STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505325	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bainbridge Island Health & Rehab Center	835 Madison Avenue North Bainbridge Island, WA 98110

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** Based on interview and record review the facility failed to ensure residents were free of physical abuse from other residents for 1 of 3 residents (Resident 1) reviewed. This failure placed residents at risk of physical injury, fear and a decreased quality of life. Findings included.Review of the facility's policy titled, Abuse: Prevention of and Prohibition Against, revised 12/2023, showed that each resident had the right to be free from abuse, the definition of abuse was willful infliction of injury, intimidation resulting in physical harm, pain or mental anguish and instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish, willful meant the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.Resident 1 was admitted on [DATE] with diagnoses of dementia and depression. The admission Minimum Data Set (MDS), an assessment tool, dated 02/18/2026, showed moderate cognitive impairment and verbal behavioral symptoms directed toward others.Resident 1's care plan, initiated 02/25/2026, showed Resident 1 had the potential to demonstrate verbally abusive behaviors r/t [related to] hx [history] of being verbally abusive, yelling and at risk for harm d/t [due to] hx of aggressive behavior. The care plan showed Resident 1 had verbal altercations with other residents on 03/05/2026, 04/10/2026 and 04/12/2026.Resident 2 was admitted on [DATE] with diagnoses of traumatic brain injury, dementia and mental health disorder. Resident 2's annual MDS, dated [DATE], showed Resident 2 had moderate cognitive impairment.Resident 2's care plan dated 03/20/2018, showed Resident 2 had the potential to demonstrate behaviors toward staff and other residents r/t poor impulse control, psychosis (mental health condition characterized by a disconnection from reality) and may strike out at male residents when agitated and use foul language and verbally lash out when angry at others.Review of a facility incident report dated 04/25/2026, showed Resident 1 was self-propelling in the hallway when Resident 2 was wheeling in the opposite direction. The report showed Resident 1 yelled, what? as Resident 2 was wheeling by Resident 1 and Resident 2 reached out with their left hand and backhanded Resident 1 knocking off Resident 1's hat and glasses and said, don't f ***ing yell at me.On 05/06/2026 at 10:04 AM, Staff A, Certified Nursing Assistant (CNA), said they were in the facility hallway on 04/25/2026 and witnessed Resident 2 wheeling down the hallway towards the entrance and heard Resident 2 say I'm getting out of here. Staff A said Resident 1 was passing Resident 2 in the hallway and said what? Staff A said Resident 2 said don't you f***ing yell at me and with a closed fist whacked Resident 1 on the side of their head. Staff A said Resident 1's glasses and hat went flying.On 05/06/2026 at 10:18 AM, Resident 2 said Resident 1 was always yelling and threatening them. Resident 2 said they were sick of it and tapped Resident 1 up alongside the head. Resident 2 said they wanted Resident 1 to know to stop threatening them. Resident 2 said they didn't do it hard enough to leave a mark because they knew how to hit someone without leaving an injury, but they wanted Resident 1 to know they weren't going to take it anymore.On 05/06/2026 at 12:34 PM, Staff B, CNA, said they had cared for Resident 1 and Resident 2. Staff B said if Resident 1 was in a mood and another resident got in their way Resident 1 sometimes yelled. Staff B said Resident 2 was easily annoyed with little tolerance for loud noise and was very (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	defensive. Staff B said they did not witness the altercation between Resident 1 and Resident 2 but were not surprised that it had happened.On 05/06/2026 at 1:38 PM, Staff C, Director of Nursing, said Resident 1 had been verbally explosive and volatile and even when Resident 1 was not yelling their tone was at times abrasive. Staff C said Resident 1 had been setting other residents off, so they had been attempting to redirect Resident 1. Staff C said Resident 2 had a short attention span and memory issues. Staff C said Resident 2 had a poor tolerance for certain people and they tended to exaggerate their response when they were touched. Staff C said they had not expected Resident 2 to react physically to another resident. Staff C said hitting was physical abuse.Reference WAC 388-97-0640(1)(3)(c)