STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505128	A. Building B. Wing	12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sequim Health & Rehabilitation	650 West Hemlock St Sequim, WA 98382

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45203 Based on interview and record review, the facility failed to provide care in a manner that promoted respect and dignity when sufficient ostomy supplies were not provided and when staff responded unprofessionally when assistance was requested for one of five sampled residents (3) reviewed for dignity. This failure placed residents at risk for embarrassment, anxiety, and diminished self-worth. Findings included . Resident 3 was admitted to the facility on [DATE] with diagnoses including Crohn's disease (a type of inflammatory bowel disease that causes swelling of the tissues of the digestive tract, which can lead to abdominal pain, severe diarrhea, fatigue, weight loss and malnutrition) and colostomy (a surgical opening in which a piece of the colon is diverted to an artificial opening in the abdominal wall) infection. The admission Minimum Data Set, an assessment tool, dated 10/30/2022, documented the resident was cognitively intact, mildly depressed, required the assistance of one staff member for supervision and set up of activities of daily living, and had an ostomy. The resident's care plan, dated 10/04/2022, documented the resident was independent with toileting needs, and the resident required the use of an ostomy pouch for the colostomy as well as an additional pouch for a fistula (an abnormal connection between two body parts or organs). On 11/15/2022 at 1:40 PM, Resident 3 said there was a problem with getting the correct ostomy supplies. The supplies the facility was providing her did not work, and it would have to changed two to three times a day instead of every two to three days. Resident 3 said at one point, there were no bags provided at all, and she had to just sit here with poop and blood all over until they finally got the supplies. Resident 3 said she did not feel staff treated her with dignity and respect. On 12/05/2022 at 1:04 PM, Resident 3 said due to the long time the facility took to supply the proper bags, she ordered them from the pharmacy and family brought them to the facility the next day. Resident 3 said she frequently had to use a towel to collect the poop and pus that drained from the ostomy and fistula. Resident 3 said on one occasion when asking a nurse for assistance with their ostomy, the nurse replied, I thought you were supposed to take care of that yourself. Resident 3 stated, I have PTSD (Post Traumatic Stress Disorder- an anxiety disorder caused by very stressful, frightening or distressing events) from that place . It was terrible the way I was treated. I was very happy to get out of there and not have to go back. (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

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:31 PM, Staff B, Director of Nursing Services, said they were aware Resident 3 required special ostomy supplies, and the last one was used over the weekend and staff did not communicate. Staff B said prior to the weekend there was a discussion and staff had located the ostomy supplies in the building, so they were not ordered. The supplies were ordered on Monday. Staff B said they were aware the resident had to use a towel to collect the drainage from the two ostomies. On 12/06/2022 at 11:30 AM, Staff F, Nursing Assistant, said they could not get supplies for whatever reason. Staff F said Resident 3 needed a specific size, but was able to manage the ostomy herself, but it had to be changed several times a day. At 12:01 PM, Staff G, Central Supply, said as soon as they were made aware of the situation, they ordered the correct supplies. The resident was supplied with what she had on hand in the meantime. On 12/07/2022 at 11:09 AM, Staff B, said they would not expect a resident to have to manage their ostomy and fistula with a towel; and if staff had informed her, she would have gone to get the correct supplies herself. At 12:21 PM, Staff A, Administrator, said they were aware of the specialize ostomy supplies needed, but was told by staff the facility had them. Staff A said they would not expect the resident to have to use a towel to contain ostomy drainage. See F691 Reference WAC 388-97-0860 (1)a

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45203 Based on observation, interview and record review, the facility failed to prevent pressure ulcer (injuries to skin and underlying tissue resulting from prolonged pressure on the skin) development and promote wound healing by implementing and following care interventions for two of four sampled residents (4 & 6) reviewed for pressure wounds. This failure placed residents at risk for wound complications, infection, delayed healing, increased pain, and a decreased quality of life. This caused harm to Resident 6 when a low air loss mattress was physician ordered and not implemented, and the resident developed two Stage 3 pressure injuries. Findings included . 1) Resident 6 was admitted to the facility on [DATE] with diagnoses including hemiplegia (paralysis affecting one side of the body). The admission MDS, dated [DATE], documented the resident was cognitively intact, had mild depression, required extensive assistance from 2 staff member for bed mobility transfers and bathing, and one-person extensive assistance for dressing, eating and personal hygiene. The MDS documented Resident 6 was at risk for development of pressure injury; and required pressure relieving devices for bed and wheelchair, and nutritional and hydration interventions to manage skin problems. Resident 6's care plan focus for has/potential pressure ulcer of bony prominences, initiated 08/20/2022, documented the resident's goal to have intact skin, remain free of redness, blisters or discoloration. The care plan included the focus, initiated 09/27/2022, for an air mattress with bolsters with the goal for resident to remain free of skin breakdown. A wound care provider note, dated 08/24/2022, documented: Wound 1: bilateral buttock had old scar tissue areas with moisture associated skin damage. Tissue type was 100% superficial. There was no documented size. A physician's order, dated, 08/24/2022, documented clean bilateral buttocks and right inner thigh with NA (normal saline) and apply EPC/barrier cream daily at bedtime. Resident 6's September 2022 MAR documented 7 omissions for wound care, indicating wound care was not provided. A wound care provider note, dated 09/21/2022, documented Wound 1: moisture associated skin disease, tissue type was 10% superficial and 90% epithelialized (wound covered). There was no documented size. A physician's order, dated 09/27/2022, documented LALM (Low air loss mattress) with bolster to bed for pressure relief. A physician's order, dated 09/28/2022, documented clean bilateral buttocks and right inner thigh with NS and apply EPC/barrier cream, apply bordered dressing every shift and when soiled. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident 6's October 2022 MAR documented 3 omissions for wound care, indicating wound care was not provided. A wound care provider note, dated 10/19/2022, documented Wound 1: left sacral coccyx Stage 3, size was 2. 0 x 1.1 x 0.3cm, tissue type was 30% granulation and 40% superficial and 30% epithelialized. Wound 2: right sacral coccyx Stage 3, was 0.5 x 1.1 x 0.2cm and tissue was 40% granulation, 30% superficial and 30% epithelialized. A wound care provider note, dated 11/02/2022, documented Wound 1: left sacral coccyx Stage 3 size was 5. 7 x 2.4 x 0.1cm. Tissue type was 50% superficial, 30% epithelialized and 20% scab. Wound 2: right sacral coccyx was Stage 3 was 4.2 x 2.5 x 0.1cm, tissue type was 50% superficial, 30% epithelialized, and 20% scab. A wound care provider note, dated 11/16/2022, documented Wound 1: left sacral coccyx Stage 3 measured 5.2 x 0.7 x 0.2cm, tissue type was 30% granulation and 70% superficial. Wound 2: right sacral coccyx Stage 3 measured 4.5 x 1.1 x 0.2cm with 30% granulation and 70% superficial. A physician's order, dated 11/17/2022, documented to clean bilateral buttocks and right inner thigh with NS and apply EPC/Barrier Cream every shift and when soiled. Apply bordered dressing. Apply Medi honey to granulation tissue. A physician's order, dated 11/27/2022, documented Doxycycline 100mg by mouth every 12 hours for open area on buttocks related to bacterial infection for 10 days, no brief, open to air, side to side positioning per resident tolerance. Resident 6's November 2022 MAR documented 7 wound care omissions, indicating wound care was not provided. On 12/05/2022 at 11:10 AM, Resident 6 was observed resting in bed with a foam mattress in place and the head of bed elevated. An air mattress was not in place. Resident 6 said she had a wound on her bottom. The resident said staff changed the dressing about once a day, and said she had never had an air mattress. At 1:31 PM, Staff B said Resident 6 had a fixed leg position due to hip abduction and it made it difficult to reposition her, as the resident could not really be positioned side to side. Staff B said she felt implementing the LALM would have been helpful, and felt it was just lack of communication and follow though that it was not in place. At 2:26 PM, Staff I said she had not seen Resident 6 for a few weeks due to the facility not having enough available staff to assist with rounds. Staff I said she was not aware if the resident was supposed to be on an air mattress, but did recall the resident had impaired mobility in her hips. Staff I said she would have to review the notes, which were not available, to be able to answer anything else. On 12/06/2022 at 10:10 AM, Resident 6 was observed resting in bed laying on her back,with the head of the bed elevated. A LALM was not in place. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	At 10:45 AM, Resident 6's wound area was observed during a dressing change. The sacral/coccyx wound area was oval in shape measuring approximately 10cm and appeared reddened with scattered dark crusted areas. At 1:17 PM, Staff H said the wound nurse followed the residents with wounds weekly, and they utilized repositioning, pillows, air mattresses, and foam dressings to prevent pressure wounds from developing. Staff H said with Resident 6's wound, staff had been diligent about getting cream on her bottom and making sure the NAs assisted with repositioning. Staff H said she did not know why the resident did not have an air mattress, stating, Somehow that one went through the cracks. On 12/07/2022 at 11:48 AM, Resident 6 was observed in bed laying on their back. A LALM was not in place. At 12:25 PM, Staff B said the air mattress had been ordered for Resident 6. 2) Resident 4 was admitted to the facility on [DATE] with diagnoses including paralytic syndrome (loss or impairment of the ability to move a body part or parts, inability to move or function). The admission Minimum Data Set (MDS), an assessment tool, dated 08/19/2022, documented the resident had severe cognitive impairment, moderate depression, and required extensive assistance of two staff members for bed mobility, transfers, dressing, toileting, bathing, hygiene and eating. The MDS documented the resident was at risk for pressure injury, did not have a pressure injury upon admission to the facility and had moisture associated skin damage. A wound care provider note, dated 08/17/2022, documented the resident had identified as Wound 1: matted hair and flaking scalp, no measurements were included. Wound 2: moisture associated skin disease Peri area and sacral coccyx described as superficial erythema (reddening of the skin), maceration (skin exposed to moisture for a prolonged period of time) and discolored, no documented size. Wound 3: coccyx with moisture associated skin damage with measurements of 3.8 centimeters (cm) x 3.2cm x 0.2cm, the wound tissue was described as 80% granulation (pink tissue growing over the wound), 20% superficial (on the surface wound caused by friction). A wound care order, dated 08/17/2022, documented back of head to clean with dandruff shampoo and pat dry every shift until resolved. A wound care order, dated 08/17/2022, documented to cleanse coccyx with wound cleanser and apply honey, and cover with bordered dressing daily in the morning. A wound care provider note, dated 08/24/2022, documented Wound 1: posterior flaking scalp. No measurements were included. Wound 2: moisture associated skin disease to peri area and sacral coccyx. Tissue described as 20% granulation and 80% superficial. No documented size. Wound 3: coccyx with moisture associated skin disease, measurements were 3.6cm x 3.2cm x 0.2cm. Wound bed was described as 20% granulation, 20% slough (dead tissue) and 60% superficial. A wound care order, dated 08/24/2022, documented posterior scalp to be cleansed with dandruff shampoo and pat dry every Tuesday, Friday, and Sunday. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A wound care order, dated 08/24/2022, documented to cleanse bilateral buttocks/peri area/coccyx with wound cleanser, pat dry, apply thin layer of Medi honey and cover with bordered dressing daily and as needed for soilage or missing. A wound care order, dated 08/31/2022, documented to cleanse bilateral buttocks/peri-area/coccyx site with wound cleanser, pat dry and apply EPC (Extra Protective Cream) and antifungal cream. Change daily and as needed for soilage or missing A daily skilled progress note, dated 09/05/2022 at 11:50 AM, documented, Sacral wound presenting as worsened from what this nurse observed last Friday. There are more/larger open areas, copious drainage, and a distinct odor. Discussed with Wound RCM [Resident Care Manager] as current ordered treatment obviously in need of a change. Wound RCM was not able to assess wound at that moment. Discussed with provider who ordered a wound culture. Order in for the morning when transportation to lab of said culture will be possible. Resident is already on Doxycycline [an antibiotic] BID [twice daily]. Treatment changed from EPC/Antifungal cream to medi honey followed by a foam dressing for both protection and the drainage. A wound care order, dated 09/05/2022, documented to cleanse bilateral buttocks/peri area/coccyx site with wound cleanser and apply Medi-honey and cover with large, bordered foam dressing. Change daily and as needed for soilage or if it came off. A physician's order, dated 09/05/2022, documented clean wound thoroughly before obtaining a wound culture of sacral wound. A physician's order, dated 09/10/2022, documented Ampicillin (broad-spectrum penicillin) 500 milligram (mg) give one capsule by mouth four times daily for wound infection. A wound culture report, dated 09/10/2022, documented growth of enterococcus faecalis (a bacteria commonly found in feces) and methicillin resistant staphylococcus aureus (MRSA) (a highly resistant bacteria which requires contact precautions) A physician's order, dated 09/11/2022, documented doxycycline (antibiotic) 100 mg by mouth two times daily for 10 days for MRSA infection. A wound care provider note, dated 09/14/2022, documented Wound 1: posterior scalp matted hair, flaking scalp. Wound 2: moisture associated skin disease to peri area and sacral coccyx, tissue described as 100% superficial with erythema. No documented size. Wound 3: coccyx moisture associated skin disease sloughing area measuring 3.0 x 2.0 x 0.2cm and wound bed described as 30% granulation, 40% slough, and 30% superficial. A wound care provider note, dated 09/21/2022, documented Wound 1: posterior scalp matted hair and flaking scalp measurements were 11.0 cm x 6.0 cm x 0.2cm, wound bed described as 60% granulation, 20% slough, and 20% superficial. Wound 2: moisture associated skin disease peri area and sacral coccyx tissue type was 100% superficial, no documented size. Wound 3: coccyx moisture associated skin disease 2.5cm x 2.1cm x 0.2cm, wound bed is described as 70% granulation and 30% superficial. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A wound order, dated 09/21/2022, documented posterior scalp, cleanse with dandruff shampoo apply solosite wound gel (wound dressing with preservatives) and cover with bordered dressing once daily on Tuesday, Friday, and Sunday. A wound care provider note, dated 10/05/2022, documented Wound 1: posterior scalp measures 11.0 x 9.0 x 0.3 with 60% granulation, 30% slough and 10% superficial. Wound 2: coccyx moisture associated skin disease area measurements were 4.5 x 6.8 x UTD (unable to determine), wound bed described as 20% granulation, 50% slough, 30% superficial. Wound 3: No longer documented. A wound care order, dated 10/05/2021, documented cleanse posterior scalp with dandruff shampoo, apply solosite wound gel and cover with bordered dressing once daily. A wound care provider note, dated 10/12/2022, documented Wound 1: posterior scalp measured 5.4 x 9.4 x 0.3cm with 80% granulation and 20% superficial. Wound 2: reclassified as Stage 4 of the coccyx with measurements of 5.4 x 5.3 x 0.3cm, wound bed described as 20% granulation, 10% slough, 20% superficial and 50% tendon (holds muscle and bone together). A wound care order, dated 10/19/2021, documented to clean posterior scalp with dandruff shampoo and apply Medi honey and cover with bordered foam dressing in the morning. A wound provider note, dated 11/02/2022, documented Wound 1: posterior scalp measures 6.8 x 10.5 x 0. 2cm, tissue type is 50% granulation and 50% superficial. Wound 2: coccyx Stage 4 pressure wound 7.2 x 3.5 x UTD with undermining at 4 o'clock to 5 o'clock to a depth of 1.4cm, tissue type was 20% granulation, 40% slough, 10% superficial and 30% tendon. Review of Resident 4's October 2022 Medication Administration Record (MAR) documented 7 omissions for coccyx wound care and 6 omissions for posterior scalp wound care, indicating wound care was not provided. Review of Resident 4's November 2022 MAR documented 4 omissions for coccyx wound care and 4 omissions for posterior scalp care between 11/1/2022 and 11/14/2022, indicating wound care was not provided. The medical record showed Resident 4 was admitted to the hospital on 11/14/2022 and required intravenous antibiotics for the treatment of the coccyx wound. A hospital provider note, dated 11/14/2022 at 2:45 AM, documented, a large wound to back of scalp, and sacral decub [decubitus pressure] bilateral worse on right . soiled with feces on initial inspection. On 11/18/2022 at 2:58 PM, Resident 4's Family Member (FM) 2 said they would visit the resident often and had concerns the wounds were not healing as they should. FM 2 said they felt staff were not assisting the resident to reposition frequently enough, and dressings were not changed as they should be. A hospital provider note, dated 11/20/2022 at 11:50 AM, documented Resident 4's Pressure sores are evidence of not being turned appropriately . the sacral wound culture grew MRSA and Proteus (a bacteria usually found in the intestinal tract) and a large palm sized wound on the posterior scalp. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 11/23/2022 at 11:45 AM, Staff E, Registered Nurse (RN), said when staff would reposition Resident 4, he would wiggle back to being on his back. Staff E said the coccyx wound was improving, but the wound on the scalp was more challenging. Staff E said Resident 4 did not refuse wound care; and if there were omissions on the wound treatment, it was more likely due to it just not being documented. On 11/23/2022 at 3:25 PM, Resident 4's FM 1 said there would be days that staff did not change the resident's dressings. FM 1 said they did not feel Resident 4 received the care he should have. FM 1 said Resident 4 was readmitted to the hospital and his wounds were infected. FM 1 said the wounds had previously been treated at the facility, but did not think the infection had resolved. On 11/28/2022 at 5:05 PM, Resident 4 said there were several occasions where he went 3 days without the dressings being changed . Staff would say they would come back and change it, but they never did. Resident 4 said they did wound rounds every Wednesday and they were always in a hurry. Resident 4 said he would be repositioned a couple of times each night, but there were occasions he was not repositioned at night. Resident 4 said the wound impacted his ability to be up in a wheelchair for extended periods of time and his ability to participate in therapy. On 12/05/2022 at 1:31 PM, Staff B, RN and Director of Nursing Services, said they had many interventions in place for pressure prevention including repositioning every 2 hours and not letting residents remain in soiled briefs for extended periods of time. Staff B said if a wound care was ordered daily, she would expect it to be done; and if it was not documented, then it wasn't done. Staff I, Wound Care Provider and Advanced Registered Nurse Practitioner, said if wound care was not performed 7 times in a month, it could have a negative impact on wound healing. At 2:26 PM, Staff I said she does rounds at the facility weekly, and Resident 4 had a wound on the coccyx and the back of the head. Staff I said the wounds initially got better, and then they worsened. Staff I said she did debridement when necessary, and said they were treated with antifungals and antibiotics. Staff I said the scalp area was originally crusty and then became an open granulating wound. Staff I said the wounds looked better the last time she saw them. Staff I said if the dressings were not changed for multiple days, it was possible to have a negative impact on healing. Staff I said she did not suspect staff were not repositioning appropriately, but she would not know because she only saw the resident for 15-20 minutes weekly. On 12/06/2022 at 11:30 AM, Staff F, Nursing Assistant (NA), said Resident 4 could not reposition himself and he needed to be assisted. At 1:17 PM, Staff H, RN and Resident Care Manager, said Resident 4's wounds were getting better and they were seen by the wound care provider weekly. Staff H said Resident 4 was non complaint with repositioning and staff did reposition him frequently. Reference WAC 388-97-1060 (3)(b)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45203 Based on observation, interview, and record review, the facility failed to ensure care was provided in accordance with professional standards when not providing needed ostomy (an opening in the body for the discharge of body wastes into a collection bag) supplies for a resident with two ostomy sites for one of one sampled residents (3) reviewed for ostomy care. This failure placed residents at risk for pain, infection, skin breakdown and a diminished quality of life. Findings included . Resident 3 was admitted to the facility on [DATE] with diagnoses including Crohn's disease (a type of inflammatory bowel disease causing swelling of the tissues of the digestive tract, which can lead to abdominal pain, severe diarrhea, fatigue, weight loss and malnutrition) and colostomy (a surgical opening in which a piece of the colon is diverted to an artificial opening in the abdominal wall) infection. The admission Minimum Data Set, an assessment tool, dated 10/30/2022, documented the resident was cognitively intact, mildly depressed, required the assistance of one staff member for supervision and set up of activities of daily living, and had an ostomy (a surgical opening from the inside of the body to the outside). Resident 3's care plan, dated 10/04/2022, documented the resident was independent with toileting needs, however the resident required the use of an ostomy pouch for her colostomy as well as an additional pouch for a fistula (an abnormal connection between two body parts or organs). On 11/15/2022 at 1:40 PM, Resident 3 said there was a problem with getting the correct ostomy supplies. The resident said the supplies the facility was providing her did not work and she would have to change them two to three times a day instead of every two to three days. Resident 3 said at one point there were no bags provided to her at all. On 12/05/2022 at 1:04 PM, Resident 3 said due to the long time the facility took to supply her the proper ostomy bags, she had ordered them from the pharmacy and family brought them to the facility the next day. Resident 3 said she frequently had to use a towel to collect the poop and pus that drained from the ostomy and fistula. At 1:31 PM, Staff B, Registered Nurse and Director of Nursing Services, said she was aware Resident 3 required special ostomy supplies, and she used the last one over the weekend and staff did not communicate. Staff B said prior to the weekend, there was a discussion and staff had located the ostomy supplies in the building, so the supplies were not ordered. Staff B said the supplies were ordered on Monday, and she was aware the resident had to use a towel to collect the drainage from the two ostomies. On 12/06/2022 at 11:30 AM, Staff F, Nursing Assistant, said he recalled that they could not get supplies for whatever reason. Staff F said Resident 3 needed a specific type. Staff F said Resident 3 was able to manage the ostomy herself, but had to change it several times a day. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:01 PM, Staff G, Central Supply, said as soon as he was made aware of the situation, he ordered the correct supplies. Staff G said the resident was supplied with what they had on hand in the meantime. On 12/07/2022 at 11:09 AM, Staff B said she would not expect a resident to have to manage their ostomy and fistula with a towel. Staff B said had staff informed her, she would have gone to get correct supplies herself. At 12:21 PM, Staff A, Executive Director, said he was aware of the specialized ostomy supplies needed, but was told by staff that the facility had them. Staff A said he would not expect the resident to have to use a towel to contain ostomy drainage. Reference WAC 388-97-1060 (3)(j)(iii)

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	505128	A. Building B. Wing	12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sequim Health & Rehabilitation	650 West Hemlock St Sequim, WA 98382

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45203 Based on observation, interview and record review, the facility failed to ensure a nutrition management system was in place that obtained correct resident weights (wts), evaluated residents, assessed meal intake, identified significant weight loss, and interventions were developed and implemented for 3 of 8 sampled residents (4, 5 & 6) reviewed for nutrition maintenance. This failure placed resident at risk for weight loss, medical complications and a diminished quality of life. Findings included . A facility policy entitled Weight Monitoring, dated 11/14/2022, documented residents were to be weighed weekly for four weeks and if weights were stable then weighed monthly. Nursing staff were to use the alerts to identify weight changes of 5% and communicate weight changes using the Nursing to Nutrition Communication Evaluation. All residents with significant weight change were to be reviewed and assessed for nutrition risk factors. 1) Resident 6 was admitted to the facility on [DATE] with diagnosis of hemiplegia. The admission Minimum Data Set (MDS), an assessment tool, dated 08/26/2022, documented the resident was cognitively intact, had mild depression, required extensive assistance from 2 staff member for bed mobility transfers and bathing, and one-person extensive assistance for dressing, eating and personal hygiene. The MDS documented the resident required a mechanically altered diet, was at risk for development of pressure injury, and required nutritional and hydration interventions to manage skin problems. Resident 6's care plan, initiated 08/20/2022, documented a nutritional focus and included goals, initiated 08/24/2022, that the resident would consume at least 75% of meals and nutritional support to promote wound healing. Interventions, initiated 08/24/2022, included needing 1:1 monitoring/feeding in assisted dining room, increase protein in diet w/ supplements, monitor and record fluid intake, monitor weight as indicated, provide supplements as ordered and notify nurse if the resident was refusing to eat. A physician's order, dated 08/19/2022, documented weekly weights for four weeks. Review of Resident 6's Weight (wt) Record documented the following: On 08/19/2022, 220.0 lbs. (pounds) via Wheelchair On 09/01/2022, 188.0 lbs. via Wheelchair On 09/10/2022, 190.0 lbs. via Mechanical Lift On 11/03/2022, 162.4 lbs. via Wheelchair Records showed, from 08/19/2022 to 11/03/2022, Resident 6 lost 57.6 lbs, a 26.2% weight loss in 76 days. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 6's electronic Health Record did not show documentation the resident was reassessed by a Registered Dietician after weight loss was identified during September 2022 or October 2022. The Health Record showed Resident 6 had been assessed by a RD on admission and quarterly assessments only. Review of Resident 6's Meal Monitoring, dated 11/02/2022 to 12/02/2022, showed no monitoring was documented for 11/02/2022, 11/03/2022, 11/05/2022, 11/06/2022, 11/11/2022, 11/12/2022, 11/19/2022, 12/01/2022, 12/02/2022; and on 11/07/2022 and 11/27/2022 documentation was for one meal only. A nutrition progress note, dated 11/24/2022 and completed by a dietician, documented, WEIGHT WARNING: Value: 162.4, Vital Date: 2022-11-03 13:25:00.0, -3.0% change from last weight [14.5%, 27.6]. Diet is regular, regular, thin liquids with cut up foods. Intake is 50-100% meals and 75% snacks. [She is] eating with assistance as needed at meals. Has significant pattern of loss from wt 09/10/2022 = 190# with -27.6#/14.5% and wt 08/19/2022 = 220# with -57.6#/26.2%. Will add 120ml [milliliter] nourishments TID [3x daily] for additional kcal, protein and fluids to help promote wt maintenance and healing of [pressure injury] sacral/coccyx area. On 12/07/2022 at 11:48 AM, Resident 6 was observed lying flat in the bed with the meal tray on the over bed table. Resident 6 was eating food with her fingers and brown liquid was dripping on the sheet covering her upper body. Staff J, License Practical Nurse, assisted the resident to an upright position. Resident 6 said she usually ate in her room and did not require the assistance of staff. Resident 6 said she was not able to find the controller to raise the bed prior to eating lunch. At 12:04 PM, Staff J, Licensed Practical Nurse (LPN), said it was usual for auxiliary staff to deliver trays, but Resident 6 should have been assisted to an upright position. At 12:09 PM, Staff K, Life Enrichment Director, said she delivered the tray to Resident 6, placed the tray and left at the direction of the resident. Staff K said she asked the resident if the head of the bed was needed to be up, and the resident stated, No, she had it. Staff K said the resident was alert and oriented, and she did as the resident directed. 2) Resident 4 was admitted to the facility on [DATE] with diagnoses including paralytic syndrome (ascending weakness). The admission MDS, dated [DATE], documented the resident had severe cognitive impairment, moderate depression, and required extensive assistance of two staff members for bed mobility, transfers, dressing, toileting, bathing, hygiene and eating. The MDS documented the resident did not have a swallowing disorder or require a mechanical or therapeutic diet. Resident 4's care plan, initiated 08/15/2022, documented a nutritional focus and included goals, initiated 08/17/2022, including the resident would not have weight loss or complications related to refusing food, the resident would consume at least 75% of meals and snacks daily, weight stability and intake to support weight. Interventions, initiated 08/17/2022, included 1:1 assistance with meals, increase protein intake, monitor weights as indicated, supplements as ordered, therapeutic snacks at HS (bedroom) and report to nurse if refusing to eat. A physician order, dated 08/12/2022, documented weekly weights were to be obtained weekly for four weeks. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order, dated 08/12/2022, documented weights were to be obtained monthly beginning 10/01/2022. Review of Resident 4's Weight Record documented the following: On 08/12/2022, 225.0 lbs. via Wheelchair On 08/19/2022, 201.0 lbs. via Wheelchair On 09/14/2022, 182.0 lbs. via Mechanical Lift On 10/01/2022, 177.6 lbs. via Mechanical Lift Records showed, from 08/12/2022 to 10/01/2022, Resident 4 lost 47.4 lbs, a 21.1% weight loss in 50 days. Review of Resident 4's electronic health record did not show documentation the resident was reassessed by a Registered Dietician after weight loss was identified during August 2022, September 2022, or October 2022. Resident 4 had been assessed by a RD on admission only. Review of Resident 4's Meal Monitor, dated 10/14/2022 to 11/14/2022, showed no monitoring was documented on 10/15/2022, 10/22/2022, 10/27/2022, 10/29/2022, 11/03/2022/11/04/2022, 11/10/2022, 11/11/2022, and 11/14/2022. One meal only was documented on 10/16/2022, 10/23/2022, 10/24//2022, 10/25/2022, 10/26/2022, 11/06/2022, and 11/12/2022. On 11/23/2022 at 11:15 AM, Staff E, Registered Nurse (RN), said when Resident 4 was admitted , he needed more assistance; but then gained the ability to feed himself and he was assisted to drink the protein shakes. At 3:25 PM, Resident 4's Family Member (FM) 2 said they would often visit, and the staff would just deliver the meal tray and leave. On 11/28/2022 at 5:05 PM, Resident 4 said staff would bring his tray, sometimes cut up the food, but leave in a hurry. The resident said if there was something else he wanted, he had to put on the call light and wait a long time before staff came back. On 12/06/2022 at 4:26 PM, the meal monitoring documentation for Resident 4 and Resident 6 for August 2022, September 2022 and October 2022 was requested from Staff A, Executive Director. On 12/07/2022 at 12:21 PM, Staff A said they were not able to access that information nor could Staff C, Regional Dietician. 3) Resident 5 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented the resident was cognitively intact, had mild depression, and required extensive assistance from 2 staff for bed mobility, transfers and bathing, and extensive assistance of one staff for dressing, eating and personal hygiene. The MDS documented the resident had no swallowing issues and required a mechanically altered diet. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 5's Weight Record documented the following: On 10/23/2022, 119.4 lbs standing On 11/03/2022, 102.0 lbs standing On 11/15/2022, 102.0 lbs wheelchair Records showed, from 10/23/2022 to 11/03/2022, Resident 5 lost 17.4 lbs, a 14.6% weight loss in 11 days. Resident 5's medical record showed a nursing to nutrition referral was initiated on 11/17/2022. On 11/23/2022 at 11:15 AM, Staff E, Registered Nurse (RN), said resident weights were obtained by nursing assistants and the licensed nurses enter the weights into the chart. Staff E said if it triggered weight loss, the nutritional team would see it and make their recommendations. Staff E said she believed someone ran a report to identify the weight loss. Staff E said they had a registered dietician who came into the facility. Staff said there was a new one, but had only seen them once. Staff E said she was not sure what the current process was regarding residents being assessed by a registered dietician. Staff E said Resident 4 did not like the food served at the facility and they encouraged him to drink the shakes that were ordered. On 12/05/2022 at 3:25 PM, Staff C, Corporate/Regional Registered Dietician (RD), said he just started with the company two months ago and the company had employed a remote RD in October 2022. Staff C said he was not sure about August 2022 or September 2022, but dieticians were in the buildings once or twice a week, and residents were expected to be assessed on admission, quarterly and as needed in between. Staff C said the RD would run reports to identify any weight loss issues that triggered. Staff C said there was a nursing to nutrition progress note that RDs looked for, and staff could call the RD to notify of weight concerns. Staff C said he would expect staff to notify the RD for a weight loss of 5 pounds or more. After reviewing the health records for Resident 4, Resident 5 and Resident 6, Staff C said he was not able to locate any RD assessments regarding the residents' weight loss. Staff C said weight loss could impact wound healing. On 12/06/2022 at 1:17 PM, Staff H, RN and Resident Care Manager, said residents were to be weighed weekly for four weeks and then monthly, unless they had lost weight. Staff H said if they had lost weight, the dietician would step in. When asked how the dietician was notified of weight loss, Staff H stated, I am assuming she can go in there [health record] and look. On 12/07/2022 at 11:09 AM, Staff B, RN and Director of Nursing Services, said residents were to be weighed upon admission and weekly for four weeks; and if weights were stable, then they would be weighed monthly. Staff B said if weight loss occurred, the RD should be notified. Staff B said when she began working at the facility on October 2022, she did not believe the facility had a RD. At 12:21 PM, Staff A, Executive Director, said he would expect staff to notify the RD when weight loss was identified. Staff A said he believed the facility had RD coverage for August 2022 and September 2022, but that person was no longer employed. Staff A said an RD may have been working remotely. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-1060 (3)(h)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45203 Based on observation, interviews, and record review, the facility failed to ensure adequate Licensed Nurse and Nursing Assistant (NA) staffing to maintain and ensure assistance according to resident care plan and preferences, and timely call light response times for five of five sampled residents (3, 4, 7, 6 & 8) and eight of eight sampled staff (F, E, L, M, I, N, O & H) reviewed for nursing staff. 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 . <Residents> 1) On 11/15/2022 at 1:40 PM, Resident 3 said she had to wait as long as 6 hours for the call light to be answered, and evenings and weekends were the worst. Resident 3 said she usually did not get evening medications until 11:00 PM. The resident said she did not feel there was enough staff to meet resident needs. 2) On 11/18/2022 at 2:58 PM, Resident 4's Family Member (FM) 2 said on 10/15/2022, they took Resident 4 out of the facility for a few hours. When they returned in the early evening, the door was locked. They rang the doorbell and no one answered. They called the facility multiple times and no one answered. They finally were able to enter by pushing on the door. FM 2 said after they got inside, they brought Resident 4 to his room, put on his call light and waited over an hour for someone to answer. On 11/28/2022 at 5:05 PM, Resident 4 said he could never get any help. He frequently waited over an hour for someone to respond to his call light, even when they had a soiled brief, or was requesting to be repositioned. Resident 4 stated, They would answer the light and then say ok, I'll be back; and then never come back. Resident 4 said he only received 2 to 3 showers the whole time he was at the facility. Resident 4 said he did not refuse any showers while at the facility. Resident 4 said he did not feel there was enough staff to meet resident needs. Resident 4 said staff said they were understaffed, and many times Resident 4 had to resort to yelling out to get assistance. Resident 4 said at night he was usually only repositioned a couple of times, and there were occasions he was not repositioned at night. Review of Resident 4's Bathing Record, dated 10/15/2022 to 11/15/2022, documented no showers were given and no refusals were documented. 3) Resident 7 was admitted to the facility on ,d+[DATE]//2022. The Medicare 5 day Minimum Data Set (MDS), an assessment tool, dated 11/19/2022, documented the resident had moderate cognitive impairment, and require assistance from one staff with all activities of daily living. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/05/2022 at 10:37 AM, Resident 7 said he had waited as long as 4 to 6 hours for his call light to be answered. Resident 7 said frequently when he put the call light on, the person answering the call light could not help him. If he requested pain medication, staff would tell him they would let the nurse know. Resident 7 said now it still takes up to two hours to get medication. 4) On 12/05/2022 at 11:10 AM, Resident 6 said she usually waited about an hour for someone to answer the call light. 5) Resident 8 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented the resident was cognitively intact and required extensive assistance from one staff member for transfers and toileting. On 12/07/2022 at 9:17 AM, Resident 8's call light was observed to be on. The resident was sitting on the edge of the bed with a gown on and hands folded in her lap. At 9:21 AM, an unidentified staff was observed going into Resident 8's room and asked the resident if they could help the resident with something. The resident told the staff she could not hear the staff member because she needed her hearing aids, and asked the staff for her hearing aids. The staff member left the room, and the call light remained on. At 9:23 AM, the staff member was observed returning to Resident 8's room with a dry erase board, and the resident was heard telling the staff she was sorry, she had glaucoma and count not read that. The staff member left the room and the call light remained on. At 9:31 AM, a nursing assistant was observed answering the call light. At 10:09 AM, Resident 8 stated, November the 25th was the worst day. The resident said nursing staff had finished attending to a dressing on her leg and then left the room and closed the door, leaving the overhead lights on. Resident 8 said she was not ready for bed yet. The resident said she put call light on and it took a long time for someone to answer it. When they did, they just opened the door and said, What do you want? Resident 8 said she told them she needed to get ready for bed, and the staff member just closed the door again. Someone came back about 20 minutes later, and gave Resident 8 the assistance she needed. <Staff> 1) On 11/23/2022 at 10:45 AM, Staff F, Nursing Assistant (NA), said he has had to care for as many as 22 residents on a day shift, usually on the weekends. When that happens, he cannot complete all assigned tasks. Staff F said things like nail care, room tidying up and quality showers may not happen. Staff F stated, Showers become bird baths. Instead of four rounds he usually can only complete three. Staff F said he did not feel there was enough staff to meet resident needs. On 12/06/2022 at 11:30 AM, Staff F said he was not always able to reposition all his residents every two hours; but he did if the resident had a wound. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) On 11/23/2022 at 11:15 AM, Staff E, Registered Nurse (RN), said she has had as many as 30 residents to care for. When asked if nurse managers were available to help, Staff E said she is usually already scheduled to work the floor. Staff E said on days, when she has over 20 residents, it was difficult to complete all assigned tasks. Usually documentation did not get done and she had to prioritize what was done. Staff E said she did not feel there was enough staff to meet resident needs. 3) On 11/23/2022 at 12:53 PM, Staff L, Licensed Practical Nurse (LPN), said she usually had to care for 45-50 residents on the night shift she worked. Staff L said it was challenging but she could handle it if there were enough NAs scheduled. Staff L said it was difficult to get all the medications passed on time. Staff L said on 10/31/2022 there was only her and another nurse schedule to work that night. Staff L said a NA stayed over to work a few hours, and another licensed nurse worked part, but not all, of the shift. Staff L said although the number of NAs has improved, the number of nurses have not. 4) On 11/23/2022 at 1:15 PM, Staff M, LPN and Float Pool Staff, said she usually cared for about 20 residents; but if she does not stay over her shift, the other nurse had to care for 35 residents after she left. Staff M said she was frequently asked to come in early or stay late. Staff M said she was able to manage, but usually the documentation was what did not get done. Staff M said she did not feel there was enough staff to meet resident needs. 5) On 12/05/2022 at 2:26 PM, Staff I, Advanced Registered Nurse Practitioner and Wound Care Provider, said she was unable to perform wound rounds for the past two weeks at the facility due to there not being staff available to assist her with her rounds. 6) On 12/05/2022 at 4:09 PM, Staff N, LPN, said she felt there was enough staff to meet resident needs, but it's the extra stuff we cannot get to . We keep them clean and safe. 7) On 12/05/2022 at 3:05 PM, Staff O, NA, said she had only been working at the facility a short time. When asked if she felt there was enough staff to meet resident needs, Staff O stated, To be honest, no. Staff O said she was not able to reposition and provide toileting care every two hours, but she did her best. 8) On 12/06/2022 at 1:17 PM, Staff H, RN and Resident Care Manager (RCM), said she was scheduled to work the floor quite often. Staff H said she worked the weekend, today, and was scheduled for more days in the coming week. Staff H said she was covering call ins, and she was scheduled to work the floor most days. When asked how this affected how she managed the care of the residents, Staff H stated, It's hard to do both jobs. On 12/07/2022 at 11:09 AM, Staff B, RN and Director of Nursing Services (DNS), said she did not have a role in determining the staffing of the facility. That was managed by Staff A, Executive Director, and Staff D, Regional Nursing Director. Staff B said she frequently was scheduled to work the floor as well as the two RCMs. Staff B said in the past two weeks she has been scheduled to work the floor about three to four days a week. When asked if this had a negative impact on her ability to monitor the care of the resident, Staff B stated, Yes. Staff B said she has had five full time nurses leave in the past two to three weeks, and that had an impact. Staff B said she would prefer to staff with more NAs and Licensed Nurses, and feels call lights should be responded to within 15 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:21 PM, Staff A, Executive Director, said he worked with Staff D to determine the staffing needs of the facility daily. Staff A said they would prefer to staff with more NAs and Licensed Nurses, but they were doing everything they could to attract and retain help. Staff A said the facility had lost three licensed nurses in the past month; only one voluntarily left. Staff A said he was considering not admitting residents. Staff A said the DNS and RCMs were being scheduled to work the floor and were not covering call ins. Staff A indicated the staffing issue interfered with their ability to monitor the care being delivered to the residents. Staff A said he was not aware of the staffing issues on 10/31/2022 when , Staff A said staff were directed to call him if there were issues, but that did not always happen. At 1:27 PM, Staff D, Regional Nursing Director, said regarding 10/31/2022, there was no way the schedule would run with only 2 nurses. She did not have access to the actual schedule, but believed another nurse worked as a NA and there was another NA for a total of 4 staff. Staff D said staffing was based on acuity and census as much as possible. Staff D said staffing was challenging, but believes there is enough staff to meet the residents needs by utilizing management to assist on the floor. Staff D said there were times nursing management had to cover the floor six to seven days a week. When asked if she felt this would impact the nurse managers ability to manage the care of the residents, Staff D stated, I do a lot of oversight remotely and if they had any additional need, they should let me know. Reference WAC 388-97-1080 (1)(9)(10) (a-c)