STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505154	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tacoma Nursing and Rehabilitation Center	2102 South 96th Street Tacoma, WA 98444

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 - Minimal harm or potential for 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** 46472 Based on interviews and record review the facility failed to ensure residents were free from abuse for 1 of 3 residents (Resident 1) reviewed for abuse. Resident 1 experienced harm when staff failed to implement and comply with facility abuse prohibition and social media policies that violated their right to privacy and resulted in substantiated mental abuse. This failed practice also placed residents at risk for humiliation, resident-to-resident altercations, and diminished quality of life. Findings included . Review of the facility's Abuse, Neglect, and Exploitation policy, undated, showed the facility would provide protections for the health, welfare, and rights of each resident by developing and implementing their abuse prohibition policy and procedures. The policy showed possible indicators of abuse included verbal abuse of a resident overheard, psychological abuse of a resident observed, and evidence or photographs/videos of a resident that are demeaning or humiliating in nature, regardless of whether the resident provided consent, and regardless of the resident's cognitive status. The policy indicated mental abuse included (but was not limited to) humiliation, harassment, threats of punishment, or abuse that was facilitatied or caused by nursing home staff taking or using photos/videos in any manner that would demean or humiliate a resident. Review of the facility's Social Media Policy-Residents, undated, showed the facility mandated all employees would maintain residents right to privacy, professional boundaries in the use of electronic media, and promptly report any identified breach of policy (including resident abuse). The facility mandated no: identification of any resident by name, sharing/posting/publishing of images or any resident-related information that was reasonably anticipated to violate resident rights or otherwise degrade/humiliate the resident, refer to any resident in a disparaging manner (even if they were not identified), and no photos/videos of residents on personal devices (including personal cell phones). <Resident 1> Review of the 05/08/2024 modified Quarterly Minimum Data Set (MDS-assessment tool) showed Resident 1 had some cognition problems, indicators of depression, and diagnoses included stroke, high blood pressure, and alcohol dependence. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the trauma informed care plan (CP), revised 01/30/2024, showed Resident 1 reported past traumatic events that included significant personal loss. Staff were directed to provide supportive care and report any signs or events of potential traumatization. Review of a Social Service Progress Note (SSPN), dated 06/18/2024 at 1:18 PM, showed a facility staff member took two videos of Resident 1 without their knowledge or permission and posted them on social media. Resident 1 recalled Staff D, Certified Nursing Assistant, entered their room about a week earlier and told Resident 1 another resident hit them. Resident 1 reported they were upset at first because they though Staff D truely was hurt. Resident 1 said they were later told by Staff D it was just a joke. Resident 1 state on the day prior (06/17/2024) Staff D asked Resident 1 how they felt about going viral, but did not know what that meant. That was when Resident 1 learned they were filmed and the videos were put on the internet. Resident 1 stated they were not asked, nor did they give permission for the videos to be recorded. In an interview on 06/20/2024 at 11:50 AM, Staff C, Registered Nurse (RN)-Consulting Nurse, stated they viewed the videos and described the content as aggregious, mentally abusive, and disheartening. Staff C stated the only person in the video was Resident 1 and heard Staff D (who was holding the phone), and Staff E, CNA, who was providing care to Resident 1's roommate at the time, behind the curtain, saying No. Staff D lied to Resident 1 about being hit by another resident and asked Resident 1 What are you going to do about it? - inciting violence, encouraging Resident 1 to defend Staff D and kick their ass. Staff C stated a group of staff were overheard giggling and talking about a viral video on 06/17/2024 at the nurse station. It was at that time that Staff F, CNA, viewed the video, but did not report the violation. Staff G, CNA, stated they heard about a video but never saw the video or who was in the video. Staff H, Maintenance Director, overheard their discussion of a viral video but did not know it contained a resident and they were in the middle of a task. Observation of a recording of the first video, on 06/26/2024 at 11:20 AM, showed the shoulder of Staff D while they walked into the room and stated [Resident 1], theres this resident out there -he just smacked me . what are you going to do? [NAME] replied Want me to beat his [a**]? Then a voice in the background that said No at the same time Staff D stated Yeah he just smacked me. [NAME] stated Where's he at? Staff D stated he's right outside. Come whoop his a** right now. How are you going to beat him up? Then a male walks into the picture and the video stopped. Observation of a recording of the the second video, on 06/26/2024 at 11:22 AM, showed Resident 1 lying on thier bed. Staff D asked Resident 1 how it felt to go viral?. In an interview on 06/26/2024 at 11:08 AM, Staff B, Director of Nursing, stated abuse was substantiated and Staff E and Staff F, who became aware of the video, should have reported the violation as soon as they obtained knowledge but did not. Refer to F-609 Reference WAC 388-97-0640 (1)(2)(3)(a)

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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. 46472 . Based on interview and record review, the facility failed to ensure 3 of 5 staff (Staff E, R, and G) immdiately reported abusive violations to the State Agency (SA) and facility administration. This failure placed residents at risk for abuse, potential for harm, and diminished quality of life. Findings included . Review of the facility Inicident Report (IR) dated 06/18/2024, showed Staff C, Certified Nursing Assistant (CNA), filmed two unauthorized videos of Resident 1 on their personal cellular device and posted the videos on a social media site. The first video showed Staff C lie to Resident 1 about another resident hitting them and encouraging Resident 1 to go beat the other resident up. In the video, Staff C used Resident 1's name and vulgar language. The second video showed Resident 1 lying on their bed, and Staff C asked Resident 1 how it felt to go viral. The IR conclusion substantiated abuse ocurred and that Staff E, CNA, and Staff F, CNA, failed to timely report the violations to the SA and facility administration. Review of the faciltiy IR witness statement by Staff E, Certified Nursing Assistant (CNA), dated 06/18/2024, showed they were in the room providing care to Resident 1's roommate with the curtain drawn and overheard the conversation Staff C had with Resident 1. Staff E stated they should have reported the conversation right after it happened but did not. Staff E stated they were unaware the video was taken until they saw it appear on the social medial site sometime in the previous week. Staff E, a mandated reporter, failed to report the converstaion they overheard immediately after it occurred and failed to report the video the observed (prior to 06/18/2024) to the State Agency (SA) and facility administration to protect the residents. Reveiw of the facility IR witness stated by Staff F, CNA, dated 06/18/2024, showed they observed the video at the nurse station during the day shift on 06/17/2024 while other staff were giggling about something. Staff F asked Staff C if Resident 1 was aware of the video and Staff C replied Resident 1 gave persmission to post the video, so Staff F thought nothing more of it. In an interview on 06/20/2024 at 12:30 PM, Staff C, Registered Nurse-Consultant, stated Staff E and Staff F should have reported the violation immediately to the State Agency as a mandated reporter and to facility administration and did not. Refer to F600 Reference WAC 388-97-0640 (2)(b)(5)(a)(b)(7)(b)(i)(ii).