STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505507	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shelton Health & Rehab Center	153 Johns Court Shelton, WA 98584

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** 49451 Based on observation, interview, and record review the facility failed to ensure an abuse allegation was reported timely for 1 of 3 residents (Resident 2) reviewed for abuse. This failure placed residents at risk for abuse, neglect and a diminished quality of life. Findings included . Resident 2 was admitted to the facility on [DATE] with diagnoses including dementia and depression. The Quarterly Minimum Data Set (MDS), an assessment tool, dated 01/31/2024, showed the resident was cognitively impaired, did not exhibit behaviors during the look back/review period and did not have impairment of upper or lower extremities. Review of the facility investigation, dated 03/14/2024 at 2:10 PM, showed during care it was alleged Staff C, Certified Nursing Assistant (CNA) grabbed Resident 2 by the front of the shirt, pulled him forward and told him that he needed to be nice to my girls and then Staff C allegedly slapped Resident 2 on the left upper arm. Review of the medical record and facility documentation showed an assessment of Resident 2 and staff interviews were not completed until the following day, on 03/15/2024. Review of a facility gathered witness statement, dated 03/15/2024 at 7:36 AM, from Staff D, CNA, documented that Staff E, CNA and Staff D, CNA had witnessed Staff C grab Resident 2 by the shirt with both hands and say, you need to be nice to my girls. The witness statement documented Staff C was aggressive with Resident 2 and Staff C was saying she was going to call the resident's spouse and then allegedly slapped Resident 2 on the left upper arm. Review of a facility gathered witness statement, dated 03/15/2024 and untimed, from Staff E, CNA, documented that Staff E was helping Staff C and Staff D change Resident 2's bedding when Staff C grabbed Resident 2's shirt and lifted him up and she told him not to touch Staff D and Staff E. On 04/03/2024 at 10:25 AM, Staff D, CNA said they did not report the incident which involved Staff C and Resident 2 until the next morning on 3/15/2024. Staff D said they did not report the allegation because both Resident 2 and Staff C were laughing during the interaction and that Staff D could have handled in better but was a good caregiver. (continued on next page)

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	On 04/05/2024 1:05 PM, Resident 2 was observed seated in a wheelchair. The resident was well groomed and watching tv. The resident could not recall any time the resident was mistreated by staff. Review of hours worked for Staff C documented Staff C worked in the facility on 3/14/2024 from 2:03 PM-9:32 PM. On 04/05/2024 at 4:35 PM, Staff B, Director of Nursing said it was the expectation for all staff to report allegations of abuse immediately so it could be investigated and reported timely. Staff B said the abuse allegation involving Staff C and Resident 2 on 03/14/2024 was not reported to Administration until 03/15/2024 and Staff C continued to work in the facility until 03/15/2024. Reference WAC 388-97-0640(5)(a)