STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505355	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Post Acute	414 - 17th Southeast Auburn, WA 98002

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 abuse for 1 of 3 residents (Resident 1) reviewed for sexual abuse. Resident 1 experienced psychological harm, applying the reasonable person approach (how a reasonable person would respond under the same circumstances), when they were inappropriately touched on their breast by Resident 2. This failed practice placed all residents at risk for the potential of sexual abuse, psychological harm, and diminished quality of life. The facility has corrected the above deficiency prior to the abbreviated survey and constituted as past non-compliance (the facility was not in compliance at the time the incident occurred; however there was sufficient evidence the facility corrected the non-compliance after it was identified) and is no longer outstanding. Findings included . Review of the facility Abuse, Neglect and Exploitation policy, dated 2023, showed the facility would provide protection for the health, welfare and rights of each resident by developing and implementing policies that prohibit abuse. The facility would keep residents free from abuse, neglect, misappropriation of resident property, and exploitation. This included freedom from verbal, mental, sexual, or physical abuse, corporal punishment, and involuntary seclusion. The policy showed sexual abuse, defined as non-consensual sexual contact of any type with a resident. <Resident 1> Review of a quarterly Minimum Data Set (MDS, an assessment tool), dated 08/07/2024, showed Resident 1 was not able to make their own decisions due to severely impaired cognition, needs known, and was rarely or never understood by others. The MDS showed Resident 1 had short and long term memory problems, was not able to recall the current season, location of their room, where they were, and staff faces and names. The MDS showed Resident 1 had no behaviors and diagnoses including a history of a stroke (brain bleed), Alzheimer's disease, aphasia (a communication disorder caused by damage to the brain that controls language, expression, and comprehension), depression, and schizophrenia (a mental health disorder that affects how people think, feel, and behave). The MDS showed Resident 1 used a wheelchair, and required staff assistance for wheelchair mobility, transfers, and hygiene care needs. (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 Resident 1's Activities of Daily Living (ADL) and communication problem care plan (CP), revised 07/23/2024, showed Resident 1 preferred female caregivers. The CP directed staff to anticipate Resident 1's needs and ensure a safe environment as Resident 1 was not able to communicate effectively. Review of an impaired cognition CP, revised 07/23/2024, showed Resident 1 had an impaired thought process due to dementia and directed staff to cue, re-orient, and supervise as needed. Review of a Nursing Progress Note (NPN), dated 08/09/2024, showed Resident 1 was placed on alert charting to monitor for signs and symptoms of distress from being touched inappropriately. Review of a facility investigation, dated 08/09/2024, showed Resident 1 was sitting in their wheelchair in the hallway when Resident 2 was observed rubbing and touching Resident 1's breast. Staff D (Licensed Practical Nurse) separated the residents and staff redirected Resident 2 away from Resident 1. During an observation and interview on 08/16/2024 at 4:00 PM, Resident 1 was observed sitting on the edge of their bed. Resident 1 stated doing good, but was unable to answer questions related to the incident with Resident 2. <Resident 2> Review of a quarterly MDS, dated [DATE], showed Resident 2 was not able to make their own decisions, needs known, and was rarely or never understood by others. The MDS showed Resident 2 had physical behavioral symptoms that were directed at others and other behavioral symptoms that were not directed at others, the behaviors occurred one to three times during a seven day look back period. The MDS showed the behaviors significantly interfered with Resident 2's care and participation in activities and social interactions, significantly intruded on the privacy and activity of others, and disrupted the care and living environment. The MDS showed Resident 2 had diagnoses including non-traumatic brain dysfunction, dementia, and a cognitive communication deficit (trouble reasoning and making decisions while communicating). The MDS showed Resident 2 ambulated independently with a walker and required staff assistance with bathing and personal hygiene. Review of Resident 2's medical record showed a NPN, dated 04/19/2023, the NPN showed a staff member saw Resident 2 touching a female resident's breast. The staff asked Resident 2 to stop and separated both residents. A NPN, dated 04/19/2023, showed Staff D, (Social Services Director) followed up with Resident 2 who denied touching another resident's breast. The NPN showed the SW identified through resident interviews another female resident who was inappropriately touched on the breast by Resident 2. Review of a NPN, dated 08/09/2024, showed staff witnessed Resident 2 ambulating with their walker, and was found Resident 2 rubbing and touching the breast of Resident 1. Review of Resident 2's behavior CP, dated 10/24/2023, showed Resident 2 had sexually inappropriate behaviors that included touching female residents, exposing their genitals and masturbation. The CP directed staff to re-direct Resident 2 to their room for privacy when observed masturbating in public, monitor for behaviors, re-direct or remove Resident 2 from situations, and intervene as necessary to protect the rights and safety of other residents. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a NPN, dated 08/09/2024, showed Resident 2 was observed by a Staff D walking over to Resident 1, asked if they could touch Resident 1's breast, and proceeded to rub Resident 1's breast. The staff member stopped Resident 2 and reported the incident to Staff B (Director of Nursing Services). Review of a facility investigation, dated 08/09/2024, showed Resident 2 was re-directed to their room after being observed by Staff D rubbing Resident 1's breast. The investigations showed both Resident 1 and Resident 2 had dementia, and Resident 2 did not recall touching Resident 1's breast. In an interview of 08/16/2024 at 3:45 PM, Staff B stated Resident 2 had a history of sexually inappropriateness, was not aggressive, and did not recall the incident with Resident 1. Staff B stated both Resident 1 and Resident 2 had dementia and were not able to recall the incident. Staff B stated Resident 2 needed increased supervision and should be kept away from female residents. In an observation and interview on 08/16/2024 at 3:55 PM, Resident 2 was observed sitting in a chair in the hallway next to the nursing station. Resident 2 was asked about the incident but did not recall what happened. When asked if Resident 2 was touched inappropriately, they responded, not yet, darn it. I wish they would. Resident 2 asked repeatedly for a kiss during the interview. During an interview on 08/16/2024 at 4:05 PM, Staff C (Nursing Assistant Certified), stated Resident 2 made sexual statements to the staff, either asking for a kiss or asking they lay in the bed with the resident. Staff C stated Resident 2 could be difficult to re-direct at times and was reminded the behavior was inappropriate. Staff C stated it was not okay for another resident to touch another resident's breast as it would be considered sexual abuse. The facility corrected the failed practice prior to the investigation by having only male caregivers work with resident 2 to decrease and remove the triggers or stimulation from females .This was past non-compliance and is no longer outstanding. REFERENCE: WAC 388-97-0640(1).