STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505311	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seattle Medical Post Acute Care	555 16th Avenue Seattle, WA 98122

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** 45146 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 2 residents (Resident 1), reviewed for sexual abuse investigations. Resident 1 experienced harm, applying the reasonable person concept (how a reasonable person would respond under the same circumstances, a reasonable person in this same situation would be upset, angry, and feel violated), when Resident 2 was observed performing nonconsensual sexual act on Resident 1. This failed practice placed all residents at risk for sexual abuse, psychological harm, and a diminished quality of life. A past noncompliance was initiated on 04/12/2025 related to F600 Free from Abuse and Neglect for failure to protect Resident 1 from sexual abuse. The facility implemented the following interventions that were initiated 04/12/2025 and corrected by 04/14/2025: - Resident 1 was assessed and monitored by licensed nurses. - Resident 2 was placed on one-on-one supervision and removed from the facility by Law Enforcement officials. - The facility conducted an interview of Resident 2's identified previous roommates for possible sexual abuse - Staff education was provided for all staff on the facility's policy of abuse and neglect prohibition, prevention, identification, reporting and investigation. - Weekly audits were completed weekly for three weeks, and the facility had ongoing weekly and monthly audits for two months and the results will be reviewed through the facility's Quality Assurance Performance Improvement Committee process. Findings included . (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: 505311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2025

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's policy titled, Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation, updated March 2025, showed, Each resident has the right to be free from abuse, including verbal, mental, sexual, or physical abuse, corporal punishment, involuntary seclusion, mistreatment, neglect, misappropriation of resident property, exploitation, and any physical or chemical restraint not required to treat the resident's medical condition. The Center [facility] implements policies and processes so that residents are not subjected to abuse by staff, other residents, volunteers, consultants, family members, and others who may have unsupervised access to residents . Sexual Abuse: Non-consensual sexual contact of any type with a resident includes unwanted intimate touching of any kind, especially of breasts or perineal area; all types of sexual assault or battery, such as rape, sodomy [anal or oral intercourse] and coerced nudity . Generally, sexual contact is non-consensual if the resident either appears to want the contact to occur but lacks the cognitive ability to consent; or does not want the contact to occur. Non-consensual contact may include, but is not limited to, situations where a resident is sedated, is temporarily unconscious, or is in a coma [a state of prolonged loss of consciousness]. RESIDENT 1 Resident 1 admitted to the facility on [DATE] with diagnoses that included anoxic brain damage (occurs when oxygen is cut off completely from the brain) and persistent vegetative state (also known as post-coma unresponsiveness, is a chronic disorder in which an individual with severe brain damage appears to be awake but shows no evidence of awareness of their surroundings). Review of Resident 1's annual Minimum Data Set (MDS - an assessment tool) dated 02/14/2025 showed Resident 1 was in a persistent vegetative state with no visible consciousness. The assessment further showed that Resident 1 was dependent on staff with all aspects of care. Observations on 04/18/2025 at 11:17 AM, showed Resident 1 was in bed positioned on their back. Further observation showed Resident 1 was not responsive and with no awareness of self or surroundings. Review of the interdisciplinary note dated 04/12/2025, showed, Today at approximately 3:00 PM, a staff member observed the resident's roommate [Resident 2] to may have been inappropriately performing unwanted sexual act to the resident [Resident 1]. Review of a facility investigation dated 04/12/2025, showed Staff J, Certified Nursing Assistant (CNA), stated that they saw Resident 2 with head/face on Resident 1's private area, while Resident 1's brief was off performing oral sex. Further review of the investigation showed the facility substantiated a resident to resident sexual abuse and Resident 2 was arrested by the Police on 04/12/2025. In a phone interview on 05/02/2025 at 8:00 AM, Resident 1's Collateral Contact 1 (CC1) stated that Resident 1 was not able to consent. CC1 stated that they felt very scared when they were notified about the incident on 04/12/2025. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 05/02/2025 at 10:14 AM, Staff J stated that on 04/12/2025 around 3:00 PM, when they were entering Resident 1's room, they found Resident 2 by Resident 1's bed. Staff J stated that Resident 2 was bending down at their waist and their head and face were in Resident 1's private area and was performing oral sex, Staff J stated that when they called Resident 2 by name and asked them what they were doing, Resident 2 stopped their action and walked back to their bed. Staff J stated that they observed Resident 1's incontinence brief was unfastened, and their private area was exposed. Staff J further stated they immediately reported it to Staff G, Resident Care Manager. In an interview on 05/02/2025 at 11:01 AM, Staff G stated that on 04/12/2025, when Staff J notified them about the incident, they went to Resident 1's room and observed Resident 1's incontinence brief was open, and their private area was uncovered. Staff G further stated they immediately placed Resident 2 on one-on-one supervision and assessed Resident 1 for injury. RESIDENT 2 Resident 2 admitted to the facility on [DATE]. Review of Resident 2's quarterly MDS dated [DATE] showed Resident 2 was cognitively intact. The assessment further showed Resident 2 was independent with sit-to-stand and able to walk at least ten feet in a room, corridor, or similar spaces. Review of the December 2024 and January 2025 Documentation Survey Report for behavior monitoring and intervention showed that Resident 2 had the following physical/verbal behavioral symptoms: - On 12/11/2024 - threatening others - On 12/18/2024 - scratching others and threatening others - On 12/20/2024 - pacing and wandering - On 12/29/2024 - grabbing others - On 01/03/2025 - wandering - On 01/04/2025 - wandering - On 01/15/2025 - physically aggressive Further review of the January 2025 Documentation Survey Report showed that the behavioral monitoring was discontinued on 01/25/2025. Review of the social service note dated 12/30/2024 showed that the facility's social worker met with Resident 2 related to occurrence of grabbing others. Further review of the note did not show if further behavioral assessment or Resident 2's behaviors directed towards others addressed under Resident 2's care plan. Review of the comprehensive care plan printed on 04/18/2025 showed there was no care plan in place for Resident 2's documented behaviors in December 2024 and January 2025. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview and joint record review on 05/02/2025 at 11:53 AM, Staff F, Social Services Director, stated that if a resident exhibited behavior towards other residents/staff, the facility would assess the resident and implement an intervention for the behaviors identified. Staff F stated they were not aware of Resident 2 having documented behaviors directed towards others. Joint record review of the social service note dated 12/30/2024 showed that Resident 2 had exhibited behavior grabbing others. Staff F stated that Resident 2's behaviors were not addressed under their care plan due to there being no behavioral trends, and the resident was not on medications that required behavior monitoring. In an interview on 05/02/2025 at 3:27 PM, Staff B, Director of Nursing, stated that if a resident exhibited physical/verbal behavioral symptoms directed towards others, the provider and their representative would be notified, a follow-up assessment would be completed, the resident would be monitored, and the behavior would be addressed under the resident's care plan. Staff B stated that they were not aware of Resident 2's documented behavioral symptoms. Staff B stated that the behavioral monitoring was discontinued when the resident was sent to hospital, and it was not reactivated when they were readmitted . Staff B further stated that Resident 1 was not able to cognitively consent to sexual activity. In an interview on 05/02/2025 at 3:58 PM, Staff A, Executive Director, stated that residents have the right to be free from any type of abuse. Reference: (WAC) 388-97-0640(1)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45146 Based on interview and record review, the facility failed to act timely and ensure resident received the necessary care and services for examination and/or treatment after a sexual assault in accordance with professional standards of practice for 1 of 2 residents (Resident 1), reviewed for sexual abuse investigations. The failure to send resident to the emergency room (ER) after sexual assault placed the residents at risk for delay in care and services, unintended health consequences, and decreased quality of life. Findings included . According to the Center for Disease prevention and control's guideline titled, Sexual Assault and Abuse and STIs [sexually transmitted infections] - Adolescents and Adults, last reviewed on 07/22/2021, showed, Examinations of survivors of sexual assault should be conducted by an experienced clinician in a way that minimizes further trauma to the person. The decision to obtain genital or other specimens for STI diagnosis should be made on an individual basis. Review of the facility's policy titled, Investigation of Alleged Sexual Abuse, updated in October 2022, showed, The Center [facility] immediately investigates suspected or alleged sexual abuse events and follows the appropriate processes as outlined .If sexual abuse is alleged and/or suspected, do not tamper with or destroy possible evidence. Example of tampering include washing linens or clothing, destroying documentation, bathing or cleaning the alleged victim before the resident has been examined (including a rape kit, if appropriate). Soiled clothing is placed in a pillowcase (do not use plastic bag) .Provide additional medical follow-up including sending the resident to the hospital emergency department for rape kit as indicated. Resident 1 admitted to the facility on [DATE] with diagnoses that included anoxic brain damage (occurs when oxygen is cut off completely from the brain) and persistent vegetative state (also known as post-coma unresponsiveness, is a chronic disorder in which an individual with severe brain damage appears to be awake but shows no evidence of awareness of their surroundings). Review of Resident 1's annual Minimum Data Set (an assessment tool) dated 02/14/2025 showed Resident 1 was in a persistent vegetative state with no visible consciousness. The assessment further showed that Resident 1 was dependent on staff with all aspects of care. Review of the interdisciplinary note dated 04/12/2025, showed, Today at approximately 3:00 PM, a staff member observed the resident's roommate [Resident 2] to may have been inappropriately performing unwanted sexual act to the resident [Resident 1]. Review of a facility investigation dated 04/12/2025, showed Staff J, Certified Nursing Assistant, stated that they saw Resident 2 with head/face on Resident 1's private area, while Resident 1's brief was off performing oral sex. Further review of the investigation showed the facility substantiated resident to resident sexual abuse and Resident 2 was arrested by the Police and removed from the facility on 04/12/2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's nursing progress note dated 04/12/2025, showed, Called placed to resident responsible party on file who made aware of resident-to-resident altercation. Further reviews of the note showed no documentation that Resident 1's responsible party were offered to transfer Resident 1 to ER for evaluation. Review of Resident 1's nursing progress note dated 04/14/2025 at 4:00 PM, showed that Resident 1's responsible party was asked if they wanted Resident 1 to be transferred to acute care for evaluation (two days after the sexual assault incident). The note further stated Resident 1's responsible party declined the transfer. Review of Resident 1's nursing progress note dated 04/14/2025 at 5:33 PM, showed that Staff D, Nurse Practitioner/On-Call Provider, was notified of Resident-to-resident altercation involving this resident [Resident 1]. In a phone interview on 05/02/2025 at 8:00 AM, Resident 1's Collateral Contact 1 (CC1) stated that on the day of the incident, the facility did not ask or offer them to transfer Resident 1 to the hospital for further evaluation. CC1 further stated that when they were asked after 2 days, they declined stating, I didn't know what the whole situation was at that time. In an interview on 05/02/2025 at 11:01 AM, Staff G, Resident Care Manager (RCM), stated that when they notified Staff D about the incident on 04/12/2025, Staff D ordered to monitor the resident and there was no order received to transfer Resident 1 for evaluation. In an interview on 05/02/2025 at 11:18 AM, Staff H, RCM, stated that they called and notified CC1 about the incident on 04/12/2025, but they did not offer to send Resident 1 to ER for evaluation. Staff H further stated that they offered the transfer on 04/14/2025 and CC1 declined. In a phone interview on 05/02/2025 at 12:05 PM, Staff C, Physician, stated that the on-call provider was the one who was notified about the incident. Staff C further stated that they would have recommended to send Resident 1 to ER for evaluation after a sexual assault. In a phone interview on 05/02/2025 at 2:20 PM, Staff D stated that they were notified by Staff G that Resident 2 was sexually inappropriate towards Resident 1 and no injury was noted. Staff D stated they advised the facility staff to monitor Resident 1 and to follow the facility's protocol. Staff D stated that they had very limited information about the incident and that staff just said that the resident roommate was being sexually inappropriate and when I asked what it was, they were not comfortable disclosing what happened. In a phone interview on 05/02/2025 at 2:53 PM, Staff E, Physician Assistant, stated that when they were asked by the facility for Resident 1's assessment, they completed full physical exam on 04/14/2025 (two days after the incident). Staff E stated that they were not made aware of the detail of the incident and They didn't say it was oral sex. Staff E further stated that it would be most necessary and appropriate to send the resident to the ER as soon as it was discovered. In an interview on 05/02/2025 at 3:27 PM, Staff B, Director of Nursing, stated that Resident 1 was not able to cognitively consent to sexual activity. Staff B was asked about the facility's protocol in case of sexual assault. Staff B stated that the facility's protocol was the victim would be sent to ER immediately to preserve the evidence. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/02/2025 at 3:58 PM, Staff A, Executive Director, stated that they would expect a victim of sexual assault/rape to be sent to ER for evaluation. Reference: (WAC) 388-97-1060 (1)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45146 Based on observation, interview, and record review, the facility failed to ensure residents received necessary assistance with toileting care for 2 of 3 residents (Resident 3 & 4), reviewed for bowel and bladder. This failure placed the residents at an increased risk of incontinence, loss of dignity, diminished quality of life, feelings of frustration and embarrassment. Findings included . Review of the facility's policy titled, Bladder and/or Bowel Incontinence, updated in October 2017, showed, Each resident is evaluated for bladder and bowel incontinence .Appropriate and individualized care plan interventions are implemented when evaluation is completed. RESIDENT 3 Resident 3 admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS - an assessment tool) dated 04/02/2025, showed Resident 3 had intact cognition and required substantial/maximal assistance with toileting. Review of the care plan area, Establish the Baseline Plan of Care, initiated on 04/10/2025 showed that Resident 3 required partial/moderate one person assistance with toilet transfer and hygiene. Review of a facility investigation, dated 04/01/2025, showed, Resident states [Resident 3] had BM [Bowel Movement] left in [Resident 3's] bedside commode (BSC) for 3 hours. The facility's investigation concluded that due to Resident 3's inability to confirm that they informed staff of needing to have BSC emptied, the facility was unable to substantiate abuse or neglect. Observation and in an interview on 04/18/2025 at 11:30 AM, showed Resident 3 was lying in their bed. Further observation showed that Resident 3 had a BSC by the left side of their bed, with large, formed BM in their BSC. Resident 3 stated they used the BSC this morning after breakfast. Resident 3 further stated that the facility staff were not responding to their care needs and stated they asked staff to empty their BSC since this morning and no one came to empty it. Additional observation on 04/18/2025 at 1:56 PM, showed Resident 3's BSC was not emptied and there was a large, formed BM in the BSC as observed previously. A joint observation and interview on 04/18/2025 at 2:04 PM with Staff J, Certified Nursing Assistant, showed Resident 3's BSC was not emptied and there was a large, formed BM in it. Staff J stated that Resident 3 was able to verbalize their needs and did not ask to have their BSC emptied. In an interview on 05/02/2025 at 11:01 AM, Staff G, Resident Care Manager, stated, Bed side commode should be emptied after each use. RESIDENT 4 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 4 admitted to the facility on [DATE]. Review of the admission MDS dated [DATE], showed Resident 4 had intact cognition and required substantial/maximal assistance with toileting. Review of the care plan area titled, Establish the Baseline Plan of Care, initiated on 04/10/2025, showed Resident 4 required partial/moderate one person assistance with toilet transfer and hygiene. Review of a facility's incident investigation, dated 04/04/2024, showed that Resident 4 reported that they had waited one to two hours for care after they turned their call-light on. The investigation showed that Resident 4 stated that they normally would call the staff for help to empty their urinal. Further review of the investigation showed the facility discussed the option of having a second urinal at bedside due to the amount/frequency of their urination. Observation on 04/18/2025 at 1:17 PM, showed Resident 4 was sitting in their room. Further observation showed that Resident 4 had two urinals sitting on their bedside table, one urinal was full, and the second urinal was half full. Resident 4 stated that their urinals were emptied that morning and waiting for the staff to empty them. In an interview and joint observation on 04/18/2025 at 2:29 PM, Staff I, Licensed Practical Nurse, stated that urinals should be emptied frequently, and staff should not wait until a urinal was full. A joint observation of Resident 4's room showed there were two urinals sitting on Resident 4's bedside table, one urinal was full, and the second urinal was half full. Staff I stated that Resident 4's urinals should have been emptied. In an interview on 05/02/2025 at 3:27 PM, Staff B, Director of Nursing, stated that their expectation was that staff should empty BSC after each use. Reference WAC 388-97-1060(3)(c)