STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505528	A. BUILDING _____ B. WING _____	**04/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEA HILL REHABILITATION AND CARE CENTER	**32049 109TH PL SE AUBURN, WA 98092**

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 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to allow one resident (Resident #1) reviewed, the right to exercise her rights as a resident of the facility and as a citizen or resident of the United States. Failure to ensure Resident #1 could exercise her rights to dispense funds without interference from the facility placed the resident at risk to feel frustrated and disrespected. Findings included . Resident #1 admitted to the facility on [DATE], and according to the 11/14/2019 Admission Minimum Data Set (MDS- an assessment tool) was determined to have care needs related to a fracture, had [DIAGNOSES REDACTED]. According to the 02/14/2020 Quarterly MDS, the resident was assessed with [REDACTED]. According to a public allegation dated [DATE]20, there was, an abuse of power regarding two social workers .they violated my mother's civil rights .they took it upon themselves to intervene financially .they're not granting her the financial freedom . In an interview on 04/09/2020 at 10:35 AM, Resident #1's son stated his mother wrote a check out to him but staff declined to give it to me. Resident #1's son stated his mother, .wanted to give it to me. Progress notes dated 03/13/2020 showed, the SSD (Social Service Director) has been working with resident, DSHS (Department of Social and Health Services) and family on safe discharge home. SSD had resident anticipated for discharge next week (Tuesday). SSD met with resident to discuss discharge Resident states her preference is to go home and have (son) be her IP (Individual Provider) .Resident is able to verbalize how she would ask for help .Resident does not require 24 hour care at this time .Resident is able to take medications independently however would benefit from someone managing her medications for safety .SSD spoke with APS investigator who states open care for misappropriation financially against son (sic). She states she can wrap up investigation this week, if she does not find any evidence . Progress notes dated [DATE]20 showed, SSD was called to front desk of care center re: resident's son .was present, stating his mother (Resident #1) had, written me a check and I want it. SSD checked in with resident who confirms she wrote (son) a 90 dollar check so he can get ready for me to come home. .Resident was not able to state what he was going to buy with her money . In an interview on 04/09/2020 at 9:15 AM, Staff B (Business Office Manager) confirmed that Resident #1 had written a check to her son, stating, .about a month ago they (staff) brought a check that she wrote to (Son) for $90.00. I gave it to Social Work. Record review showed no indication Resident #1 was deemed incompetent to make decisions and no documentation the resident had a Power of Attorney (POA). Review of care plan documents showed no indication the resident was assessed as unable to make financial decisions or dispense her own funds. In an interview on 0[DATE]3/2020 at 11:10 AM, Staff C, Director of Social Services, confirmed Resident #1 was not deemed incompetent to make her own decisions and that Resident #1 had the right to issue a check to whomever she wanted. REFERENCE WAC: 388-97-0180(1-4) .

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.