STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505436	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER: Gig Harbor Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 3309 45th Street Court Northwest, Gig Harbor, WA 98335	

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 observation, interview and record review, the facility failed to protect a resident's right to be free from sexual abuse and timely put appropriate interventions in place to protect vulnerable residents for 1of 2 sampled residents (Resident 1) reviewed for abuse. This failure placed residents at risk of further abuse, mental anguish, and a diminished quality of life.Findings included.Review of the facility policy titled Abuse dated 10/20/2022 showed in the event of an allegation or observation of abuse, the facility would immediately assess the resident and protect the resident and other residents from further harm or incident. Review of the policy showed the resident's plan of care would be revised to reflect interventions to minimize recurrence. Review of the policy showed staff were encouraged to identify, correct, and intervene in situations in which abuse was more likely to occur. Review of the policy showed sexual abuse was defined as non-consensual sexual contact of any type with a resident.RESIDENT 1Resident 1 admitted to the facility on [DATE] with diagnoses that included dementia (a decline in cognition) and anxiety disorder. The admission Minimum Data set (MDS), an assessment tool, dated 12/23/2025, showed Resident 1 was moderately cognitively impaired.Review of the care plan, dated 12/18/2025, showed Resident 1 had a cognitive impairment. Review showed Resident 1 was on a locked unit due to wandering and exit seeking. Review of the care plan showed Resident 1 was able to ambulate independently without assistive devices.Review of the facility incident investigation, dated 02/02/2026 at 11:45 AM, showed Resident 1 was found in another resident's room and had been touched by that resident. Review of the investigation showed Resident 1 said the resident had taken them into the room (Resident 2's room) and touched them.Review of a progress note, dated 02/02/2026 at 12:45 PM, showed Resident 1 was in another resident's room and had been touched by that resident. The nurse took Resident 1 back to their room and was told by Resident 1 that Resident 2 had taken them into their room and touched them inappropriately. Observation on 02/04/2026 at 09:55 AM, showed Resident 1 ambulating independently in the hall with no assistive devices. During an interview on 02/10/2026 at 01:26 PM, Resident 1 said the other resident touched them and they did not want that to happen. Resident 1 said they could not understand why the other resident touched them. During an interview on 02/04/2026 at 10:08 AM, Staff C, Licensed Practical Nurse (LPN), said on 02/02/2026, Resident 1 was taken by the hand into another resident's room where they touched their breasts.RESIDENT 2Resident 2 admitted to the facility on [DATE] with diagnoses that included dementia, aphasia (a language disorder) and cognitive communication deficit. The 5-day Medicare MDS, dated [DATE], showed Resident 2 was severely cognitively impaired.Review of a facility incident investigation, dated 02/02/2026 at 11:45 AM, showed Resident 1 and Resident 2 were seen in the room of Resident 2 together. Review of the document showed a Certified Nursing Assistant (CNA) witnessed Resident 2 touching Resident 1 on the breasts.Review of a progress note, dated 02/02/2026 at 6:35 PM, showed Resident 2 was found touching Resident 1 inappropriately. Review of the progress note showed (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	after the incident, Resident 2 was redirected back to their room whenever they tried to enter other residents' rooms.Review of the progress notes showed Resident 2 had sexually inappropriate behaviors as follows:01/31/2026 Resident 2 touched a CNA inappropriately02/01/2026 Resident 2 motioned a CNA to get into bed with them02/02/2026 Resident 2 rubbed the social workers arm and directed them towards their bed02/02/2026 Resident 2 was found touching Resident 1's breasts02/04/2026 Resident 2 exposed their genitals to a CNAReview of the behavior care plan showed Resident 2 did not have interventions put in place for sexually inappropriate behaviors until 02/02/2026, despite having documented sexually inappropriate behaviors prior to that. Review of the care plan showed one-to-one supervision with staff was initiated on 02/03/2026, the following day.Observation on 02/04/2026 at 10:00 AM showed Resident 2 walking in the hall using a front wheel walker with Staff D, CNA, following at a short distance, within line of sight providing one to one supervision. Observation showed Resident 2 approach the locked doors to the unit. Observation showed Resident 2 was speaking a foreign language with Staff D attempting to communicate with them using verbal and hand queues. Observation showed Resident 2 became anxious and began crying while walking away from Staff D. Observation showed Resident 2 began yelling out while walking down the hall towards the dining room. Resident 2 was unable to be interviewed due to poor cognition and memory recall.During an interview on 02/04/2026 at 10:08 AM, Staff D said Resident 2 was on one-to-one observation because sexual abuse had occurred.During an interview on 02/04/2026 at 10:09 AM, Staff C, Licensed Practical Nurse (LPN), said Resident 2 took Resident 1 by the hand, took Resident 1 into Resident 2's room, and touched Resident 1's breasts. Staff C said Resident 2 was then placed on one-to-one observation with a male CNA.Observation on 02/04/2026 at 10:43 AM showed Staff D sitting in a chair in the hallway talking to Resident 2. Observation showed Staff D continuing to sit in the chair while Resident 2 walked into the dining room way from them. Observation showed Resident 2 exited the dining room and entered their room while Staff D continued to sit in the chair, out of line of sight of Resident 2.Observation on 02/04/2026 at 12:14 PM, showed the door closed on Resident 2's room. Staff D was sitting in a chair in the hallway. Resident 2 was not visualized.Observation on 02/04/2026 at 02:17 PM, showed Staff E, CNA, assisting residents in the day room, walking around a corner and unable to constantly visualize Resident 2 while on one-to-one supervision until 02:25 PM.During an interview on 02/04/2026 at 12:40 PM, Staff E, CNA, said Resident 2 had been having behaviors with female staff and had been inappropriate with them.During an interview on 02/04/2026 at 12:45 PM, Staff H, CNA, said Resident 2 had shown inappropriate sexual behaviors towards CNAs. Staff H said they did not know what to do for Resident 2 if they had behaviors and would have had to ask the nurse or the manager for guidance if Resident 2 had behaviors.During an interview on 02/04/2026 at 11:20 AM, Staff I, activities/social services, said on the morning of 02/02/2026 they went into Resident 2's room to introduce themself. Staff I said Resident 2 grabbed by the arm and led them to the bed. Staff I said other staff had said Resident 2 had been sexually inappropriate with staff. Staff I said they let the nurse know Resident 2 had been handsy and tried to get Staff I into bed. When asked if care plan interventions had been put in place when staff noted Resident 2 was having sexually inappropriate behavior, Staff I said interventions had not been put into place. Staff I said Resident 2 had exhibited sexually inappropriate behaviors with female staff but had not been seen showing them to other residents.During a joint interview on 02/11/2026 at 12:56 PM, Staff J, Unit Manager/LPN, and Staff B, Director of Nursing Services/Registered Nurse (DNS/RN), said sexual abuse was substantiated. Staff B and Staff J said they knew the inappropriate touch happened. Staff B and Staff J said Resident 2 spoke a foreign language. Staff B and Staff J said communication with Resident 2 was difficult, even with an interpreter, making their ability to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	understand boundaries difficult due to cognition. Staff B and Staff J said Resident 2 was discharged to a sister facility on 02/05/2026 where they could better monitor them by staff with more training.During a joint interview on 02/11/2026 at 01:12 PM, Staff A, Administrator, and Staff B RN/DNS, said once they found out about the inappropriate touch, they put a one-on-one supervision in place for Resident 2. Staff A and Staff B said this was not immediately implemented because of a delay in notification to facility management. Staff A and Staff B said appropriate interventions should have been implemented immediately to protect Resident 1 as well as all other residents.Reference WAC 388-97-0640(1)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately report to the state agency, witnessed sexual abuse for 1 of 2 residents (Resident 1) reviewed for abuse. This failure placed residents at risk of further abuse, psychological distress, and a diminished quality of life.Findings included.According to the Nursing Home Guidelines - The Purple Book, Sixth Edition, dated October 2015, page 25, Resident to Resident incidents with sexual abuse/assault, should be reported to the Department of Social Health Services (DSHS) Hotline number, logged within five days, and Police or 911 called.Review of a facility policy titled Abuse showed all alleged violations involving abuse would be reported immediately, but not later than two hours after the allegation was made. Review showed the allegation would be reported to the administrator, or designee, and to other officials, including the state survey agency and adult protective services. Resident 1 admitted to the facility on [DATE] with diagnoses that included dementia (a decline in cognitive function) and anxiety disorder. The admission minimum data set (MDS), an assessment tool, dated 12/23/2025, showed Resident 1 was moderately cognitively impaired.Resident 2 admitted to the facility on [DATE] with diagnoses that included dementia, aphasia (a language disorder) and cognitive communication deficit. The MDS dated [DATE], showed Resident 2 was severely cognitively impaired.Review of an incident report, dated 02/02/2026 at 11:45 AM, showed Resident 1 was touched inappropriately by Resident 2.Review of a progress noted, dated 02/02/2026 at 12:45 PM, showed Resident 1 was found in the room of Resident 2 by a Certified Nursing Assistant (CNA), being touched on the breasts. Review showed the CNA notified the nurse. Review of the documentation showed the nurse wrote an alert report to inform the managers of the incident.Review of the state agency report showed the incident was reported on 02/03/2026 at 10:42 AM, which was outside of the two-hour time frame.Review of the incident investigation documentation for incident dated 02/02/2026, showed the nurse failed to immediately report the inappropriate touching to the administrator, state agency, and police, despite being a mandated reporter.During an interview on 02/04/2026 at 10:08 AM, Staff D, CNA, said if abuse occurs, they would report it to their supervisor.During an interview on 02/04/2026 at 10:09 AM, Staff C, Licensed Practical Nurse (LPN), said if abuse is suspected or occurs, they would report it to the manager, family, and report to the DSHS hotline.During an interview on 02/04/2026 at 12:40 PM, Staff E, CNA, said if they witnessed abuse they would immediately report to their supervisor and the DSHS hotline.During an interview on 02/04/2026 at 12:53 PM, Staff F, LPN, said if abuse occurred or is suspected, they would report it and document it within two hours. During an interview on 02/04/2026 at 12:56 PM, Staff G, Registered Nurse (RN), said if abuse was suspected or occurred, they would notify a supervisor as soon as possible.During a joint interview on 02/11/2026 at 01:12 PM, Staff A, Administrator, and Staff B, Director of Nursing Services (DNS)/RN, said they became aware of the incident the following morning on 02/03/2026, when Staff B was reviewing progress notes from the previous day. Staff A and Staff B said the incident should have immediately been reported verbally to the administrator and DNS. Staff A and Staff B said the incident should have been reported to DSHS and the police within two hours.Reference WAC 388-97-0640(5)(a)