STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505436	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gig Harbor Health and Rehabilitation	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 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 report allegations of abuse timely for 1 of 3 sampled residents (Resident 1) reviewed for abuse. This failure placed residents at risk of abuse, mental anguish, and a diminished quality of life.Findings included.According to the Nursing Home Guidelines - The Purple Book, Sixth Edition, dated October 2015, page 25, staff to resident allegations 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, revised 10/20/2022, 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 1Resident 1 admitted to the facility on [DATE] with diagnoses that included myocardial infarction (heart attack), sepsis (the body's severe response to a massive infection), unsteadiness on feet, muscle weakness, cardiomyopathy (an enlarged heart), and presence of automatic internal cardiac defibrillator (AICD, a small battery powered device surgically placed under the skin used to treat life threatening heart problems). The 5-day Medicare minimum data set (MDS), an assessment tool, dated 03/04/2026, showed Resident 1 was moderately cognitively impaired.Review of a facility incident investigation, dated 03/08/2026 at 10:00 AM, showed on 03/07/2026, Resident 1 was assisted by Staff F, Registered Nurse (RN) to the bathroom. Review showed Staff F told Resident 1 they needed to transfer themself to and from the toilet. Review showed when Resident 1 asked Staff F if they would return to help them off of the toilet, Staff F told Resident 1 they would have to transfer themself or they would have to stay there forever. Review of the incident investigation showed Staff E, Certified Nursing Assistant (CNA) answered Resident 1's call light 03/07/2026 at 09:00 PM and found Resident 1 in the bathroom. When Staff E offered assistance to Resident 1, Resident 1 told Staff E they had already done it themselves because Staff F had told them to do it themselves or they would have to stay there forever. Review showed Staff E reported the incident to the oncoming CNA at shift change. Review of a written statement by Staff G, CNA, dated 03/08/2026 at 07:45 PM, showed Resident 1 reported significant pain in their left arm. Review of the statement showed Resident 1 disclosed the allegation from 03/07/2026 to Staff G. Staff G immediately reported the allegation to their supervisor.During an interview on 03/18/2026 at 12:49 PM, Resident 1 said they had recently had a AICD placed and they were not supposed to use their left arm for anything. Resident 1 said when Staff F came into their room to answer the call light, Staff F told them to transfer themself into the wheelchair. Resident 1 said it caused pain to transfer themself. Resident 1 said they had to transfer themself back to the wheelchair once they were done on the toilet because they did not think Staff F would assist them.During an interview on 03/26/2026 at 01:50 PM, Staff E, CNA said they returned from their break and seen the call light on for Resident 1's room. Staff E said they asked Resident 1 who helped them clean up and Resident 1 said they did it themself. Staff E said Resident 1 reported to them that Staff F said to them they had to wipe themself or they would have to stay there forever. Staff E said they reported the concern to the oncoming CNA during shift change. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff E said they did not report the allegation to a supervisor because Resident 1 asked them not to. Staff E said they had received abuse training recently from Staff C, Registered Nurse/Assistant Director of Nursing Services (RN/ADNS). When asked what that training included, Staff E said they were supposed to report any allegation of abuse.Review of a document titled Summary Report of Education, dated 02/26/2026 at 01:30 PM, showed abuse education, including reporting of alleged violations. Review showed Staff E had signed the form, showing they had received the abuse education. During an interview on 03/26/2026 at 01:58 PM, Staff D, Licensed Practical Nurse (LPN), said they found out about the allegation on 03/08/2026, the following day, from Staff G. Staff D said Staff F was scheduled to work again that evening. Staff D said Resident 1 heard Staff F and seen them in the hallway, making Resident 1 upset. Staff D said Resident 1 told Staff G about the allegation but asked them not to report it to anyone. Staff D said Staff G reported the allegation of abuse despite Resident 1 asking them not too. Staff D said Staff E should have reported the allegation when they became aware of it even though Resident 1 did not want them to. During an interview on 03/26/2026 at 02:00 PM, Staff C, RN/ADNS, said abuse education was completed the end of February of 2026. Staff C said the education included immediate intervention for abuse and neglect allegations and reporting all allegations to the abuse coordinator and/or supervisor within 2 hours. Staff C verified Staff E's signature on the education roster. Staff C said abuse should be reported even if a resident requests it not be. During an interview on 03/26/2026 at 02:15 PM, Staff A, Administrator said all allegations of abuse should be reported immediately to the administrator, Director of Nursing, or any other available management. Staff A said allegations should be reported even if a resident tells them not to. Reference WAC 388-97-6040(5)(a).