

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER Shelton Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Actual harm Residents Affected - Few	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 prevent and limit the spread of a gastrointestinal (GI) illness and Norovirus (a virus causing acute GI outbreaks in long-term care facilities, resulting in symptoms such as nausea, vomiting, and diarrhea, which rapidly spread from person to person) by ensuring GI Contact Precaution(limiting direct or indirect contact with the resident or environment by wearing gown and gloves during resident care for residents requiring transmission based precautions and washing hands with soap and water) were followed for 23 of 34 (1, 2, 5, 6, 7, 8, 9, 11, 13, 15, 17, 18, 19, 20, 24, 25, 26, 27, 30, 31, 33, 35, and 36) residents reviewed for a GI or Norovirus illness. The facility failed to cohort (a group of residents with similar symptoms) and isolate residents with the illness and protect residents exposed to the illness. Residents 1 and 2 experienced harm when they developed nausea, vomiting and/or diarrhea that required treatment with medication when they were not moved to a different location after their roommate showed signs of a GI illness. The facility failed to consistently surveille potential and active illness in resident and staff. The facility failed to notify the local health jurisdiction, residents, families, and the public in a timely manner of the outbreak. The facility failed to remove Resident 1 from isolation in accordance with the facility policy. These failures placed the residents, visitors, and staff at an increased risk of GI illness or Norovirus and diminished quality of life.Findings included.<Room Assignments>The facility policy, Norovirus Prevention and Control, revised 07/16/2025, documented the facility will follow guidelines and established standards of practice observed by the Center for Disease Control and Prevention (CDC) for Norovirus prevention and control.The CDC recommendations, Key Infection Control Recommendations for the Control of Norovirus Outbreaks in Healthcare Settings, undated, documented when a Norovirus infection is suspected, adherence to personal protective equipment (PPE) use according to GI Contact Precautions (CP) when entering the resident care area. Symptomatic residents should be placed in single occupancy rooms. If unable to accommodate single occupancy rooms, efforts should be made to separate the symptomatic residents from asymptomatic residents. These efforts may include placing a cohort of residents in multi-occupancy rooms or in designating care area. Minimize resident movements within a facility during a Norovirus outbreak. Restrict symptomatic and recovering residents from leaving the designated area unless it is for essential care or treatment. Suspend group activities for the duration of a Norovirus outbreak. Place residents with Norovirus on CP for a minimum of 48 hours after the resolution of symptoms. Exclude ill personnel from work for a minimum of 48 hours after the resolution of symptoms. The importance of performing frequent hand hygiene should be reinforced. During outbreaks, use soap and water for hand hygiene after providing care or having contact with residents suspected or confirmed with Norovirus.Resident 1Resident 1 was admitted to the facility on [DATE] with diagnosis of chronic obstructive pulmonary disease (a lung disease which makes it hard to breathe). The quarterly (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 505507	Facility ID: 505507
		If continuation sheet Page 1 of 13

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F 0880 Level of Harm - Actual harm Residents Affected - Few	minimum data set (MDS), dated [DATE], documented Resident 1 had no cognitive impairment and was dependent on staff with activities of daily living (ADLs).Resident 24 was admitted to the facility on [DATE] with diagnosis including diabetes mellitus (a condition where the body does not produce enough insulin). The quarterly MDS dated , 05/27/2026, documented Resident 24 had severe cognitive impairment and was dependent on staff with ADLs.On 07/22/2026 at 12:17 PM, Resident 1 said her roommate, Resident 24, became ill two days before they did. Resident 1 said they were not offered a different room once their roommate became ill. Resident 1 said they felt they were bound to get the illness. Resident 1 said they had nausea then vomiting, lasting three days. The resident said this was really tough. They said they were on isolation a long time and it felt like two weeks. Resident 1 said they stayed in their room about four days total. Resident 1 said they were told they had to wear a mask and wash their hands if they left the room. Resident 1 said they felt like the illness was probably spread by staff who did not wash their hands properly. Review of Nursing Progress notes, dated 07/09/2026, documented Resident 24 had a poor appetite, nausea and vomiting.Progress notes, dated 07/10/2026, documented Resident 1 had several episodes of vomiting in the evening.The Medication Administration Record (MAR), dated July 2026, documented Resident 1 required Geri-lanta (a medication used for GI upset) on 07/10/2026 and 07/13/2026.Resident 2Resident 2 was admitted to the facility on [DATE] with diagnosis including a stroke. The annual MDS, dated [DATE], documented Resident 2 had no cognitive impairment and was dependent on staff with ADLs. Resident 17 was admitted to the facility on [DATE] with diagnosis including diabetes mellitus. The admission MDS, dated [DATE], documented Resident 17 had no cognitive impairment and was dependent on staff with ADLs.On 07/22/2026 at 3:13 PM, Resident 2 was observed in her bed. The resident could not answer historical questions. Resident 2 appeared to have limited range of motion requiring dependence on staff with ADLs. On 07/23/2026 at 10:42 AM, Resident 2's family member (FM) said she was not made aware of a GI outbreak at the facility until they went to visit Resident 2 who was sick at that time of the visit. Resident 2 had vomiting and diarrhea. Resident 2's FM was not told when or if the resident had been exposed to the GI illness. A new room was not offered to the resident once her roommate became symptomatic.At 2:23 pm, Staff K, Registered Nurse (RN), said Resident 2 became symptomatic once the outbreak spread to their hall. She was not sure who had the illness first, Resident 17 (Resident 2's roommate) or Resident 2. Resident 2 had started to develop symptoms of vomiting and diarrhea during the night. When the family came into visit during the day, she informed the family Resident 2 was symptomatic.Progress notes, dated 07/09/2026, documented Resident 17 had an episode of diarrhea.Progress notes, dated 07/10/2026, documented Resident 2 had vomiting and diarrhea.The MAR, dated July 2026, documented Loperamide (a medication used to treat diarrhea) was administered to Resident 2 on 07/10/2026. The Daily Census sheet, dated 07/12/2026, showed four unused resident rooms. On 07/22/2026 at 2:54 PM, Resident 15 and Resident 34 were observed talking in their rooms. Resident 15 said they were very ill with the whole works. This included nausea, vomiting, and diarrhea. The resident said, it was really bad and they were really miserable. Resident 15 said it lasted about three to four days. Resident 34 said they did not get ill and they tried to stay on their side of the room during Resident 15's illness. Resident 34 said they were not offered a different room during this time. Resident 15 said CP lasted several days after her symptoms resolved. Resident 15 said they felt the residents near the doorway got sick first and they felt the illness was spread by the staff not washing their hands. On 07/23/2026 at 3:30 PM, Staff E, said the facility had a GI and Norovirus outbreak. They first started seeing symptoms of nausea, vomiting, and diarrhea. This started on 07/07/2026 with more cases on 07/08/2026. Then it spread throughout the facility. Staff E said they did not consider moving residents who were asymptomatic out of the symptomatic (continued on next page)		

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F 0880 Level of Harm - Actual harm Residents Affected - Few	residents' rooms. She acknowledged the facility had open rooms they could have used for asymptomatic residents. Staff E said she heard somewhere, she was not sure where, they no longer recommend moving residents out of rooms or cohorting residents. Staff E said she was not familiar with the facilities policy directing staff to move residents who were asymptomatic to another room. Staff E stated that residents become contagious once they show signs of symptoms and they would have had time to move the asymptomatic residents. Staff E said she did not review the facility policy or the CDC Centers for Disease Control recommendations. She said she did discuss the GI outbreak guidance with Staff B, RN/Director of Nursing Services. Staff E acknowledged Resident 1 was out in the common area while on isolation. Staff B agreed both Resident 1 and Resident 2 became symptomatic after their roommates' showed symptoms and would have had time to move the residents out of their rooms and they did not follow the policy of moving roommates or cohorting residents. On 07/28/2026 at 3:25 PM, Staff B stated residents on isolation were in the hallways with other asymptomatic residents. Staff B said they did not follow their policy for Norovirus outbreaks. Staff B said the outbreak did not go as it should have.<Prevention & Observations>On 07/13/2026 at 11:45 AM, Staff C, RN, said they were waiting for results on a Norovirus test to determine if a resident had the virus. At 12:02 PM, Resident 5's room was observed to have a sign directing staff to follow GI CP and another sign directing staff on how to don (apply) a gown, gloves, and a mask. At 12:05 PM, an unknown staff member came to Resident's 5 room entryway carrying the resident's lunch tray. The staff member had a gown, gloves, and mask already on and did not wash their hands or apply clean PPE at the room entryway. The staff did not wash their hands at the sink once they dropped off the tray and left the room. At 12:20 PM, Resident 1, Resident 3, Resident 8, and Resident 37 were all observed in a common area near sitting or standing close to each other. On 07/14/2026 at 12:23 PM, a sign was posted on the front entry indicating the facility was having a Norovirus outbreak and provided visitors with guidance on methods to prevent the spread of the illness. At 12:25 PM, Staff B said masks were not needed in the hallway but I would put one on if you go in the rooms. Staff B said they have a few residents left on precautions but are at the end of the outbreak. At 12:35 PM, Staff J, Physical Therapy Assistant, was observed to enter Resident 30's. Staff J did not perform hand hygiene or don a gown and gloves before entering the room. Staff J had a mask on his face and did not don a clean mask when entering the resident's room. At this time, Staff D acknowledged Staff J entered Resident 30's room without proper PPE or hand hygiene. Staff D pointed to the signs posted outside the resident's door directing staff to wear PPE, including masks. Staff D said there is no reason to wear masks in the hallways because the GI illness is spread by contact with residents or the environment. At 12:40 PM, Staff J pushed Resident 30 out of the room, without changing his mask or hand hygiene. He pushed the resident to a common area in the facility and performed exercises with them. At 12:48 PM, Staff J returned Resident 30 to their room without donning PPE or performing proper hand hygiene. At 12:53 PM, Staff F, Nursing Assistant (NA), entered Resident 30's room donning a clean gown and gloves after hand hygiene. Staff F did not change the mask on her face before entering the room. Staff F obtained a dirty food tray from the room. At 12:54 PM, Staff F removed her gown and gloves and washed her hands with soap and water. She did not change her mask when leaving the resident's room. Staff F was observed adjusting her mask with her hands. At the same time, Staff G, NA, was observed to enter Resident 11's room donning a clean gown and gloves after hand hygiene. Resident 11's room was observed to have a sign directing staff to follow GI CP. Staff G did not change the mask on their face before entering the room. Staff G obtained a dirty food tray from the room. She removed her gown and gloves and washed her hands with soap and water. She did not change her mask. When asked why they were wearing masks, Staff F said there is a bug going (continued on next page)		

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F 0880 Level of Harm - Actual harm Residents Affected - Few	around here. Both Staff said they did not change their mask when they entered the CP rooms. Staff F, Staff G, and Staff H, NA, said they change their masks periodically but not in between each resident's rooms. All three staff said they touch the residents' environment when entering the residents rooms. They said they received education from Staff E, RN and Infection Preventionist (IP), on how the GI illness is spread and what PPE to wear. They said they did not get education on replacing their mask between residents. At 1:49 PM, Staff I, NA, was observed in Resident 13's room with a mask on. Staff I then left the room, used hand sanitizer hanging in the hallway to wash his hands. Staff I did not change his mask and proceeded down the hall. Staff I was observed touching his mask to adjust it with his hands. Staff I said he believed the outbreak started about 3-4 days ago. Residents had symptoms including stomach distress, diarrhea, nausea, and vomiting. Staff I said he is wearing the mask due to the outbreak and changes it a few times a day. Staff I said he did not get education regarding precautions needed during the outbreak but noticed the sign on the door when entering the building. He had been warned earlier to wash his hands with soap and water, however. At 1:52 PM, Staff E said some residents came out of CP today and the GI outbreak was resolving. At 1:59 PM, Staff J said he was wearing a mask due to the current GI outbreak. Staff J said he wears the same mask all day without changing it. Staff J was observed to adjust his mask with his hands. Staff J said he did not wash his hands or wear PPE when entering and exiting Resident 30's room which required CP. He acknowledged he had Resident 30 in a common area doing therapy and the resident was on CP. Staff J said he was told there was a stomach bug going around but did not receive education on precautions to take during the outbreak or when to change his mask. Staff J said, I may have brought residents to the therapy room who were on precautions, adding I probably did. On 07/23/2026 at 11:56 AM, Collateral Contact (CC) A, Public Health Nurse and Local Health Jurisdiction, said she was notified of the outbreak on 07/13/2026. The facility did not ask for any assistance in managing the outbreak. CC A said masks are not used for a GI outbreak or Norovirus because the illness is not spread through the air or droplets. Masks should not have been used in the hallways, and all PPE should be changed between residents. CC A said residents are contagious as soon as they show signs or symptoms of the illness. At this time, the facility should have moved the asymptomatic residents out of the double rooms. CC A said the facility should have acted promptly. CC A said she was disappointed with the facility's response to the outbreak. On 07/23/2026 at 2:14 PM, Staff AA, Dietary Manager, said staff were given education to wear a mask in the hallways during the GI illness. Staff were instructed to change masks between residents. At 2:37 PM, Staff O, LPN, and Staff P, LPN, said a lot of staff were wearing mask during the GI outbreak, but they were not sure why since the virus is spread by contact. They felt maybe staff felt better wearing masks. On 07/23/2026 at 3:30 PM, Staff E said they first started seeing symptoms of nausea, vomiting, and diarrhea in residents. Staff E said they notified staff of the GI outbreak and instructed them to start monitoring residents. Staff E said all residents were on isolation until 07/14/2026 and 07/15/2026. This included Resident 1 and Resident 8, who were in the common hallways with other residents. Staff E said she educated staff on how the virus was spread and the proper GI CP. Staff E said staff should wear a clean gown and gloves when entering a CP resident's room and use soap and water to wash hands. Staff E said she did not know why so many staff wore masks in the halls. She said she did not education staff to wear masks. Staff E said she educated staff on changing masks between resident rooms, and they have had this education many times in the past. Staff E showed documentation she did not educate housekeeping staff, three of whom were symptomatic, until 07/14/2026 and therapy staff until 07/22/2026. On 07/28/2026 at 3:25 PM, Staff B said she was aware staff did not follow GI CP, proper hand hygiene procedures, or changing of mask between (continued on next page)		

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F 0880 Level of Harm - Actual harm Residents Affected - Few	resident rooms.<Surveillance>The LTC Acute Gastroenteritis Surveillance Line List - Resident Only, undated, listed 18 residents with the illness including symptoms of nausea, vomiting, and diarrhea. Seven of the eighteen residents listed did not have an onset date listed. One stool specimen was collected for Resident 19, confirming Norovirus. No other residents were tested for Norovirus. Symptom resolution was noted for 5 residents. The identified space used to confirm if the GI illness was related to the GI or Norovirus outbreak was blank for all 18 residents. Five residents (Resident 2, 20, 33, 35, and 36) with GI symptoms documented in the medical record were absent from the log. Record review and line listing showed the following: 07/07/2026 - Resident 7, Resident 11, and Resident 18 had either nausea, vomiting, or diarrhea. Resident 7 was roommates with Resident 6. Resident 8 had a roommate. Resident 11 had a roommate. 07/08/2026 - Resident 9, Resident 5, Resident 30, and Resident 13 had either nausea, vomiting, or diarrhea. Resident 9 had a roommate and was positive for Norovirus. Resident 30 had a roommate. Resident 13 had a roommate. 07/09/2026 - Resident 6, Resident 27, Resident 17, Resident 24, and Resident 20 had either nausea, vomiting, or diarrhea. Resident 17 is roommates with Resident 2. Resident 24 is roommate with Resident 1. Resident 20 is roommates with resident 19. Resident 20 was not represented on the Line List. 07/10/2026 - Resident 31, Resident 2, Resident 1, Resident 25, and Resident 33 had either nausea, vomiting, or diarrhea. Resident 31 had a roommate. Resident 2 and Resident 33 were not represented on the Line List. 07/12/2026 - Resident 15 had diarrhea. Resident 15 is roommates with Resident 34. 07/13/2026 - Resident 26 and Resident 19 had either nausea, vomiting, or diarrhea. The LTC Acute Gastroenteritis Surveillance Line List - Staff Only, undated, documented ten staff members were identified as having symptoms including nausea, vomiting, and diarrhea. The onset and resolution date was listed for 4 of the 10 staff. The log did not indicate what unit/residents the staff worked with or when they returned to work. Staff K, RN, worked 07/02/26 - 07/04/2026. She had symptoms of nausea, vomiting, and diarrhea on 07/01/2026 with a resolution of symptoms on 07/04/2026. Staff R, LPN, worked 07/07/2026 - 07/09/2026. She had symptoms of nausea, vomiting, and diarrhea on 07/10/2026 with a resolution of symptoms on 07/12/2026. Staff R returned to work 07/13/2026 - 07/15/2026. Staff V, NA, was listed as having symptoms of nausea, vomiting, and diarrhea. No onset date or resolution date was listed for the staff. Staff V worked 07/07/2026 - 07/09/2026 and 07/12/2026 - 07/16/2026. Four housekeeping staff were noted as having nausea, vomiting, and diarrhea with no onset or resolution dates. The surveillance did not identify any trends or patterns with the staff line list. On 07/14/2026 at 1:06 PM, Staff G, NA, said residents have been exhibiting signs and symptoms of vomiting and diarrhea for about 7-9 days. She said the illness started on Team 1 then subsequently spread to each wing, pointing down the hall. On 07/23/2026 at 11:56 AM, CC A, said she was notified of the outbreak on 07/13/2026. The facility did not ask for any assistance in managing the outbreak. Later, after the 13th, the facility provided a line list of residents and staff with missing dates and information. At 2:23 pm, Staff K, RN, said the GI illness started on Team 1 (Rooms 148-169) then later spread to Team 2 (Rooms 129-146) and Team 3 (Rooms 102-127). Residents' symptoms included nausea, vomiting, and diarrhea. Staff were notified to monitor residents for the GI illness. Resident 6 became ill after their roommate Resident 7. Resident 6 has some episodes of poor appetite normally, but they refused food for a couple days, vomiting and required Tylenol (a pain medication). Staff K thought the symptoms Resident 6 experienced were out of the ordinary for them but added it was hard to tell. Staff K said she was off a couple days, and Resident 6 appeared much better after she returned. At 2:37 PM, Staff O, LPN, said the outbreak occurred a couple of weeks ago and initially showed up in rooms on Team 1. These rooms were put on isolation. Slowly, one or two residents showed up with symptoms. The symptoms lasted 24-48 hours. (continued on next page)		

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F 0880 Level of Harm - Actual harm Residents Affected - Few	07/13/2026 after they got a positive Norovirus test on Resident 9. The GI outbreak was resolved by 07/14/2026. Staff E said family and residents should have been notified of the outbreak. On 07/28/2026 at 3:25 pm, Staff B said families, visitors, and residents were not notified of the GI outbreak. A sign notifying visitors was not posted until 07/13/2026. < Isolation> On 07/22/2026 at 12:17 PM, Resident 1 said they had been symptomatic with GI illness. The nausea and vomiting lasted three days. They said they were on isolation a long time and it felt like two weeks. Resident 1 said they were allowed to leave their room while on isolation. At 2:54 PM, Resident 15 said she had the GI illness for about 3-4 days. Resident 34 said they did not get ill and they tried to stay on their side of the room during Resident 15's illness. Both residents said they did not leave their room for a week or two. Resident 15 said CP lasted several days after her symptoms resolved. Review of electronic health records showed Resident 8 and Resident 6's medical record lacked evidence of signs or symptoms of a GI illness. The LTC Acute Gastroenteritis Surveillance Line List - Resident List, undated, documented Resident 8 had symptoms of diarrhea. Resident 6 was identified as having symptoms of nausea, vomiting, and diarrhea. On 07/23/2026 at 3:30 PM, Staff E said all residents on The LTC Acute Gastroenteritis Surveillance Line List were on isolation. Staff E said she was aware Resident 8 had no signs or symptoms documented in the record, was out in common areas, but was in isolation. Staff E could not answer why Resident 8 was on CP and did not determine if the resident met the criteria for the illness. Staff E said Resident 8 was on CP but did not know there were no symptoms documented in the resident's medical record. Staff E acknowledged Resident 1 was out in the common area while on CP. Staff E acknowledged Resident 26 and Resident 17 had documented signs and symptoms of the illness on 07/13/2026 but were removed from isolation on 07/14/2026, 24 hours after symptoms resolved. Staff E acknowledge some residents did not have CP removed according to the policy and were on CP for days later. Staff E said her and Staff B discussed the 24 hour removal time frame and was not aware of what the policy stated. On 07/28/2026 at 3:25 PM, Staff B said residents should be removed on isolation 48 hours after symptoms resolved. Staff B was unaware Resident 17 and Resident 26 had symptoms on 07/13/2026 while isolation was removed on 07/14/2026. Staff B acknowledged some residents were in isolation longer than 48 hours after symptom resolution. Reference: WAC 388-97-1320(1)(a)(2)(b)(c)		

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NAME OF PROVIDER OR SUPPLIER Shelton Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 review, revise and implement a comprehensive plan of care to include resident risk for bruising 3 of 4 (3, 4, 5) resident reviewed for bruising and for infection control measures for 14 of 21 sampled residents (1, 2, 6, 8, 13, 15, 17, 19, 20, 24, 25, 26, 30 & 31) reviewed for care plans. The failure placed residents at risk to receive inappropriate and inadequate care to meet their individualized needs. Findings included. <Bruising> Resident 3 was admitted to the facility on [DATE] with diagnoses including dementia. On 07/13/2026 at 01:05 pm, Resident 3 was observed with two small fading bruises on their forearms. Progress notes dated 05/30/2026 and 07/08/2026 documented Resident 3 had bruises of unknown origin. The Medication Treatment Record (MAR), dated July 2026, documented Resident 3 received Plavix (a medication used to prevent blood clots), Trulicity (an injection used to reduce blood sugars), and naproxen (a medication used to control pain) which all contribute to bruising. The care plan did not show Resident 3 was at risk of bruising. Resident 4 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (a lung disease which causes difficulty with breathing and dry, thinning skin). On 07/23/2026 at 2:28 pm, Resident 4 was observed with thin, fragile skin. Resident 4 had many bruises on their hands, arms, and a small bruise on the forehead. Progress notes, dated 04/20/2026, 05/20/2026, 06/17/2026, and 07/12/2026 documented Resident 4 had episodes of bruising. The MAR, dated July 2026, documented Resident 4 received prednisone (used to reduce inflammation in the lungs) which increases the risk of thin, fragile skin and bruising. The care plan did not show prednisone would increase the risk of Resident 4's bruising. Resident 5 was admitted to the facility on [DATE] with diagnoses including COPD. On 07/13/2026 at 12:02 pm, Resident 5 was observed to have thin, fragile skin. Progress notes, dated 06/03/2026 and 06/29/2026 noted episodes of bruising of unknown origin. The MAR, July 2026, showed Resident 5 received aspirin (used to prevent blood clots), insulin injections (used to control blood sugar), and budesonide (used to reduce the inflammation in the lungs), which all increase the resident's risk of bruising. The care plan did not show Resident 5 was at risk of bruising. On 07/28/2026, 2:50 pm, Staff B, registered nurse (RN) and Director of Nursing (DNS), said the resident's care plans were not updated to reflect their risk of bruising. <Infection Control> Resident 1 room entryway was observed to have a sign directing staff to use gastrointestinal (GI) Contact Precautions (a directive to staff to wear gown and gloves during resident care and washing hands with soap and water). The resident's care plan did not reflect GI Contact Precaution (CP). Resident 2 room entryway was observed to have a sign directing staff to use GI CP. The resident's care plan did not reflect GI CP. Resident 6 room entryway was observed to have a sign directing staff to use GI CP. The resident's care plan did not reflect GI CP. Resident 8 room entryway was observed to have a sign directing staff to use GI CP. The resident's care plan did not reflect GI CP. Resident 13 room entryway was observed to have a sign directing staff to use GI CP. The resident's care plan did not reflect GI CP. Resident 15 room entryway was observed to have a sign directing staff to use GI CP. The resident's care plan did not reflect GI CP. Resident 17 room entryway was observed to have a sign directing staff to use GI CP. The resident's care plan did not reflect GI CP. Resident 19 room entryway was observed to have a sign directing staff to use GI CP. The resident's care plan did not reflect GI CP. Resident 20 room entryway was observed to have a sign directing staff to use GI CP. The resident's care plan did not reflect GI CP. Resident 24 room entryway was observed to have a sign directing staff to use GI CP. The (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's care plan did not reflect GI CP. Resident 25 room entryway was observed to have a sign directing staff to use GI CP. The resident's care plan did not reflect GI CP. Resident 26 room entryway was observed to have a sign directing staff to use GI CP. The resident's care plan did not reflect GI CP. Resident 30 room entryway was observed to have a sign directing staff to use GI CP. The resident's care plan did not reflect GI CP. Resident 31 room entryway was observed to have a sign directing staff to use GI CP. The resident's care plan did not reflect GI CP. On 07/23/2026 at 3:30 pm, Staff E, RN and Infection Preventionist (IP), said she was in charge of handling a recent GI outbreak. The resident's had symptoms of nausea, vomiting, and diarrhea requiring staff to use GI CP when caring for residents. Staff E said not all residents had their care plans updated. She said she dropped the ball on this, it was her responsibility and it should have been done. She said she had more than one job assignment and it takes away from her ability to adequately do infection control tasks. Reference (WAC) 388-97-1020(1), (2)(a)(b)		

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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 observations, interviews, and record review the facility failed to thoroughly investigation and implement interventions for allegations of injuries of an unknown origin for 3 of 4 residents (3, 4, 5) residents reviewed with allegation of injuries of unknown origin. The failure left residents at risk for unidentified abuse and/or neglect, recurrence of events, and a decreased quality of life. Findings included.<Resident 3>Resident 3 was admitted to the facility on [DATE] with diagnoses including dementia. The quarterly minimum data set (MDS) dated , 07/13/2026, documented Resident 3 had severe cognitive impairment and required dependence on staff with activities of daily living (ADLs). On 07/13/2026 at 01:05 pm, Resident 3 was observed with two small fading bruises on their forearms. The Medication Treatment Record (MAR), dated July 2026, documented Resident 3 received Plavix (a medication used to prevent blood clots), Trulicity (an injection used to reduce blood sugars), and naproxen (a medication used to control pain) which all contribute to bruising. The care plan, dated 03/20/2026, documented Resident 3 should avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short. The care plan directed staff to use a draw sheet or lifting device to move the resident and use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. The care plan was updated on 04/21/2026 to show Resident 3's wheelchair had a drop seat with a pommel cushion. The care plan did not show Resident 3 was at risk of bruising due to wandering or due to medication which increased the resident's risk of bruising. Progress notes, dated 05/30/2026, document Resident 3 had a 3.5 cm (centimeter) x 3 cm bruise to the thigh, a 2 cm x 1.5 cm bruise to the right knee, and a 2 cm x 1.5 cm bruise to the left inner thigh. Bruise/Skin Tear/Abrasion investigation, dated 05/30/2026, documented Resident 3's developed bruises to the thigh, knee, and left inner thigh. The investigation documented Resident 3 required assistance from staff with ADLs, had a history of falls and impulsiveness, and attempted to be independent with mobility. The staff reported the resident wanders in the hallways and is at risk of bruising due to the risk of Plavix. The resident is seen self-propelling in their wheelchair and go into rooms and offices. It is reasonable the resident bumped into a doorway during a transfer and sustained bruising. The care plan is noted as updated. No staff interviews were included in the investigation to determine the cause of the resident's bruising. Progress notes, dated 07/08/2026, documented Resident 3 had an 8 cm x 5 cm bruise to the left medial knee and a 7 cm x 9 cm bruise to the left lateral upper leg. Bruise/Skin Tear/Abrasion investigation, dated 07/07/2026, documented Resident 3's bruising to the left medial and lateral knee. Resident 3 required assistance from staff with ADLs, had a history of falls and impulsiveness, and attempts to be independent with mobility. The staff reported the resident wanders in the hallways and is at risk of bruising due to the risk of Plavix. Resident 3 has a pommel cushion in their wheelchair which may have contributed to the bruising which will be removed. Staff were interviewed about their awareness of the bruising, but not to the potential causal factors. On 07/23/2026 at 2:17 pm, Staff K, registered nurse (RN), said Resident 3 wanders a lot finding them all over the building and in staff offices. When a resident has a bruise, they are supposed to try and implement interventions related to preventing further bruises. Staff K could not recall interventions for Resident 3 to prevent bruising. Staff K did not think Resident 3 bruises much. Staff K was not aware of bruising Resident 3's forearms. On 07/28/2026, 2:50 pm, Staff B, RN and Director of Nursing (DNS), said Resident 3 does wander throughout the facility. Staff B said the care plan was not updated to remove the pommel cushion at the time of the bruising. Staff B was not aware of bruising Resident 3's forearms and said an incident report should have been (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed. Staff B said she did not implement interventions with the 05/30/2026 bruise and has not had a discussion with Resident 3's guardians about additional interventions to prevent bruising. <Resident 4>Resident 4 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (a lung disease which causes difficulty with breathing and dry, thinning skin). The quarterly MDS dated , 07/23/2026, documented Resident 4 had moderate cognitive impairment and required dependence on staff with ADLs. On 07/23/2026 at 2:28 pm, Resident 4 was observed with thin, fragile skin. Resident 4 had bruises on the left hand and wrist, the right wrist, the right arm, and a small bruise on the forehead. Resident 4 said they were bruised on the right wrist during a blood draw. Resident 4 said the remainder of the bruising occurred during personal cares. The left hand was bruised when staff grabbed at their hand when trying to pull them forward. The bruise on their head occurred when staff bumped the resident in the head with the mechanical lift that morning. Resident 4 said they recall the past bruising episodes, and they are typically occurring during transfers with facility staff, often times with when using the mechanical lift. The resident said they hate using the mechanical lift as a result. Resident 4 said the sling pulled on their neck while getting up a while ago and it still hurts. The MAR, dated July 2026, documented Resident 4 received prednisone (a steroid used to reduce inflammation in the lungs) which increases the risk of thin, fragile skin and bruising. The care plan, dated 04/18/2024, documented the resident should avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short, keep skin clean and dry, use lotion on dry skin, and directed staff to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. The care plan was updated on 05/26/2026 showing staff were educated on proper use of the mechanical lift. The care plan did not document how prednisone would increase the risk of Resident 4's bruising. Progress notes, dated 04/20/2026, documented Resident 4 had a 2.5 cm x 1 cm bruise to the left medial foot and a 0.4 cm x 1 cm bruise to the left medial knee. The resident said their foot slid off the footrest and hit the foot pedal causing the bruise to the foot. The knee bruise occurred when staff were providing personal cares. Bruise/Skin Tear/Abrasion investigation, dated 04/20/2026, documented Resident 4 had bruising to the left foot and knee. The resident said their foot slid off the footrest and hit the foot pedal causing the bruise to the foot. The knee bruise occurred when staff were providing personal cares. Resident 4 has mild cognitive impairment, is dependent on staff for transfers and bed mobility, is on oxygen, and is at risk of bruising due to steroid use, use of Plavix, and diabetes. The bruising was found not to be due to abuse or neglect. The care plan was noted as updated. No interventions were noted and no interviews with staff to determine how the injuries that occurred were included. Progress notes, dated 05/20/2026, documented Resident 4 had a bruise on the left leg measuring 9 cm x 3 cm. The resident said their leg was hit on the mechanical lift during a transfer. Bruise/Skin Tear/Abrasion investigation, dated 05/20/2026, documented Resident 4's bruises to the left shin. Resident 4 has mild cognitive impairment and is at risk of bruising due to Plavix use. Staff did not know how the bruise occurred. An in-service was performed on 05/27/2026 with staff safe use of the mechanical lift. Progress notes, dated 06/17/2026, documented Resident 4 had three red bruises to the left forearm. Measurements were 4.4 cm x 3 cm, 1 cm x 2 cm, and 1 cm x 1 cm. The resident said it happened while the staff were transferring them to their wheelchair. Bruise/Skin Tear/Abrasion investigation, dated 06/17/2026, documented Resident 4's three bruises to the arm. The resident said it happened while the staff were transferring them to their wheelchair about a week ago. Resident 4 has mild cognitive impairment, is dependent on staff for transfers and bed mobility and is at risk of bruising due to use of steroids and Plavix. The investigation determined Resident 4 was likely was bruised in a different situation, while they were transported by emergency medical (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services (EMS). No interventions were identified. The care plan was noted as updated. Progress notes, dated 07/12/2026, documented Resident 4 had a bruise on the upper right forearm measuring 5 cm x 6 cm. The resident said it occurred when they were asleep. Bruise/Skin Tear/Abrasion investigation, dated 07/12/2026, documented Resident 4 with a bruise to the right forearm. Resident 4 has mild cognitive impairment, is dependent on staff for transfers and bed mobility and is at risk of bruising due to use of steroids and Plavix. A call light clip was determined to be the probable cause of the bruise. Staff interviews noted the resident told staff the bruising occurred when staff were moving them. No care plan interventions were noted on the care plan. Progress notes, dated 07/23/2026, documented Resident 4 had a small red mark 1 cm x 1 cm to the right forehead. The resident said it happened during the transfer from the bed to the wheelchair. The resident is alert and orientated x 2-3 with forgetfulness [they are] not very good at recounting events due to tiredness and forgetfulness. Bruise/Skin Tear/Abrasion investigation, dated 07/23/2026, documented Resident 4 had a small red mark to the forehead which the resident reported occurred during a transfer. The resident is at risk of bruising due to Plavix use. Resident 4 did not report the injury immediately to staff and it is reasonable that staff did not observe [the mechanical lift] come into contact with the resident during transfer. The resident holds onto the sling during transfer and may have adjusted their hands during the transfer, causing the injury. No intervention was identified. Progress notes, dated 07/24/2026, documented Resident 4 had a bruise to the right upper arm, one superior measuring 3 x 3 cm and one distal measuring 3.5 cm x 3 cm. On 07/23/2026 at 1:51 pm, Staff M, nursing assistant, said they have been told to be careful transferring Resident 4 and that bruises may occur during transfers. Staff M did not think this was the cause of the bruises but were unsure of the cause. On 07/28/2026, 2:50 pm, Staff B said they did staff training in May regarding Resident 4's bruising but has not implemented further interventions relate to the ongoing allegations of bruising during care. Staff B said Resident 4 is not always reliable in their recall. Staff B said they did not consistently implemented interventions or update the care plan. Staff B said they have not discussed further interventions to prevent ongoing bruises. <Resident 5>Resident 5 was admitted to the facility on [DATE] with diagnoses including diagnoses of chronic obstructive pulmonary disease. The quarterly MDS dated , 05/27/2026, documented Resident 5 had moderate cognitive impairment and some dependence on staff with ADLs. The MAR, July 2026, showed Resident 5 received aspirin (used to prevent blood clots), insulin injections (used to control blood sugar), and budesonide (a steroid used to reduce the inflammation in the lungs), which all increase the resident's risk of bruising. The care plan did not show Resident 5 was at risk of bruising or received medication which increased the risk of bruising. On 07/13/2026 at 12:02 pm, Resident 5 was observed to have thin, fragile skin. The resident said they were told someone comes and hits her at night causing bruising. Progress notes, dated 06/03/2026, documented Resident 5 had bruises to the left hand measuring 2.2 cm x 2 cm and 1.5 cm x 1 cm to the left forearm. Bruise/Skin Tear/Abrasion investigation, dated 07/23/2026, documented Resident 5 had a bruise to the wrist. The resident did not recall how they received the bruise. The resident has moderate cognitive impairment, is bedfast, and receives aspirin and a steroidal inhaler as medication. It was determined the resident came into contact with the overbed table or bed causing bruises. No interventions were implemented. No staff interviews were obtained. Progress notes, dated 06/29/2026, documented Resident 5 had a bruise to the left eye measuring 3 cm x 1 cm, a bruise to the chest measuring 15.5 cm x 8 cm, and a bruise to the lower left medial arm measuring 4 cm x 2.5 cm. Bruise/Skin Tear/Abrasion investigation, dated 07/23/2026, documented Resident 5 had bruises to the eye, chest, and arm. The resident stated they did not recall what happened, then later stated someone came in the night while they are sleeping and hit them. The (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident has moderate cognitive impairment, is bedfast, and receives aspirin and a steroidal inhaler as medication. Resident 5's fingernails were observed to be long. The resident's bruises were determined to be self-inflicted due to rubbing of the eye and scratching of the chest. The bruising on the arm was determined to be due to medication injections. The was plan was noted a updated. On 07/14/2026 at 12:35 pm, Staff D, licensed practical nurse (LPN), said she believes Resident 5's bruising is caused by pulling the bedside table up close to their chest. She has witnessed them do this. Staff D said she reported the bruising on 06/29/2026 and felt the bruising on the chest could have been caused by the table or pulling items close to their chest. On 07/213/2026 at 2:20 pm, Staff L, LPN, said Resident 5 likes to have everything close to her and pulls up her bedside table and fan close to her chest. She thought Resident 5's bruising could be caused by the bedside table. On 07/28/2026, 2:50 pm, Staff B said she did not believe Resident 5's chest bruise could be from the bedside table. Staff B said there were no interventions such as padding of the bedside table when it was thought to cause bruising on 06/03/2026. Reference WAC 388-97-0640(5)		