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	10/09/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45203 Based on interview and record review, the facility failed to report to the state agency and/or log allegations of abuse/mistreatment by staff on the reporting log within five working days for 1 of 3 residents reviewed for abuse and neglect. This failure placed residents at risk for repeated incidents, unmet care needs and unidentified abuse and/or neglect. Findings included . Review of Nursing Home Guidelines, The Purple Book, dated October 2015 showed on page 7 that the facility should report via telephone and via the reporting log any act where there is reasonable cause to believe the act caused fear of imminent harm. Review of the undated facility policy titled, Prevention and Reporting: Resident mistreatment, Neglect, Abuse ., showed that facility staff were to report to the Director of Nursing or Executive Director any allegation of abuse, neglect or mistreatment, who would then immediately report to the state agency. All alleged violations involving abuse or mistreatment would be reported within 2 hours of when the allegation was made and no later than 24 hours if the allegation did not involve abuse or serious bodily injury. The investigation should include review of all allegations of abuse and be documented in the electronic accident and incident report form. Resident 1 was admitted to the facility on [DATE] with diagnosis of left hip fracture. A (struck out) Incident note dated 09/29/2024 at 12:47am, by Staff C, Licensed Practical Nurse (LPN), showed they received a call from Resident 1's family member (FM) who was concerned due receiving several calls from Resident 1 reporting being abused and assaulted by staff and feeling anxious. Staff C went to Resident 1's room , accompanied by staff, and found the resident awake and on the phone with the police department, the resident became increasingly anxious and verbalized an account of being assaulted at approximately 8:00pm and reported that three aids aggressively forced her to bed and tortured her when trying to remove her pants, Resident 1 reported being shoved and handled inappropriately and was expressing fear for her life and requested transport back to the hospital. Staff C reported the allegation to Staff B, Director of Nursing (DNS), Registered Nurse (RN), and followed up with Resident 1's FM and law enforcement. Resident 1 was transported to ER via non urgent ambulance. (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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A late entry Incident note, dated 09/29/2024 at 12:10am by Staff C, showed they received a call from Resident 1 FM, concerned that the resident reported feeling unsafe. No signs of harm were observed, the resident was on the phone to police reporting she felt unsafe, the resident was anxious and agitated and requested transport back to hospital. The complaint intake, dated 09/30/2024 at 3:00pm, showed Resident 1 verbalized they felt attacked and reported staff pushed me into the bed from my chair, and ripped my pants and underwear off and hurt my hip. Review of the facility mandated reporting log for September 08, 2024, through October 08, 2024, showed no entry for Resident 1's allegation of abuse towards staff had been completed or reported to the state agency via the hotline or the facility mandated reporting log. On 10/08/2024 at 3:21pm, Staff B, said she had double checked the mandated reporting log with the risk management log and there was nothing missing from it. At 7:49pm Staff D, Certified Nursing Assistant (CNA), said they recalled Resident 1 and had assisted 2 other staff in the transfer, there was nothing out of the ordinary, but the resident was apprehensive of transferring and the staff explained the process to her. Staff D said she left after the transfer was completed and the other two staff assisted the resident with changing. Staff D was asked to fill out a witness statement the next day but reported no one had asked her for it and still had it in her possession. Staff D reported no one from facility management had spoken to her about the allegation. At 8:09pm Staff C, LPN, said signs and symptoms of abuse included if a resident reported abuse and the resident could be paranoid or anxious. If a resident reported abuse to him or he saw signs of abuse he would report it to Staff B. If the facility did not follow up, he would report to the state agency. Staff C said on 09/28/2024 Resident 1 was assisted by staff and was observed sleeping about 9:30pm, at 11:30pm she was observed awake, shouting, and anxious. Resident 1 reported to him she was put in bed against her will, assaulted an abused. Resident 1 reported she did not feel safe there and wanted to leave. Staff C said Resident 1 denied being injured, had no complaints of pain and declined to talk to him anymore. Staff C said he believed Resident 1 made an allegation of abuse and he reported it to his supervisor, Staff B. When asked why he struck the 09/29/2024 incident note out on 10/02/2024, he said he did not recall striking the note out but was asked by Staff B to put in a less detailed note. On 10/09/2024 at 10:51am, Staff B, DNS, RN said that a Resident being transferred against their will and staff being rough with care could be considered abuse. Staff B said she did ask Staff C to put in a less detailed note because she felt the note was more of a statement, verses what was factual and what Staff C observed. Regarding Resident 1's allegation of abuse, Staff B said they did an investigation and determine the allegation was unfounded and did not need to be reported or logged. At 11:13am Staff A, Administrator said he recalled Resident 1's name, but was not aware there was an allegation of abuse, he was under the impression she was calling out during care. When asked if a resident made an allegation of abuse would that be expected to be included on the facility mandatory reporting log, Staff A said he would have to look into that, he felt they had determined the allegation was unfounded. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: WAC 388-97-0640(5)(a) (6)(c)