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Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505403 | A. Building<br>B. Wing | 05/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bethany at Silver Lake | 2235 Lake Heights Drive<br>Everett, WA 98208 |

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** 42927

Based on interview, and record review, the facility failed to ensure 2 of 2 sampled residents (Residents 1 and 2), who resided on a secured Special Care Unit (SCU), were free from sexual abuse. Resident 2 experienced pyshcosocial harm in the form of emotional distress, applying the reasonable person approach, when the facility failed to prevent sexual activity between two residents with cognitive deficits who were unable to consent to sexual relations. This failure placed all residents on the unit at risk of unwanted sexual contact, injury and psychological harm.

Findings included .

Review of an undated facility policy, titled, Special Care Unit, showed the unit provided a safe environment for independent ambulation or wheelchair mobility for residents with poor safety judgement such as a resident who wandered into other resident's rooms.

Review of a facility policy, titled, SCU Admission, Transfer, Discharge, revised date 10/11/2021, showed the unit was intended to provide a structured and secure environment for residents with dementia (a condition with impairment of memory and decision-making ability).

Review of the State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, revised 02/03/2023, showed sexual abuse, is defined as non-consensual sexual contact of any type with a resident.

<RESIDENT 1>

Resident 1 admitted to the facility on [DATE] with diagnosis of dementia.

Review of the census tab in the electronic record showed Resident 1 resided in the South unit (SCU) from 04/03/2024-04/17/2024. The resident was moved to the SCU due to wandering/elopement behaviors.

Review of the Admission Minimum Data Set, (MDS, assessment of resident's abilities and medical conditions), dated 03/19/2024, showed Resident 1 had a BIMS (cognitive function test) score of four which meant they had severe cognitive impairment and required supervision to propel their wheelchair and walk 10 feet.

(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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Resident 1's current care plan, showed a focus area for altered thought processes initiated on 03/23/2024 with an intervention of cue, reorient and supervise as needed. There was a focus area for Behavior problem of hypersexuality-asking others to have sex with them initiated on 04/29/2024 with an intervention for 1:1 monitoring that was initiated on 04/29/2024.<br><br>Review of a progress note, dated 04/17/2024 at 11:20 PM, showed Resident 1 was moved to the North Unit (a non-secure unit) from the South unit (SCU) at 3:00 PM. The nurse documented the resident was forgetful and confused.<br><br>During an interview on, 04/22/2024 at 3:57 PM, Resident 1 was observed sitting in their wheelchair in the hallway outside of their room and an interview was attempted. Resident 1 was not able to give any details about an incident with Resident 2 and stated they did not know why they had been moved from the previous unit (SCU).<br><br>Review of a progress note, dated 04/22/2024 at 10:30 AM, showed Resident 1 was in another resident's room and told staff that the other resident was their sister.<br><br>Review of a progress note, dated 04/25/2024 at 10:30 AM, showed Resident 1 came to the activity office several times, raised their eyebrows, and told the staff member hello gorgeous. When the staff member told Resident 1 that was not appropriate communication, Resident 1 swore at the staff member and left the office.<br><br>Review of a progress note, dated 04/29/2024 at 2:39 PM, showed Resident 1 asked staff if they had sex with someone would that get them kicked out of here (facility). This was reported to the administrator and the resident was then placed on 1:1 monitoring.<br><br>Review of a behavioral health services note, dated 04/29/2024, showed that Resident 1's immediate recall was impaired (remembered zero of three items,) and that their judgement and insight were limited. The note showed they recommended close monitoring of behaviors.<br><br><RESIDENT 2><br><br>Resident 2 admitted to the facility on [DATE] and resided on the SCU. Resident 2 had a diagnosis of dementia.<br><br>Review of the Quarterly MDS assessment, dated 03/22/2204, showed Resident 2 had severe cognitive impairment and was rarely understood.<br><br>Review of Resident 2's current care plan showed a focus area of wandering, initiated on 10/11/2023, and impaired cognitive function with impaired decision making, initiated on 09/30/2023. The care plan was updated on 04/17/2024 with the addition of disrobing to the focus area and interventions of redirect, assist with clothing, and provide privacy when behavior occurs was added to the care plan on 04/18/2024.<br><br>During an interview on 04/22/2024 at 4:10 PM, Staff F, Licensed Practical Nurse (LPN)/Nurse manager, stated Resident 2 liked to hold hands with others.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 04/22/2024 at 4:16 PM, Staff G, LPN, stated that Resident 2 sometimes would hold other peoples' hands.<br><br>During an interview on, 04/22/2024 at 4:34 PM, Resident2 was observed lying in bed with no clothes covering their legs and pants were noted on the floor at the bedside. An interview was attempted but Resident 2 was not able to give any details about an incident with Resident 1. Resident 2 shrugged their shoulders to one question and stated I don't know to another.<br><br><SEXUAL ABUSE><br><br>Review of a facility risk management system document, labeled other, dated 04/16/2024, showed Resident 1 was found in Resident 2's bed and both residents were naked.<br><br>Review of a witness statement included with the risk management system document showed Staff C, hospitality aide, found both residents in bed together. Staff C had documented that Resident 1 had reported they had the hots for (Resident 2) earlier. The statement showed Staff C observed Resident 1 providing oral sex to Resident 2.<br><br>Review of Resident 2's progress note, dated 04/16/2024 at 8:20 PM, showed Resident 2 was in their bed with another resident and they were both naked. The note showed Resident 2 was tearful for a short while after the incident.<br><br>During an interview on 4/22/2024 at 4:16 PM, Staff D, Registered Nurse (RN), stated they entered Resident 2's room after Staff C reported the two residents were naked in bed together. Staff D stated Resident 1 was putting on their clothes and reported it was all their (Resident 1's) fault. Staff D stated Resident 2 was capable of disrobing and getting into bed without assistance. Staff D stated they were in the hallway near Resident 2's room when the incident occurred but had their back to that room, so they did not see Resident 1 enter the room.<br><br>During an interview on 04/29/2024 at 3:47 PM, Staff C stated they had gone to check on Resident 1 and they were not in their room. Staff C stated they looked for the resident and found them in Resident 2's room. Staff C stated they observed both residents were naked. Resident 2 was lying in bed and Resident 1 was hunched over Resident 2, providing oral sex.<br><br>During an interview on 04/29/2024 at 4:22 PM, Staff E, Assistant Director of Nursing Services/ RN, stated both Resident 1 and Resident 2 were cognitively impaired and not able to consent to sexual activity. Staff E stated that Resident 1 had been seen by a behavioral health professional and they reported Resident 1 did not have the cognitive ability to not attempt sexual behavior with other residents, so Resident 1 was placed on 1:1 monitoring.<br><br>Refer to WAC 388-97-0640 (1) |