STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505017	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Care Center	2821 South Walden Street Seattle, WA 98144

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44295 Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from sexual abuse for 1 of 3 residents (Resident 1) reviewed for sexual assault. This failed practice resulted in psychological harm, applying the reasonable person approach, for Resident 1 who experienced an attempted sexual act by another resident (Resident 2) and resulted in Resident 1 being transferred to a hospital emergency room (ER) for evaluation. This failed practice placed all residents at risk for the potential of sexual abuse, psychological harm, and diminished quality of life. Findings included . Review of the facility policy titled, Abuse and Neglect- Clinical Protocol, revised 03/2018, showed sexual abuse was defined as a nonconsensual sexual contact of any type with a resident. The policy showed the nurse would assess the resident and document related findings, such as; injury and pain assessment, and report findings to the physician. The physician would evaluate or refer the resident for evaluation to rule out sexual assault. The physician's input would be included to investigate alleged abuse or neglect and the physician would order measures required to address the consequences of the abuse situation, such as a psychological evaluation. <Resident 1> Review of a Quarterly Minimum Data Set (MDS), an assessment tool), dated 02/27/2024, showed Resident 1 had severe impairments to their decision-making ability, had no behaviors, could usually understand and be understood by others . The MDS showed Resident 1 had medically complex conditions including heart disease, dementia, and disorientation. The MDS showed Resident 1 used a walker to ambulate, was independent with bed mobility, and required supervision for transfers. Review of an At risk for decline in mood state Care Plan (CP), revised 05/29/2024, showed Resident 1 was at at risk for decline in mood due to feeling down, having a diagnosis of dementia, and a history of emotional disturbances. The CP directed staff to provide assistance with situations that caused distress, anger, and anxiety. Review of a trauma CP, dated 07/28/2022, showed Resident 1 had a history of trauma due to a difficult childhood and serious undiagnosed mental issues. The CP directed staff to inform social services if Resident 1 displayed any new behaviors and monitor for signs and symptoms of residual trauma. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a Nursing Progress Note (NPN), dated 05/22/2024, showed Staff C (Assistant Director of Nursing, Licensed Practical Nurse, LPN) documented at 6:30 PM a staff member walked passed Resident 1's room and saw Resident 2 with their pants down and on top of Resident 1 who was exposed from the waist down. The staff member intervened, removed Resident 2 who was placed with a one-on-one caregiver and called the physician who gave orders for Resident 1 to be evaluated at the hospital. Staff C documented police officers arrived at the facility and interviewed Resident 1 who stated they had a visitor in their room, initially said they were playing, and stated yes, they had intercourse. Staff C documented that Resident 1 stated they allowed the intercourse to occur. The NPN showed Staff C documented police officers interviewed Resident 2 who stated yes they were in another resident's room, denied having intercourse with Resident 1 and stated they were just talking. Review of a NPN, dated 05/23/2024, showed the hospital social worker called the facility to inquire if Resident 1 and Resident 2 were boyfriend and girlfriend because Resident 1 told hospital staff that Resident 2 was their boyfriend, they didn't do anything that Resident 1 didn't want them to do. An additional NPN, dated 05/23/2024 showed Resident 1 returned back to the facility and had sexually transmitted infection tests done at the hospital with results still pending. Review of hospital documents, dated 05/22/2024, showed hospital staff documented that Resident 1 reiterated that they engaged in consensual sexual activity of kissing and intercourse with their boyfriend (Resident 2). The hospital documents showed Resident 1 did not want to be seen for sexual assault and Resident 1's Collateral Contact (CC) agreed to not have a Sexual Assault Nurse Examiner (SANE) complete an exam. The hospital documents showed Resident 1 had their urine tested , had a Urinary Tract Infection (UTI) and was given medication to treat the infection. In an interview on 05/24/2024 at 11:50 AM Staff C stated that Resident 1 was diagnosed with a UTI and told hospital staff that Resident 2 was their boyfriend. Staff C stated staff had never observed them together or attempting to follow each other. Staff C stated Resident 1 had no history of sexual behaviors, hospital staff assessed Resident 1 with no physical signs of sexual intercourse, so a rape kit (a kit to collect evidence of a sexual assault) was not done. In an interview on 05/24/2024 at 12:20 PM Staff F (LPN) stated they were not present for the incident between Resident 1 and Resident 2. Staff D stated Resident 1 was confused, would say things that did not make sense and did not have any sexually inappropriate behaviors. In an interview and observation on 05/24/2024 at 12:22 PM, Resident 1 was observed sitting on the edge of the bed eating lunch. When asked about the sexual incident Resident 1 stated no, nothing happened and they had not been touched inappropriately but worried about the older man. Resident 1 stated, I was okay that day and after being at the hospital was worried about the old man and their safety. Resident 1 stated they (the old man) was their friend and I was too close to him, he was suffering. <Resident 2> (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a Annual MDS, dated [DATE], Showed Resident 2 had some impairments to their decision making, had no behaviors, sometimes was able to understand others, and usually could make themselves understood. The MDS showed Resident 2 had diagnoses including non-traumatic brain dysfunction, dementia, depression, and a psychotic disorder (a mental disorder characterized by disconnection from reality). The MDS showed Resident 2 had no impairments to their upper or lower body, used a walker and a wheelchair to ambulate, and was independent with toileting, personal hygiene, bed mobility and transfers. Review of a Decline in mood state CP, revised 02/01/2023, showed Resident 2 had a decline in mood due to dementia with behavioral disturbances, psychosis and fluctuating levels of confusion. The CP directed staff to provide assistance with situations that caused distress, anger or anxiety. A behavior CP, initiated 07/31/2019 and revised on 05/23/2024, showed Resident 2 had behaviors of sexual encounters with other residents. The CP directed staff to re-direct Resident 2 away from female residents and a one-on-one caregiver to re-direct the resident. Review of a NPN, dated 05/22/2024, showed Staff D Licensed Practical Nurse (LPN) documented Resident 2 was forgetful and oriented to self and was last seen watching television in the day room at 5:40 PM. Staff D documented at 6:40 PM they were notified that Resident 2 was found with their pants and underwear pulled down on top of Resident 1 who was lying on their back with their groin area exposed trying to perform sexual act. Staff D documented they did not observe any skin to skin contact or penile erection. Staff D documented both residents were separated, Resident 1 was assessed for injury to their groin area and no injuries or skin issues were noted. Resident 1 told Staff D that Resident 2 was their friend, this was not their (Resident 2) fault, did not hurt them, and please don't tell anyone. Staff D documented that Resident 2 stated to them that Resident 1 let them touch them, they didn't force anything, did nothing wrong, just touched them. Staff D placed Resident 2 on a one on one caregiver and moved Resident 2's room to a different floor of the facility. Review of a NPN, dated 05/28/2024, showed Resident 2 remained with a one on one caregiver and made multiple attempts to enter another resident's room but was redirected by staff. In an interview on 05/24/2024 at 11:50 AM Staff A (Administrator) stated that staff were not aware of Resident 2's sexual inappropriateness but when reviewing Resident 2's record found in February 2020 Resident 2 was found lying in bed with a female resident, was put on a one-on-one caregiver at that time for 10 days. Staff A stated the one on one caregiver was discontinued and they couldn't determine why the one on one caregiver was discontinued. Staff A stated they were surprised by the incident but staff were not monitoring Resident 2 any sexually inappropriate behaviors. Review of Resident 2's NPN's dated 07/19/2019, showed no documentation on why staff initiated a behavior CP for sexual encounters. Review of NPN, dated 02/2020, showed no documentation of Resident 2's incident of being found lying in another female resident's bed. In an interview and observation on 05/24/2024 at 12:10 PM, Resident 2 was observed sitting in their wheelchair and a one-on-one caregiver was present in the room. Resident 2 stated they did not know anyone at the facility, didn't have a girlfriend at the facility, and didn't remember what happened the other day. Resident 2 stated it was a misunderstanding, they don't want to be the bad guy and was innocent. Resident 2 stated they were getting a lot of attention lately which concerned them, it was freaking them out and they didn't understand what was going on. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 05/24/2024 at 12:39 PM, Staff D LPN stated they were not present for the incident between Resident 1 and 2 but they were familiar with Resident 2. Staff D stated they used to work with Resident 2 in the past and had not observed any sexually inappropriate behaviors prior to the incident. REFERENCE: WAC 388-97-0640(1)