STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505488	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Beach Rehab	19235 - 15th Avenue Northwest Shoreline, WA 98177

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 an allegation of sexual abuse for 1 of 5 residents (Resident 1), reviewed for abuse reporting. The failure to report an allegation of sexual abuse to the State Agency placed the residents at risk for repeated incidents and unidentified abuse.Findings included.Review of the facility's policy titled, [Facility] Freedom from Abuse, Neglect, Exploitation and Misappropriation of Resident Property, dated September 2022, showed, It is the policy of this facility that all suspected, alleged, or actual cases of resident abuse.shall be thoroughly and completely investigated and reported according to Federal and/or State regulations. It showed that Sexual abuse means non-consensual sexual contact of any type with a resident. It further showed that Mandated reporters are to immediately report all alleged violations to the Administrator, state agency and all other required agencies.when they have reasonable suspicion of abuse.has occurred.Resident 1 discharged to the hospital on [DATE] and did not return to the facility.Review of the quarterly Minimum Data Set (MDS-an assessment tool), dated 02/06/2026, showed that Resident 1 was cognitively intact.Review of the February 2026 grievance log showed a grievance made by Resident 1 on 02/04/2026.Review of the Grievance Communication Form, dated 02/04/2026, showed that Resident 1 reported an interaction with another resident that ?surprised' her.In an interview on 04/15/2026 at 11:30 AM, Resident 1 stated that in January [2026], I was going down the hallway, he [Resident 2] called me over to outside his room, put his hands on my face, said you're [you are] pretty, and gave me a kiss. Resident 1 stated it was not a wanted kiss and not consensual. Resident 1 stated the Director of Nursing and the Administrator talked to me and everyone knew it happened. Resident 1 stated, After it happened I wouldn't [would not] go to the activities room because he [Resident 2] was there. Resident 1 further stated, it tore me up inside. I was scared all the time and did not want to return to the facility after going to hospital unless they got rid of him [Resident 2].Review of the incident log for January 2026, February 2026 and March 2026, showed no documentation that the allegation of sexual abuse was reported to the state agency.Review of the activity note dated 02/03/2026, showed Staff B, Activities Director, documented that Resident 2 continues to be blunt and make inappropriate comments and behaviors at times.In an interview on 04/14/2026 at 12:31 PM, Resident 2 stated that they did not remember any interaction with Resident 1.In an interview on 04/12/2026 at 11:29 AM, Staff B stated that Resident 2 would sometimes say inappropriate things, he might say to residents, ?oh, you're pretty, your outfit is nice. Staff B stated that I'm [I am] sure I could hear him say ?you're pretty' to Resident 1. Staff B stated that their assistant as part of an internal action plan called caring partners asked Resident 1 if they felt safe in the facility and Resident 1 told them about the incident with Resident 2. Staff B stated, when it came to light, the Administrator [Staff A] and Director of Nursing, investigated it. Staff B further stated that Resident 1 stopped coming to activities after whatever happened triggered her anxiety and she already did not come a lot [to activities].In an interview on 04/21/2026 at 11:45 AM, Staff C, Social Services Coordinator, stated that Resident 1 had told them that Resident 2 had said you're pretty, he said ?he come here', and he kissed her. Staff C stated that they found out six (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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(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	weeks after the incident happened and no one knew until she told me. Staff C stated that they reported the incident to the Administrator and the Director of Nursing. Staff C stated that Resident 1 stopped going to activities and their anxiety went up about talking about the incident. Staff C stated, I don't think she made it up, she wouldn't [would not] just say that I believe her. In a follow-up interview at 1:42 PM, Staff C stated that I don't [do not] think it [the kiss] was mutual. She was shocked when it happened and it was not agreed upon.In an interview on 04/21/2026 at 2:10 PM, Staff A stated that they reported to the state agency any allegations of abuse, neglect, resident to resident incidents. Staff A stated that sexual abuse has to do with two people, involves something intimate, unwanted sexual advance, touch. Staff A stated that a non-consensual kiss reported by a resident was an allegation of sexual abuse and that they would report it to the state agency. When asked if Staff A reported the incident between Resident 1 and Resident 2, when they first heard about it, Staff A stated that when they had heard that Resident 1 stated that another resident kissed her, we went to talk to her and she stated that she didn't want this to go any further and she said she didn't want other staff to know about it. Staff A stated that that they did write a vague grievance report and did an investigation and that she was having more anxiety about having the incident documented or reported. In a follow-up interview at 3:37 PM, Staff A stated, we didn't report it and we were going to but she [Resident 1] was having more trauma about reporting it. Staff A stated that we wanted to honor her wishes. Staff A further stated that they usually reported resident to resident incidents and in this case they did not.Reference: (WAC) 388-97-0640 (5)(a).