure on the skin for a long time) of the right foot. The quarterly MDS, dated [DATE], documented Resident 6 had severe cognitive impairment and was dependent on staff with bathing.Record review of the care plan, dated 05/23/2025, documented Resident 6 will receive a bed bath every Sunday and Wednesday.On 09/18/2025 at