STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505182	A. BUILDING _____ B. WING _____	**08/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PROVIDENCE MOUNT ST VINCENT	**4831 35TH AVENUE SOUTHWEST SEATTLE, WA 98126**

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 -** Immediate jeopardy **Residents Affected -** Some	**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 prevent a pattern of resident to resident altercations for two (#3 and #4) of ten sample residents, which included Resident #1 slapping and grabbing Resident #2's arm causing a skin tear, yelling at Resident #3 and #4, and shoving a walker toward Resident #4, a resident who was seated, and Resident #3, an ambulatory resident. In addition, the facility failed to identify, protect, assess, report, and prevent a pattern of aggressive acts toward fell ow residents on seven occasions, 04/06/2020, 04/07/2020, 04/11/2020, 05/04/2020, 05/10/2020, 05/22/2020, and 06/07/2020. The facility failed to recognize these incidents as abuse, analyze the circumstances of these abusive behaviors, or implement plans for prevention or recurrence. Failure to recognize and analyze multiple incidents of resident to resident altercations and provide adequate supervision and care planning with interventions, placed residents who lived in the area at risk of serious injury or harm, including continued abuse. This failure resulted in an Immediate Jeopardy (IJ) related to abuse on 06/23/2020. The facility reassessed Resident #1, provided a 1:1 care giver and trained staff regarding recognizing and reporting resident to resident altercations and abuse, which led to the removal of the IJ on 07/13/2020. Refer to CFR 483.21, F 657; Care Plan Timing and Revision 483.12, F 609; Reporting of Alleged Violations 483.25, F 689; Free of Accidents Hazards/Supervision 483.75, F 867; QAPI/QAA Improvement Activities Findings included . Review of the medical record showed Resident #1 was admitted to the facility on [DATE] with multiple diagnoses, including a stroke and depression. A 07/09/2018 Pre-admission Screening and Resident Review (PASRR - a mental health assessment) showed Resident #1 did not speak English and had limited communication, and impaired cognition. A 05/25/2020 Care Area Assessment (CAA - an assessment summary) showed, . dementia is a contributing factor. Per note review, impaired recent memory, impaired recall judgment. This summary also showed, Resident is ambulatory with FWW (front-wheeled walker) from room to dining room with staff supervision. In an interview on 06/18/2020 at 11:47 AM, when asked about Resident #1's mood and behavior, Staff M, Resident Assistant (RA) stated, (Resident #1) has a specific chair which is meant for him and he wants no one, and if he finds someone sitting on it he fight. I heard he was fighting one of the residents because of the chair in the dining room. Staff M identified Resident #4 as a resident who sat in Resident #1's preferred chair and, (Resident #4) goes to his chair often. She always because she doesn't know, but we redirect her. (Resident #1) tries to talk to them in his language. His voice is loud. When asked how other residents reacted to Resident #1's loud voice, Staff M stated, They are scared. When asked how often Resident #1 became loud, Staff M stated the incidents occurred when other residents sat in Resident #1's preferred chair. Review of a 01/26/2019 progress note showed, (Resident #1) was witnessed slapping at (Resident #2) when she was sitting in what (Resident #1) believed to be his usual chair . sitting on his walker and would not back away. Attempted to move his walker with him out of the way of (Resident #2). (Resident #1) would not budge, reached around me and grabbed (Resident #2's) upper R (right) arm tightly with one hand. I grabbed his hand to try to remove it and he released it and grabbed (Resident #2) R (right) forearm with both hands, I had to pry his hands from her arm, loudly yelling for him to stop and let go. (Resident #2) cried out, 'That really hurts; you'll break my arm!' Was able to pry arm away and assisted (Resident #2) out of seat to a seat on the other side of DR (Dining Room). Law enforcement contacted and spoke with (Resident #1). He denied harm to other resident and said (through translation) that he didn't want anyone to sit in his chair and become sick like him. He stated he had asked (Resident #2) to move and she had not. Agreed not to harm others. Review of a 01/30/2019 Investigative Report (IR) showed, due to dialect and dementia issues staff have found the on-line 'In-Demand' translator service of minimal value with (Resident #1) as translators rarely understand him .he tried to get (Resident #2) out of his chair and being unable to communicate resorted to trying to physically pull her up. This caused minor arm injury to (Resident #2) . Even though police were involved, staff do not believe given (Resident #1's) level of dementia, we do not think their presence or reminders about this would serve as any deterrent for him . Family explained there may be a cultural component in addition to obvious communication problem. (Resident #1's) family says he considers the chair contaminated with his 'germs' and not safe for other people to sit in. This sounds like a rationalization to us but we do lack familiarity with his culture . All 3 North staff including support staff, have been advised of the situation and are attempting to discourage any other residents from sitting in 'his chair'. We are also keeping (Resident #2) away from him. .I have asked staff to obtain an order for [REDACTED]. This IR showed Resident #2 sustained a 1.5 inch skin tear to the right forearm. Review of a 10/24/18 Baseline CP included with the 01/30/2019 IR showed Resident #1, Does not follow directions .Disoriented to situation and time, confused and forgetful and He would get upset with someone sitting in recliner chair. Make sure no other resident will sit there to prevent altercation 01/26/19. Review of a comprehensive CP plan showed a Behavior CP, original date of 01/23/19, and no interventions that directed staff on how to monitor Resident #1 to prevent another resident to resident altercation. In an interview on 06/23/2020 at 8:42 AM, when asked if the CP showed how staff would make sure other residents would not sit in Resident #1's preferred chair, Staff D, Neighborhood Coordinator (NC), stated, Well it should say 'Redirect them away.' Everyone knows his routine. It would be mainly redirecting other residents and looking for obstacles in his pathway. When asked if the investigation showed the facility followed up to ensure staff familiarity with (Resident #1's) culture, Staff D stated, I'm afraid not. Included in the 01/30/2019 IR was a form titled, Event Report and dated [DATE]. This form asked for a brief description of the event, and event-specific questions like what was seen or heard prior to the event, what the resident was doing prior to the event, if anyone else was present, what the resident said about the event, what the staff thinks caused the event, and if the staff had any important information to tell about the event. This form showed a housekeeper and a Primary Nurse (PN) for 3 North were present during the resident to resident altercation. In addition, this form showed the staff's answer to, What do you think caused this event? was, Staff can't communicate with (Resident #1). Don't speak (unintelligible writing followed). The IR did not show documentation the facility interviewed the second eye witness identified, the 3 North PN, beyond the progress note written on 01/26/2019. In this continued interview, when asked when the Event Report was used, Staff D stated, I often edit them myself. It's a general (facility) form when an incident occurs. It's the standard form used to collect staff statements and information which can sometimes collect data or context we didn't know about. When asked if the investigation included all possible witness statements that could provide information to help prevent recurrence of altercations, Staff D acknowledged the investigation did not include the second eye witness' Event Report and stated, Yes, it should be included and a good attempt to get as many as possible. Review of a 05/20/2019 progress note showed, As told to me by RA (Resident Assistant) who was there: This resident (Resident #1) was walking towards his room in the hallway. Another resident (Resident #3) was also walking with a RA from the opposite direction. (Resident #1) was heard by (Resident #3) to be muttering something in his own language as they came close to each other. (Resident #3) came forward to inquire what the other had said. Instead

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.

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) of replying, (Resident #1) shoved his walker towards (Resident #2), who didn't get hit by the walker because RA stopped it in time. (Resident #3) immediately extended her hand/fist up, about to slap/punch (Resident #1) and this again was stopped by the RA with her arm. Both were separated and instructed to go and stay in their rooms. A 05/22/2019 IR showed, Staff are now aware that when they are present with (Resident #3) it is important to make sure she is not crowded by other residents. The same will be added for (Resident #1). He cannot use speech to express frustrations and when he is moving he is impulsive. He should be monitored to assure a clear pathway. He does however move independently and staff may not be present. The care plans for both residents have been edited to add this approach. This IR did not show the facility included witness statements or Event Reports. No updated CPs for Resident #1 were included with the 05/22/2019 IR. Review of Resident #1's comprehensive Behavior CP, while it showed an effective date of 05/23/19, did not show additional interventions between 02/01/19 and 06/14/2020, including when and how to provide supervision or monitoring to prevent further resident to resident altercations. In this continued interview on 06/23/2020, when asked if the record showed if and how staff supervised Resident #1, Staff D stated, Frequent visual checks. The staff know they required supervision. When asked if the record showed the facility reviewed, developed and implemented interventions to prevent future altercations or abuse between Resident #1 and other residents after the 05/20/2019 resident to resident altercation, Staff D stated, The staff were all made aware we all need to keep an eye on him. Educating the staff and everyone being aware of the conflict that occurred and making sure they keep visual contact with him. No further information was provided. When asked what became of the Mental Health referral mentioned in the 01/26/2019 IR, Staff D stated, I don't honestly remember. When asked if this IR ruled out if abusive behavior occurred, Staff D stated, I don't think it ruled it out. I think the behavior was abusive. Review of Resident #3's 05/23/2019 CP included with the IR showed, Redirect other residents if she or they block each other's pathway to reduce conflict, Walks with either supervision, or independently, and Monitor to avoid personal space violations. In this continued interview, when asked if the record showed how staff monitored Resident #3 in order to prevent another resident to resident altercation, Staff D stated, I am sure of that. No further information was provided. Review of a progress note dated 09/12/2019 and timed at 6:38 AM showed, (Resident #1) placed on alert for altercation with another resident, (Resident #3). (Resident #3) was in recliner chair in DR that resident has identified as belonging to him; this is the regular chair that he sits in when in DR. Both residents with dementia and difficulty communicating needs. (Resident #1) is Cantonese speaking. He approached chair with (Resident #3) in it during report. Staff heard yelling and were able to intervene prior to physical contact. Removed (Resident #3) to another chair. An IR dated 09/20/2019, eight days after the resident to resident altercation occurred, showed (Resident #1) reacts with hostility if other residents block his pathway and he also believes the black leather easy chair, which he loves, actually belongs to him. He gets in it very early in the morning and prefers to rest there most of the day, frequently walking independently to his room to use the toilet or lay down for a while, and while (Resident #3) strongly prefers using the brown leather easy chair, on occasion she uses the black one. This had occurred resulting in conflict with (Resident #1) several months ago. Review of the IR showed no witness statements or Event Reports were included. In this continued interview, when asked if the 09/20/2019 IR showed the facility re-evaluated the effectiveness of how staff monitored or supervised Resident #1, Staff D stated Well, obviously it happened again. I would think so. I can't say that's the case. I don't think we are there yet. I don't know if there was an assessment of the problem other than what is in the nursing notes for behaviors. When asked if the CP or the IR included interventions that showed how staff supervised Resident #1 differently after the third resident to resident altercation, Staff D stated, I think I am still working on that one. I don't think that is closed yet. When asked if the IR ruled out abuse, Staff D stated, No. When asked if the 09/20/2019 IR showed a root-cause-analysis, to include review of witness statements, Event Reports, and trending of incidents, Staff D stated, I don't know. When asked if the facility followed-up or reconsidered mental health services for Resident #1, Staff D stated, We did just reconsider. I will talk to the nurse practitioner again. It's not that it's not a problem. He didn't harm anybody. We are still working on that one. When asked if waiting 18 months was an acceptable timeframe for follow-up on mental health services after repeated resident to resident altercations, Staff D stated, Maybe not. Review of Resident #1's April 2020 Medication Administration Record [REDACTED]. Aggressive acts towards fell ow residents, and instructed staff that if these (behaviors) occur, notify PN (Primary Nurse) or NC at or before shift exchange. Notification = Intervention: Y or NA (Not Applicable). Review of this MAR indicated [REDACTED]. An I was marked as the intervention on 04/07/2020. Review of 04/06/2020, 04/07/2020 and 04/11/2020 progress notes did not show documentation of the identified aggressive acts towards fell ow residents, any indication who Resident #1 was aggressive towards, what staff did to protect the resident(s), or how interventions changed to prevent recurrence of aggression. Review of the facility incident log showed no documentation the 04/06/2020, 04/07/2020 and 04/11/2020 incidents of resident to resident aggression were investigated by the facility to rule out abuse and prevent recurrence of aggressive acts towards fell ow residents, or reported to the State Agency (SA). In this continued interview on 06/23/2020, when asked if aggressive acts towards fell ow residents is considered a resident to resident altercation and reportable to the SA, Staff D stated, Three episodes . I was not the one informed in any of those. When asked if aggressive acts towards fell ow residents warranted an assessment or follow-up of the identified behavior, Staff D stated, I would have hoped. There's no notes. They didn't back it up. I don't think they told me about it. When asked if he expected follow-up notes to clarify the aggressive acts, Staff D stated, There should have been some explanation. I don't remember hearing about it. When asked if the progress notes between 04/06/2020 and 05/11/2020 showed how interventions changed to prevent recurrences of resident to resident altercations or aggression between Resident #1 and other residents, Staff D stated, I don't think so because if I didn't hear about it there wouldn't be a change. When asked if the record showed staff supervised or monitored Resident #1 to prevent resident to resident altercations, Staff D stated, These three incidents, I have to definitely say no. Review of a progress note dated 05/10/2020 and timed at 9:37 PM showed, (Resident #1) showed hostile reaction when the dining chair where he usually sat on was taken. He mumbled something in a loud demanding voice and was pointing simultaneously at the resident sitting nearby. RN was immediately alerted that he might be referring to the chair, so another chair was promptly pulled up for him to sit. This was resolved without any incident. Review of the facility reporting log did not show the 05/10/2020 incident was followed-up by the facility to rule out abuse, evaluated to prevent recurrence of resident to resident altercations or abusive behaviors, or reported to the SA. In this continued interview on 06/23/2020, when asked if the 05/10/2020 progress note showed who Resident #1 was hostile towards, or if staff assessed the other resident to rule out abuse, Staff D stated the progress notes did not identify who the other resident was and, I don't think a Datix (incident report) report was filed. No further information was provided. A May 2020 MAR indicated [REDACTED]. aggressive acts towards fell ow residents, and instructed staff that if these occur, notify PN or NC at or before shift exchange. Notification = Intervention: Y or NA. In addition, this MAR indicated [REDACTED]. Review of 05/04/2020 progress notes did not show documentation of the identified aggressive acts towards fell ow residents, what staff did to protect the resident(s) involved at the time of the incident, or how interventions changed to prevent recurrence of aggression. Review of the 05/22/2020 progress notes showed, However, prior to dinner, (Resident #1) had one brief episode of aggressive behavior concerning the chair placed at his usual spot but occupied by a female resident. He was demanding for dinner, speaking in his native Chinese language. All 3 staff were able to alleviate his anger. Review of 05/22/2020 progress notes did not show the facility followed-up to evaluate Resident #1's aggressive behavior, what staff did to protect the female resident involved at the time of the incident, or how interventions changed to prevent recurrence of aggression. Review of the facility incident log showed no documentation the 05/04/2020 and 05/22/2020 incidents of resident to resident aggression were investigated by the facility to rule out abuse and prevent recurrence of aggressive acts towards fell ow residents, or reported to the State Agency (SA). In this continued interview on 06/23/2020, when asked if he was aware of the aggressive acts towards other residents identified by staff in the May 2020 MAR, Staff D stated, Evening shift has more of a problem. Why I don't recall any of these two . When asked if he expected an investigation of aggressive acts, Staff D acknowledged they should be investigated and stated, You do a Datix (incident report), and I would have asked for more specifics (like) who was involved and what exactly happened in detail, and make a decision as to if we need to do an incident report or not. This not that thorough, and I wish she had given more detail in the progress note. It would have been nice. Review of progress notes and the comprehensive CP between 05/22/2020 and 06/07/2020 did not show documentation staff evaluated or modified interventions to prevent recurrences of resident to resident altercations or abusive behaviors between Resident #1 and other residents. A progress note dated 06/07/2020 and timed at 9:25 PM showed, Had been contended (sic) sitting on his usual seat but his behavior changed today when he thought someone would be sitting next to him. He uttered in a loud angry voice, shoved his 4-wheeled walker towards the seat, and jerked it away from him. The other

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) resident was moved away from him. Review of the facility incident log showed no documentation the 06/07/2020 incident was investigated by the facility to rule out abuse and prevent recurrence of resident to resident altercation, or reported to the SA. In this continued interview on 06/23/2020, when asked if the facility evaluated what uttered in a loud angry voice, shoved, or jerked away from him mean, Staff D stated, I can't tell you. Not a lot of detail here. I don't know if the other resident was aware or upset by it. Not enough detail, no. It is pretty bad English. It's not a wildly clear progress note of the incident. I don't know what they meant by that. Review of Resident #1's 05/23/19 CP and progress notes between 06/07/2020 and 06/14/2020 did not show documentation staff evaluated or modified interventions to prevent recurrences of resident to resident altercation between Resident #1 and other residents. Review of 06/15/2020 progress notes showed, (Resident #1) is placed on alert charting for recent resident to resident altercation that happened earlier today at 2:10 PM; while this LN was carrying out doctor's orders in the nurses station, this LN heard a loud noise in the dining room area and saw (Resident #1) yelling at another resident (Resident #4) who was sitting in his chair (FYI: (Resident #1) does (sic) like anybody else sitting in his chair); (Resident #1) was also pushing the chair where (Resident #4) was sitting with his FWW; (Resident #4) was not hit physically but she was upset; this LN ran to the incident area right away, separated (Resident #1) and (Resident #4) right away, and made sure they were both safe, and provided emotional support; this LN called provider for above both residents and notified with above info; NC was also notified, SW (Social Worker) was attending the 3N shift change meeting on this date when there was a commotion from the dining area. (Resident #1) came out of his room and went to the chair/table where he always sits. He became upset when he found another resident in his chair. He began yelling in Cantonese and pushing his walker into the chair. He never removed his hands from the walker handles, but continued to shout and push the chair until the other resident removed herself. (Resident #4) became upset, crying and unsure of what she did wrong, I have spoken to (POA) to report the emotional upset suffered by (Resident #4), after being yelled at by another resident . She was not harmed physically at all but was emotionally upset so I directed the (SW) to file an online mandated reporter report to (the SA), and (Resident #4) continued to be in tears and stated that she didn't want to be near the guy and didn't do anything wrong. She was in this condition for approximately 2 hours until she was taken for a walk by the activity coordinator. Review of the 06/19/2020 IR showed, Activity Director had made laminated signs with their (Resident #1 and #4) names on it for their chairs. It is too early to tell if either resident is aware or cares, but it is helping remind staff. Care plans for both residents updated. An observation on 06/18/2020 at 11:46 AM showed Resident #1 in the DR seated in a stationery chair against the wall. Above the chair was an 8 by 11 inches laminated sign with the words, (Resident #1's name) chair. In an interview on 06/18/2020 at 12:00 PM, when asked about the presence of the laminated sign above Resident #1's preferred chair, Staff O, Licensed Practical Nurse (LPN), stated, I'm not really sure how long it's really been there. When asked what interventions were in place to prevent resident to resident altercations, Staff O stated, New intervention is to redirect residents. Staff O did not indicate the laminated sign was a new intervention to deter resident to resident altercations. In an interview on 06/18/2020 at 12:15 PM, when asked if Resident #1 had any behavior issues, Staff R (RA) stated, Yes if he doesn't like it he doesn't like it, because he doesn't understand most English, so I use phone to translate. One time I noticed agitated but when it happened I am not here it was with (Resident #4), and this is now his second time. The same thing, it's the chair. We tried to write (Resident #4's) chair but it don't work, she sits everywhere. But that only chair is (Resident #1's) chair. He is very particular. When asked about the laminated sign above Resident #1's preferred chair, Staff R stated, It doesn't make sense because (Resident #4) doesn't know. (Resident #1) only wants that chair. It's not going to be effective. Staff R did not show an understanding of the laminated sign's purpose, which was to remind staff to redirect residents away from Resident #1's preferred chair. In an interview on 06/18/2020 at 12:15 PM, when asked about the laminated sign above Resident #1's preferred chair and how long the laminated sign had been in use, Staff N (RA) stated, I did not notice he has a sign posted on wall. Staff N stated the intent of the laminated sign was, For staff to know it is the (Resident #1's) chair. In an interview on 06/22/2020 at 10:38 AM, when asked about the laminated sign above Resident #1's preferred chair, Staff P, Registered Nurse (RN), stated, Oh, is it behind? I didn't even see that. When asked what the purpose of the laminated sign was, Staff P stated, To help (Resident #1) feel comfortable. When asked if this was the first time she recognized the laminated sign, Staff R stated, Yes. The above findings were discussed with Staff D in the continued interview of 06/23/2020. When asked what the purpose of the laminated sign was, Staff D stated, How they could not see it (the sign)? It's been there for a week. Slightly a little more than a week. Most people know. It's to communicate mainly to staff to remind them this is (Resident #1's) chair and not to have anyone siting on it. It's for the staff. Staff D acknowledged the staff's knowledge deficit of the laminated sign above Resident #1's preferred chair detracted from effective and consistent implementation to redirect residents away from Resident #1's chair. Review of the 06/19/2020 IR showed, We considered a (local hospital) Mental Health Team referral but decided not to pursue this as [MEDICAL CONDITION] medications are not appropriate for this level of behavior. I did ask one of my Evening shift nurses to speak to him regularly. This is to encourage him to tell us when he is upset or frustrated, help his mood and ask him not to yell at other residents. In this continued interview, when asked if the intervention to request from Resident #1 not to yell at other residents was a realistic expectation for a cognitively impaired and impulsive resident, Staff D stated, Well not completely. When asked if mental health team recommendations were limited to the use of [MEDICAL CONDITION] medications, Staff D stated, They do provide practical care approaches. When asked if the facility re-addressed a mental health team referral after the 05/20/2019 and 09/12/2019 resident to resident altercations, which by then the facility had identified instances of slapping, grabbing/pulling residents by their arm, shoving walker at seated or ambulatory residents and yelling, Staff D stated, Will get notes. No further information was provided. Review of Resident #1's June 2020 MAR indicated [REDACTED]. In this continued interview with Staff D, when asked why non-pharmacological approaches were developed in June 2020, instead of May 2019 when the second resident to resident altercation occurred, Staff D stated, In hindsight, sure. Why didn't we do this six or nine months ago? We are trying to come up with new and different things. We just didn't make that one. It's a good one to make. Review of a 06/19/2020 IR showed, Resident #4 sat in (Resident #1's) chair while he was briefly away. He returned, saw (Resident #4) in his chair, got upset and yelled at her . This IR did not show documentation the facility evaluated how long Resident #4 had been sitting in Resident #1's preferred chair, how briefly Resident #1 had been away from his preferred chair, or accounted for Resident #1's or staff's whereabouts prior to the altercation. In addition, this IR did not include a statement of the assigned primary aide for Resident #1, or analyzed how Resident #1 walked into the DR towards his chair when he was supposed to be supervised. In this continued interview, when asked when the last time Resident #1 was seen prior to the altercation of 06/15/2020, Staff D stated, We don't show that in the record. We don't track people's physical whereabouts throughout the day. We just know he is either in his room or in his chair. We don't track where he spends his time. When asked if the IR showed where staff were when the resident to resident altercation occurred, Staff D stated, (The SW and Nurse) were both in the dining room. I asked them both (the nurse and SW) to write progress notes to which they did, so that is their witness statement. When asked if obtaining a statement from Resident #1's assigned aide, and establishing the aide's whereabouts prior to the altercation, would help determine how the interventions to supervise or monitor Resident #1 failed, Staff D answered, It would play an important role. In this continued interview, when asked if the 06/19/2020 IR showed the staff supervised Resident #1, Staff D stated, They were nearby. When asked how did nearby staff supervise Resident #1, when the resident managed to enter the DR, walk towards his preferred chair, and engage in an altercation with Resident #4, Staff D stated, No, he was not directly eyeballed or supervised when he came out of his room. When asked if the staff present in the DR intervened to prevent the resident to resident altercation, Staff D stated, No. She (SW) was talking to someone else, and (Nurse) was at the med (medication) cart. Staff D acknowledged staff did not supervise Resident #1, which allowed the resident to be unaccounted for an undetermined period of time prior and leading up to the resident to resident altercation. When asked how did interventions change after the 06/15/2020 altercation, Staff D stated, Get more family visits. More phone visits. More positive impact on mood. When asked how those interventions provided supervision for Resident #1, Staff D stated, The nurse reminds the aides to keep an eye aware of his presence. When asked if that was any different from monitoring or supervising the resident for the past 18 months, Staff D stated, Well, no, not necessarily. Everybody keeps an eye on him. When asked if the facility evaluated why the supervision or monitoring failed after repeated acts of aggression or resident to resident altercations, Staff D stated, No. When asked if the facility analyzed when the altercations occurred, adjusted interventions accordingly, and implemented those interventions to prevent additional altercations including abuse, Staff D stated, One hole in the program is we have the behavior monitor but we don't print them out to analyze them, which might be a good idea before you find it. Documentation was present but not analyzed. The above findings were shared with Staff A (Administrator) and Staff

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F 0600 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 3) C (Risk Management) on 06/23/2020 at 12:04 PM in a joint interview. Staff A identified Staff C as the Abuse Coordinator and the staff responsible for incident management in the facility. When asked how recurrence of resident to resident altercations were addressed by the facility, Staff C stated, You're gonna' look at what was your interventions. When the second episode happens, then ask if there is something similar between the first and second incident, were the interventions in place. Ask why are the interventions not working, what changed and if it happened for the same reasons. Then we need to look at different interventions. Ask if there is a pattern with resident
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 interviews and record review, the facility failed to ensure falls with substantial injuries, involving two (#6 and #11) of nine residents reviewed for accidents were reported to the State Agency (SA) as required. This failure precluded the state agency from being aware, and investigate circumstances surrounding the resident's fall/and or death. Additionally, this failure did not uphold the facility's regulatory requirement for reportng. Findings included . RESIDENT #6 Resident #6 admitted to the facility on [DATE]. According to the 11/12/2019 Annual Minimum Data Sets (MDS- an assessment tool), the resident was admitted with disabling conditions incuding anxiety, and was identified as being at risk for falls due to weakness. Review of a facility Investigation Report dated 05/22/2020 (WHAT TIME?) showed, Staff Z, a Registered Nurse (RN), noted Resident #6 was found sitting on the floor in her room, between the sink and the bed. When the resident was asked, she said, she was reaching up, trying to grab something out of her closet which was next to the sink, lost her balance and fell backwards. The fall was unwitnessed. Further review of the Incident Investigation Report IR showed, Staff Z, assessed Resident #6 and assisted her up from the floor with a Hoyer lift with the assistance of a Certified Nurse's Aide. Upon assessment, the resident had complaints of increased pain and significant bruising to the left chest area and hip. The resident also reported she had hit her head. Staff Z notified the doctor about Resident #6's fall incident with the assessment results. The doctor issued a new order to transfer the resident to the hospital for further treatment. Resident #6 returned to the facility from the hospital emergency room (ER), the following day on 05/23/2020 at 7:20 AM. Review of the hospital Computed Tomography (CT) scan dated 05/23/2020, revealed substantial bruising to left chest and posterior thigh. Review of progress notes dated 06/04/2020 showed Resident #6 developed a very large left posterior thigh hematoma. Resident #6 later passed away in the facility on 06/04/2020. Review of Resident #6's death certificate dated 06/05/2020 showed left chest and thigh contusions the resident sustained [REDACTED]. An interview on 06/23/2020 at 2:00 PM, when Staff G, the Neighborhood Coordinator (NC) was asked if she reported Resident's fall on 05/22/2020 to state agency as required, as the resident sustained [REDACTED]. When asked, if the facility reported the resident's fall on 05/22/2020, to state agency as required, Staff G said No. Review of the facility's reporting log did not show the facility reported the resident's fall on 05/22/2020 as required. RESIDENT # 11 Resident # 11 admitted to the facility on [DATE]. According to the 04/10/2020 Annual Minimum Data Set, an assessment tool, the resident was sometimes understood and sometimes able to understand conversation, and had severe cognitive impairment. Review of the facility abuse investigative log revealed on 03/05/2020, the resident had unwitnessed fall in her room. Laying on her stomach with head turned to the right. All her blankets were covering her and her stuffed seal was down by her legs. Nursing assessment revealed redness to the left side of her body including the side of her face, arm, and leg. Review of the facility abuse investigative log revealed no indication this incident was reported into the State Agency. Review of Email from Staff B Director of Clinical services dated 05/22/2020, Following Resident#11 and history of falls. Only one fall was substantial this year, which was logged. The other falls were not substantial and did not require being logged. In an interview on 06/23/2020 with Staff S, LPN revealed Resident was found on the floor covered with her beddings, No major injuries were noted. Reported the incident to the compliance specialist and confirmed that it was not reported to the state agency. In an interview on 06/23/2020 with Staff L, Neighborhood Coordinator revealed that Resident #11 was not able to provide any information about the fall, Resident is at high risk of falls related to poor safety awareness, and restless at times. When asked how abuse was ruled out, Staff L indicated all Residents nearby were asleep or not capable to of causing a fall. When asked if the state agency was notified, Staff L said No. REFERENCE: WAC 388-97-0640 (6) (c).
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to revise comprehensive care plans (CPs) for four (#1, #8, #9 and #11) of nine residents whose CPs were reviewed for accidents, behaviors and falls. These failures placed the residents at risk for unmet care needs. Findings included Refer to CFR 483.12, F867 - QAPI/QAA Improvement Activities 483.25, F689 - Accidents 483.12, F600 - Freedom from Abuse, Neglect and Exploitation Review of a facility policy dated 12/2017 and titled Nursing Center Resident Care Plan showed CPs were initiated on the day of admission, and reviewed and updated at least quarterly and in the event of a significant change in condition. RESIDENT #8 Review of Minimal Data Set (MDS) an assessments tool since Resident #8 admitted to the facility dated 04/20/2019, 10/17/2019, 12/26/2019 and 03/25/2020, showed the resident required extensive physical assistance of staff for transfers and toileting. Review of Care Area Assessments (CAAs) dated 03/25/2020, showed the resident was identified as being at high risk for falls, and had a decline in cognition from moderate to severe cognitive impairment. These assessment showed the resident was identified as being at high risk for falls due to poor safety judgement impatience and impulsivity. Record review showed, Resident #8 experienced multiple unwitnessed falls in her room on 12/29/2020, 03/18/2020 and 06/02/2020, attempting to self-transfer. Review of the CP did not show staff revised the CP with new interventions to prevent the resident from falling. In an interview on 06/23/2020 at 12:00PM Staff L, a neighborhood coordinator acknowledged and stated the care plan should have been revised and was not. RESIDENT #9 Similar findings were noted for Resident #8 who admitted to the facility with [DIAGNOSES REDACTED]. The resident had impaired cognition and required assistance of staff for all Activities of Daily, Living including redirecting, and cuing. Record review showed, Resident #9 fell on [DATE] at 4:15 AM, near the breakfast bar when she ambulated without a walker, lost her balance and fell . Further record review showed the resident had another unwitnessed fall on 05/15/2020 at 4:00 AM. The facility investigation dated 05/15/2020 showed, the resident slid off the recliner, lost balance and fell , as she underestimated the distance between her standing and the recliner due to cognitive impairment. Further record review showed the resident fell again on 06/16/2020. The fall occurred in the resident's room and was unwitnessed. According to the facility investigation dated06/16/2020, the resident fell due to being awake and pacing in the hall way whole night, causing the resident to be tired, loosing balance and falling. Review of the CP and the Resident Information Sheet (RIS) did not show staff revised the CP with each fall incident to prevent further falls. In an interview on 06/23/2020 at 11:40 AM, Staff F, a neighborhood coordinator acknowledged Resident #9's CP for fall prevention had not been revised since 2018. Failure to revise the resident's CPs with new fall preventative interventions, precluded staff from knowing and rendering appropriate care based on assessed resident needs to prevent falls. RESIDENT #1 Review of Resident #1's medical record showed recurring incidents of resident to resident altercations between 01/26/19 and 06/15/2020. Review of a 06/19/2020 Investigative Report (IR) showed, the care plan and behavior monitor has been revised last Fall. Review of a 05/22/2019 IR showed, Staff are now aware that when they are present with her (Resident #3) it is important to make sure she is not crowded by other residents. The same will be added for (Resident #1) . He should be monitored to assure a clear pathway. He does however move independently and staff may not be present. The care plan for both residents have been edited to add this approach. This IR did not include Resident #1's updated CP. Review of Resident #1's comprehensive Behavior CP, with an original date of 01/23/2019 and an effective date of 05/23/2019, showed no documentation staff developed or changed interventions between 05/22/2019 and 06/14/2020 to include Resident #1 should be monitored to assure a clear pathway, or how staff would monitor Resident #1 to prevent resident to resident altercations.

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PROVIDENCE MOUNT ST VINCENT	4831 35TH AVENUE SOUTHWEST SEATTLE, WA 98126

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) In addition, while review of a Baseline CP showed the undated interventions of, He reacts badly when his pathway is blocked. When staff present while he is walking, help other residents out of his way, it showed the date of Thursday, October 24, 2019; five months after the 05/20/2019 altercation. Review of a 09/20/2019 IR showed staff identified Resident #1 preferred a black leather easy chair . gets in it very early in the morning and prefers to rest there most of the day . Review of Resident #1's Baseline CP, dated 10/24/2019 (six weeks after the incident) and included with the 09/20/2019 IR, showed no documentation that included the resident's preference of sitting in the black leather easy chair very early in the morning. In an interview on 06/23/2020 at 8:42 AM, when asked if six weeks after an incident was considered a timely CP review, Staff D stated, Well, part of it would be ongoing discussions about what are we doing and what's going to work. We are doing new and different things. The COVID situation hampered the effort somewhat. When asked if the facility had a COVID-19 pandemic in 2019, Staff D answered slowly after a prolonged pause, Yeah, and acknowledged there was no COVID-19 pandemic to interfere with updating Resident #1's CP between June and October 2019. When asked if the CP showed the facility updated the interventions as indicated in the 05/22/2019 and 09/20/2019 IRs, Staff D stated, No. Similarly, review of a 06/19/2020 IR showed, Activity Director made and had laminated the signs with their names on it for their chairs . Care plan for both residents updated. Review of Resident #1's comprehensive CP showed no documentation it had been updated to include the new intervention identified to prevent resident to resident altercations. In this continued interview on 06/23/2020, when asked if Resident #1's CP showed the intervention of the laminated sign, Staff D stated, No. I don't know if it's even in his care plan. I don't remember putting it in his care plan. Most people know. Maybe we need to review his care plan, and acknowledged the CP was not, but should have been, updated. When asked when CPs were updated, Staff D stated, In general, at shift change report and when the changes happen, and also happen at least quarterly. It's not been as good lately. When asked if Resident #1's Behavior CP showed it was reviewed and revised to address recurring altercations since 05/22/2019, Staff D stated, No. RESIDENT #11 Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident had impaired cognition and required assistance of staff for all Activities of Daily, Living including redirection and queuing. Record review showed, Resident #11 fell on [DATE] at 3:30 PM in her room with staff assistance. Further record review showed the resident had falls on 03/05/2020 at 4:00 AM in her room. The facility investigation dated 03/05/2020 showed, the resident may have become restless or attempted to get out of bed and ended on the floor. Further record review showed the resident had another unwitnessed fall on 05/16/2020 at 2:00 pm in her room. According to the facility investigation dated 05/16/2020, the resident unable to tell what happened, its unknown if she attempted to get out of bed or rolled out. Review of the Care Plan dated 08/07/2019 showed, At risk for falls related to impaired balance, recent falls, cognitive impairment from Alzheimer's dementia and current narcotic use. The CP or Resident Information Sheet (RIS) did not show staff revised the CP with each fall incident to prevent further falls. REFERENCE: WAC 388-97-1020 (5)(b)
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure services provided met professional standards of practice for two (# 1 and #7) of ten residents reviewed. Failure of nursing staff to notify the doctor when Resident #7 experienced a change in condition, and when a delay in a diagnostic services occurred for Resident #1, placed the residents at risk for a delay in treatment and adverse outcomes. Findings included . An undated facility policy titled NOTIFYING RESIDENT/REPRESENTATIVES AND PROVIDERS ABOUT CHANGES AND EVENTS stated the facility must inform the resident or representative and consult with the provider when any of the following occur . 2. A significant change in the resident's physical, mental, or psychosocial status. RESIDENT #7 According to the annual Minimum Data Set (MDS - an assessment tool), dated [DATE], Resident #7 admitted to the facility on [DATE] with medically disabling conditions, including altered mental status, [MEDICAL CONDITION], chronic pain and [MEDICAL CONDITION]. This MDS identified the resident had severely impaired cognition and required physical assistance of staff for all Activities of Daily Living (ADLs), including bed mobility, toileting and medication administration. Review of an Incident Investigation Report (IIR) dated [DATE], showed Resident #7 was found on the floor at the door side of her room in prone position, with her hands bent at the elbows close to her face by Staff J, Resident Assistant (RA). According to this IIR, there was a lot of brown emesis mixed with food particles of digested and undigested food noted on the floor and on Resident #7's face. Staff I, Licensed Practical Nurse (LPN), assessed and pronounced Resident #7 as deceased . Review of progress notes dated [DATE] showed Resident #7 was noted with mustard colored emesis and complaints of abdominal pain around 5:00 PM. According to the progress notes, Staff DD, a Registered Nurse (RN) notified the resident's doctor who issued a new order to administer [MEDICATION NAME], an anti-nausea/ vomiting medication for Resident #7 to stop the nausea and vomiting. These progress notes also showed Resident #7 was assessed to have decreased appetite, lower energy levels and appeared paler than her baseline, indicating a decline in the resident's health condition. Review of nurse's progress notes dated [DATE], written at 2:46 PM, showed, Resident #7 had another vomiting episode, declined to eat breakfast and lunch, and remained in the bed for the entire shift. Review of progress notes dated [DATE] at 9:20 PM, showed the resident continued to have poor appetite and exhibited calling out behavior. Progress notes dated [DATE] written at 1:41 PM, showed, Resident #7 had liquid and brown emesis on the morning of [DATE] at 7:30 AM. This progress note show, Staff BB, notified Resident #7's provider Staff AA, an advanced nurse practitioner, via voice mail about the resident's change in condition. According to the nurse's progress note, Staff BB, left a voice message to request Resident #7's provider to re-evaluate the resident the following day on [DATE]. Review of [DATE] progress notes written at 4:53 PM, showed Resident #7 was mostly asleep during evening the shift, was noted to have generalized weakness, and had an episode of liquid dark brown emesis at 4:00 AM and 7:30 AM. These progress notes showed, the resident was arousable, but not vocal per the resident's baseline, indicating a significant decline in the resident's health condition. In spite of Staff W, Registered Nurse (RN), awareness of the resident's change in condition related to vomiting coffee brown emesis (an indication of possible internal bleeding), twice on [DATE] at 7:30 AM and 4:00 PM, decreased appetite, generalized weakness and sleeping most of the shift, Staff DD did not urgently notify Resident #7's provider timely in-order to allow for urgent clinical interventions for better resident outcome per facility's policy and procedure. Review of progress notes dated [DATE] written at 1:41 PM showed Staff BB left a non-urgent voice mail for the provider, inconsistent with the facility's policy for provider notification of a resident's significant change in condition. Review of progress notes dated [DATE], showed Staff DD, noted a smear of brown emesis on Resident #7's blanket cover close to the resident's mouth, indicating the resident had another episode of brown emesis. In an interview on [DATE] at 11:30 AM, when Staff I was asked about an indication of dark brown emesis, Staff I, stated It could be an indication the resident may have been bleeding internally. Staff I, was then asked if she notified the doctor about dark brown emesis, Staff I stated No and later said she did not, as Staff DD, from the previous shift had already notified the doctor. On [DATE] at 4:00 PM, when Staff AA, a medical provider for Resident #7, was asked if the facility's licensed staff, had notified him of the resident's dark brown emesis on [DATE] at 1:41 PM, [DATE] at 4:53 PM and on [DATE] at 9:35 PM Staff AA, said he was not aware Resident #7 had been throwing up dark brown emesis. Staff AA, further stated that if he was notified of the resident's symptoms (vomiting coffee brown emesis), he could have responded in a more urgent manner such as, STAT laboratory tests (Expedited diagnostic tests) in order to rule out internal bleeding, or transfer the resident to the emergency room for evaluation. Staff AA, further said, Vomiting coffee brown emesis could be an indication of internal bleeding, and it requires urgent interventions. Staff AA stated I acted upon the information I was provided by the licensed Staff. Efforts to interview Staff BB and Staff DD failed. The failure of the facility's licensed staff to thoroughly assess, monitor, and intervene timely, by notifying the resident's medical practitioner, with Resident #7's assessment results, as required, in accordance with facility's policy and procedure failed to uphold required professional standards of practice, and placed the resident at risk for delayed treatment and worsening condition. RESIDENT #1 A [DATE] progress note showed, Increased RUE/RLE (Right Upper Extremity/Right Lower Extremity) [MEDICAL CONDITION] (swelling) . MD saw resident this am (morning) and ordered a ultrasound. A [DATE] progress note showed, venous Doppler (ultrasound) not performed yet . due to the overflow of requests, the service will be delayed and will need to wait for the dispatcher's call tomorrow for the ETA (Estimated Time of Arrival). Review of the medical record showed no documentation staff notified the physician of the delayed ultrasound test. A [DATE] progress note showed, a Doppler is ordered for right upper extremity and lower extremity which has yet to be done, and another note of the same date showed, Doppler studies have not been completed to date. Review of the medical record showed no documentation staff notified the

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) physician of the delayed ultrasound test. Four days after the original ultrasound order of [DATE], a [DATE] progress note showed, Ultrasound to RLE done first not upper d/t (due to) insurance coverage and MD (physician) aware and re-wrote order for RLE; will do RUE later. The above findings were shared with Staff B, Director of Clinical Services. On [DATE] at 8:35 AM, when asked what was expected of staff when a delay in diagnostic services was encountered, Staff B stated, Notify the provider and find out how we wants to handle it, does he want a STAT (urgent or rush), is it ok to wait, or to send them to the hospital. REFERENCE: WAC [DATE](2)(b)(i)(ii),(6)(b)(i).
F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to recognize, comprehensively assess, monitor, or treat disturbed sleep patterns for one (#9) of one resident reviewed for disturbed sleep pattern. These failures caused harm to Resident #9, who experienced continuous pacing and lack of sleep, resulting in a diminished quality of life and sustaining a fall with substantial injury to the left hip, and requiring hospitalization for a surgical procedure to fix the [MEDICAL CONDITION]. Findings included . PROMOTING SLEEP POLICY AND PROCEDURE Review of the sleep policy and procedure dated 01/2015 and last revised on 07/2017 read in part: .PMSV nursing staff assess and intervene to promote optimum sleep quality in short and long -stay residents. POLICY INTERPRETATION AND IMPLEMENTATION ASSESSMENT 2. If the screening assessment suggests unsatisfactory sleep quality, factors contributing to sleep disturbance are identified. Information from this assessment is used to identify specific sleep problems that direct development of an individualized care plan. RESIDENT #9 Resident #9 was a long term resident of the facility who was admitted on [DATE]. The resident's [DIAGNOSES REDACTED]. A review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE], showed the resident had impaired cognition and needed queuing from staff to complete most activities of daily living including sleep promotion. Review of Incident witness statement dated 06/16/2020, showed Resident #9 had been up the whole night, was pacing back and forth on the unit hall way, when she experienced a fall and sustained a left [MEDICAL CONDITION]. Review of the Incident Investigation Report (IIR) root cause analysis dated 06/16/2020, showed, the cause of Resident #9's fall was due to, self-induced tiredness as the resident spent whole night pacing back and forth, causing her to loose balance and fall. Review of nurse's progress notes dated 04/22/2020, showed, Resident #9 experienced significant difficulty sleeping in the recent past, being up wandering and restlessness during the middle of the night. Review of the May 2020, Medication Administration Record [REDACTED]. Further review of the listed interventions for target behaviors related to difficulty sleeping instructed staff to provide sleep. In interview on 06/23/2020 at 11:45 AM, when Staff F, the Neighborhood Coordinator (NC) was asked how staff promoted sleep quality as instructed in the MAR for the resident, Staff F did not respond. Staff F then continued and stated, Initially, the resident slept well and did not need any sleep interventions based on admission sleep assessment. Staff F, further said that Resident #9 had developed sleep disturbances in the past few months. In an interview on 06/23/2020 at 11:45 AM, when Staff F was asked if the resident was re-assed after a change in sleep pattern? Staff F, said No. In interview on 06/23/2020 at 11:45 AM, when staff F was asked if Resident #9's doctor was notified of the resident's change in sleep pattern. Staff F, said, the doctor was aware of the resident's change in sleep pattern, but he did not issue any new orders such as, sleep medication, to aid the resident to sleep. Review of Resident #9's Care Plan (CP) and Information Sheet did not include interventions, on how staff were to care for the resident in order to promote sleep. In interview on 06/28/2020 at 10:45 PM, Staff J, a regularly assigned night care giver, was asked, how she promoted sleep for Resident #9, Staff J was unable to state specific interventions on how she was to promote sleep for the resident, then later stated I provided her whatever I could. Review of the resident's medical record did not show the staff assessed the resident's sleep quality, to identity factors or circumstances causing the resident's sleep disturbance. Nor did the facility develop a care plan to promote sleep, based on the assessed sleep needs, as stated in the facility's sleep promotion policy and procedure. The failure to assess Resident #9's sleep disturbances, identify factors causing the resident's sleep disturbances or develop and implement interventions to promote resident's sleep resulted in harm, when Resident #9 spent sleepless nights and experienced fatigue, resulting in the resident falling and sustaining a fractured Left hip. REFERENCE: WAC 388-97-1060 (1)
F 0689 **Level of harm -** Actual harm **Residents Affected -** Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an environment that was free from accidents for four (#5, #8, #9 and #38) of seven sample residents reviewed for accidents. The facility failed to implement preventative interventions to prevent further falls for Resident#5, #8, #9 and #38. This failure resulted in harm when Resident #8, #9 and #38, fell and sustained [MEDICAL CONDITION] requiring surgical procedures to repair [MEDICAL CONDITION], resulting in death. Additionally, this failure placed Resident #5 at risk for recurrent falls and serious harm. Findings include: FACILITY'S FALL POLICY Review of the facility's policy for fall prevention, revised on ,[DATE], read in part: Interventions after fall 4. Residents are re-assessed quarterly, with a change in condition that affects fall risk factors or when the root cause of a new fall is due to a previously unidentified risk factors for that resident. Care plan revisions are added or discontinued in response to changes in risk factor. Post fall care planning 2. Care plan changes are made in accordance with the findings of the root cause analysis. RESIDENT #8 According to the annual Minimum Data Set (MDS) assessment, dated [DATE], Resident #8 was initially admitted to the facility on [DATE] with medically disabling conditions including altered mental status, history of falls and vision impairment. This MDS identified the resident had severely impaired cognition and required physical assistance of staff for all Activities of Daily Living (ADLs), including mobility and transfers. Review of MDS assessments since Resident #8 admitted to the facility dated [DATE], [DATE], [DATE] and [DATE], consistently showed the resident required extensive physical assistance of staff for transfers and toileting. Review of Resident #8's comprehensive Care Plan (CP) and the resident information sheet dated [DATE], which was printed on [DATE] showed transfers: (Independent to extensive assistance with Front Wheeled walker (FWW)), inconsistent with MDS assessments which identified Resident #8 as requiring one person physical assistance with transfers and toileting. The CP did not reflect the actual care level the resident required based on assessed care needs. FALL #1 Review of progress notes dated [DATE], showed Resident #8 had an unwitnessed fall in her room at 8:00 AM. According to the progress notes, when asked, the resident stated, she stood up after using the bedside commode, lost balance and fell . Further review of the progress notes showed, the cause of the fall was due to the resident forgot to use the call light for assistance before transfer to the commode. The plan to prevent further accidents included to remind the resident to use the call light for assistance with transfers. Review of Resident #8's medical record did not show the facility completed a thorough investigation to determine the root cause of the fall and implement revised preventative measures to prevent further falls. On [DATE] at 12:30 in interview, when Staff S, a licensed nurse was asked, who determined the level of assistance the resident required for transfer and toileting? Staff S said It was the direct care givers, Resident Aides (RA). Staff S was then asked if the RA had expertise and were expected to make clinical judgements related to level of care required to transfer or toilet a resident. Staff S did not answer. On [DATE] at 12:30 PM Staff S, was asked, if she coordinated with the nurse who completed MDS assessments before developing a CP for Resident #8 in order to implement an interdisciplinary resident centered care plan, Staff S said No. when Staff S was asked what resources she utilized to develop the resident's care plan for toileting and transfers in order to prevent accidents for Resident #8 who admitted with a history of falls, Staff S said she consulted with the nurse's aides who provided direct care for the resident and understood the level of care the resident required, inconsistent with the facility's CP policy and procedure and professional standards of practice which required a licensed nurse to conduct assessments. Review of progress notes dated [DATE] showed the resident forgot to use the call light to ask for assistance when she attempted to self-transfer after using the bedside commode, lost balance and fell . The fall was unwitnessed, and the resident did not sustain any injuries. In a joint interview on [DATE] at 12:00 PM, with Staff A, the administrator and Staff B, the Director of Nursing Services (DNS), and Staff L, the Neighborhood coordinator was asked to provide a completed investigation for the fall incident dated [DATE], Staff L was unable to provide. Additionally Staff L was asked, what interventions were put in place to prevent further falls, Staff L did not respond. FALL #2 According to

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 6) progress notes dated [DATE], Resident #8 was transferred to a different unit as a precaution to prevent the spread of COVID-19, as her roommate tested positive for COVID-19. Review of progress notes dated [DATE], showed Resident #8 had an unwitnessed fall in her room at 11:10 AM (2 days after moving to a different room). When the resident was asked, she said she attempted to get a bowl of water to brush her teeth, lost balance and fell . According to progress notes dated [DATE], the cause of the fall was due to the resident's impaired cognition, impatience, impulsivity and new care givers still learning the resident's routine. Review of the facility's Incident Log (IL) for [DATE], found the facility did not log Resident #8's fall incident on [DATE], and the facility could not provide evidence of investigation of incident. On [DATE] at 11:30 AM, when Staff L was asked if the fall incident dated [DATE] was investigated in order to prevent further accidents for Resident #8, Staff L, said No and did not provide the incident investigation, but later provided written notes of the incident. The written notes were dated [DATE] (the date of the interview [DATE]). Review of the Care Area Assessments (CAA's) dated [DATE], with a look back period of seven days, showed Resident #8 had a significant decline in cognition from moderate impaired cognition to severely impaired cognition, declining Brief Interview for Mental Status (BIMs) score, from 12 out of fifteen (,[DATE]) to six out of fifteen (,[DATE]), indicating a significant decline in mental cognition. Review of the CP, did not show the staff revised Resident #8's plan of care to compensate for the resident's impulsivity and severely impaired cognition to prevent further falls for the resident. Additionally, this care plan did not include specific revised interventions to instruct staff, how often staff were to check on the resident and ensure the resident's toileting needs were met based on the resident's assessed care needs, which included the resident's poor safety awareness, impulsivity and inability to use the call light for assistance. FALL #3 Review of the Incident Investigation Report (IIR) dated [DATE], showed Resident #8 again, experienced a fall in her room as she attempted to self-transfer to use the bedside commode for toileting. According to progress notes dated [DATE], the resident sustained [REDACTED]. Review of progress notes dated [DATE] showed, the resident was transferred to the hospital for further evaluation. Review of the facility's IIR summary dated [DATE], showed Resident #8 sustained a left [MEDICAL CONDITION] and underwent a failed surgical procedure to fix the left hip, and later passed away on [DATE]. Review of Resident #8's death certificate dated [DATE], indicated the resident's immediate cause of death was the left femur fracture as a consequence of [MEDICATION NAME] force injury to the left hip related to the fall incident on [DATE]. In spite of staff's awareness of Resident #8's decline in cognition, and forgetfulness to use call light for assistance, unsteady gait and a history of falls, there were no specific preventative measures to address the resident's toileting care needs to prevent further falls. Further review of the IIR showed the root cause of the fall was due to the resident's poor self-awareness, not using the call light for assistance. In interview, on [DATE] at 12 pm, Staff L and Staff B the Director of Nursing Services (DNS) acknowledged and stated,staff should have revised the care plan with interventions to prevent further falls. The failure to revise preventative measures to address the resident's toileting/transfer care needs based on identified assessed needs, precluded the staff from ensuring the resident's care needs were met, resulting in the resident's subsequent fall and [MEDICAL CONDITION] hip while attempting multiple times to self-transfer to use a bedside commode. RESIDENT #9 According to the annual MDS, dated [DATE], Resident #9 admitted to the facility on [DATE] with medically disabling conditions that including altered mental status and Dementia complicated by depression with behavioral disturbance. This MDS identified the resident had severely impaired cognition and required physical assistance of staff for all Activities of Daily Living (ADLs), including mobility, transfers and toileting. FALL #1 Review of the Incident Investigation Report (IIR) dated [DATE] showed Resident #9 had a witnessed fall near the breakfast bar at 4:15 AM. According to the IIR, the resident was observed parking her Front Wheeled Walker (FWW) at the phone column across from the breakfast bar, and ambulated without a walker to the breakfast bar when she lost balance and fell . The resident did not sustain any injuries. Further review of the IIR dated [DATE] showed the root cause of the resident's fall, was due to walking without a walker, cognitive deficits leading to poor safety judgement by underestimating where she leaves the walker and to the chair. Review of Resident #9's care plan did not show staff revised Resident #9's CP at the end of the two shifts following the resident's fall as stated in the facility's fall policy for accident prevention to address a new fall's unidentified risk factor. On [DATE] at 11:30 AM, Staff F, the unit neighborhood Co-coordinator, was asked how staff insured the resident's safety after the Resident #9's fall incident on [DATE]. Staff L said staff were instructed to check on the resident frequently to ensure she does not fall. Review of Resident #9's CP did not include care instructions for staff to check on the resident frequently, as stated in the IIR Action /Plan for prevention of Recurrence. When asked, Staff L was unable to explain how frequently staff were to check on the resident. Staff L acknowledged there were no revised implemented preventative interventions to prevent fall recurrences for Resident #9, and stated the CP should have been revised to reflect accident preventative measures to prevent further falls. FALL #2 Review of the IIR dated [DATE] at 4:00 AM, showed Resident #9 had an unwitnessed fall in her room at 4:00 AM, and was found sitting on the floor by Staff J. Further review of the IIR showed that Resident #9 was last seen at 2:30 AM, when she was observed continuously/repeatedly changing her socks. When the resident was asked, she was unable to state what caused her to fall. Review of the IIR root cause analysis showed, the cause of the fall was due to Resident #9's attempt to sit on her recliner but was too far forward on the seat, and as she sat, she slid right off in front of recliner. The resident underestimated the distance of her standing and her recliner due to cognitive impairment. Review of the IIR preventative plan dated [DATE] indicated no revised fall preventative interventions to prevent falls. The action/plan prevention recurrence of falls showed staff were to continue to perform more visual checks and keep the FWW at the resident's side. Despite the staff's awareness of the resident's cognitive impairment, forgetfulness to use the walker for ambulation and poor safety awareness due to dementia, there were no revised implemented interventions to address how staff were to ensure the resident's safety, as previously implemented interventions were not effective, as evidenced by the resident's repeated falls. FALL #3 Review of nurse's progress notes and IIR dated [DATE] at 4:05 AM, showed Staff J, a Certified Nurse's Aide (CNA) heard a loud noise. When Staff J, walked into the hallway, she heard Resident #9 calling out for help. When Staff J walked in Resident #9's room, she found the resident had fallen, and was sitting in the floor with one hand on the walker. Review of nurse's progress notes dated [DATE], Staff H, a licensed nurse, assessed the resident and noted, the resident had increased pain to left hip. Resident #9's doctor was notified of the resident's fall incident and post fall assessment results. The doctor issued a new order to X-ray the resident's left hip. According to progress notes dated [DATE], X-ray results showed a left [MEDICAL CONDITION]. The resident was transferred to the hospital per doctor's order for further evaluation of the fractured left hip. Resident #9 underwent a surgical procedure to repair a fractured left hip for which she could not recover, and later died on [DATE]. Review of Resident #9's death certificate showed the resident deceased on [DATE]. Review of the IIR root cause analysis dated [DATE], showed the cause of the Resident #9's fall was due to the resident's self-induced tiredness and was worn out due to being awake the whole night, and wandering back and forth without sleep, causing the resident to loose balance and fall. Review of the CP dated [DATE], showed Resident #9 was identified as a fall risk related to history of falls in the past 6 months, bilateral lower extremity weakness, history of shortness of breath and increased confusion and wandering. This CP did not include fall interventions, but instructed staff to refer to the resident's information sheet for interventions to prevent falls. Review of Resident #9's information sheet printed on dated [DATE] and on [DATE], did not show specific care interventions to prevent further falls for Resident #9 as instructed in the comprehensive care plan. On [DATE] at 2:30 PM in interview, Staff J, a regularly assigned night shift care giver to Resident #9 explained that the resident had experienced difficulty sleeping in past few months prior to the fall incident on [DATE]. Staff J Further stated that the resident spent most nights pacing back and forth in the hall and did not even try to sleep. On [DATE] at 10:30 PM, in an interview, Staff J was asked how she ensured Resident #9's safety and was free from accidents, as the resident spent sleepless nights wandering in the unit hallways. Staff J stated I offered her whatever I could offer her. Staff J did not state specific fall precautions that she implemented in order to prevent the resident from falling. On [DATE] at 10:45 PM , in an interview, Staff H, the regularly assigned night shift licensed nurse acknowledged Resident #9 had experienced difficulty sleeping, since acute hospitalization for mental evaluation at the Geri-psychiatry unit three months prior to the fall on [DATE]. The failure to implement accident preventative measures to prevent residents from falling caused harm to Resident #8 and #9 leading to death. Additionally, the facility's failure to investigate and identify accident hazards and implement interventions to prevent further falls, placed Resident #9 and #8 and all residents at risk for recurrent falls resulting in serious harm. RESIDENT #38 According to the admission progress notes of [DATE], Resident #38 was admitted to the facility on [DATE] with medically disabling conditions that included vision impairment due to [MEDICATION NAME] degeneration, tremors and a left [MEDICAL CONDITION]. Review of a hospital discharge summary dated [DATE] showed, Resident #38 sustained a left [MEDICAL CONDITION] after a traumatic fall at home on [DATE], and underwent a surgical procedure to fix the [MEDICAL CONDITION] (two

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F 0689 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 7) days prior to admission to the facility). Review of a Physical/Occupational Therapy (PT/OT) notes dated [DATE] showed Resident #38 was assessed upon admission to the facility, was identified to be at high risk for falls, and required Contact Guard Assistance (CGA) from staff for transfers. These notes showed the resident used a wheel chair for mobility. Review of Resident #38's Incident Investigation Report (IIR) dated [DATE] showed Resident #38 was found on the floor close to the sink in her room at 5:06 PM (four days after admission to the facility). According to IIR, the resident stated that after washing her hands at the sink, she attempted to turn to the right side to grab her walker, tripped and fell on her left side. Further review of the above IIR showed, Staff FF and Staff GG assessed Resident #38 after the fall. Upon assessment, the resident had complaints of increased pain to the left hip. Staff FF notified the doctor with the assessment results. The doctor issued a new order to X-ray the resident's left hip. Review of the X-ray results showed a new fracture to the left hip, and the resident was transferred back to the hospital for further treatment to fix the fracture. Review of Resident #38's Care Plan (CP) dated [DATE], identified the resident as being at high risk for falls, and showed the resident required Contact Guard Assistance (CGA) from staff with a Front Wheeled Walker (FFW) for transfers. This CP further showed the resident required to be set-up for grooming. Review of the PT/OT notes dated [DATE] showed the resident had Poor, unable to correct balance standing dynamic. Further review of PT/OT notes showed, the resident presented with impaired endurance and unable to walk to the length of the bathroom. These PT/OT notes instructed staff to set up the resident for grooming seated at the Edge of the Bed (EOB) with grooming supplies. In an interview on [DATE] at at 4:46 PM, Staff EE said he assisted Resident #38 to walk to the the sink to wash her hands using a FWW at around 5:00 PM during dinner time. Staff EE then left the resident standing at the sink washing her hands, to pass dinner trays to other residents. A few minutes later, Staff EE heard Resident #38 calling out for help. Staff FF and Staff GG entered the resident's room and found the resident on the floor laying on the left side. On [DATE] at 4:50 PM, when Staff EE was asked, he said he did not check the resident's CP for interventions to prevent the resident from falling, but instead asked the resident if she was, ok standing at the sink, and the resident seemed to be ok but lost balance and fell . Staff EE's action was inconsistent with the resident's care interventions based on the PT/OT assessments which instructed staff to use a wheel chair for mobility/and or set up the resident for grooming with grooming supplies at the edge of the bed. Staff EE also said that during the investigation of Resident #38's fall, Staff EE was counseled by the Staff G, a Neighborhood Coordinator, that he should not have left the resident by herself at the sink, as instructed in the resident's plan of care due to the resident's poor standing balance. Review of the IIR conclusion dated [DATE], completed by Staff G showed Staff EE, felt the resident was stable at the sink and he left for few minutes as noted by the care plan, an action inconsistent with care instructions for the resident's fall prevention interventions assessed to require by PT/OT disciplines, and as indicated on the Resident Information Sheet dated [DATE]. Review of the above IIR showed Staff G concluded that The careplan was followed (by Staff EE), contradicting Staff EE's acknowledgment that he shouldn't have left the resident alone by the sink. This IIR conclusion dated [DATE] written by staff G was inconsistent with the interview statement provided by staff EE during his counseling session with Staff G, who reprimanded staff EE for leaving Resident #38 un-attended at the sink. The facility's failure to implement appropriate fall preventative measures for Resident #38, based on assessed care needs, caused harm to Resident #38 when she fell and sustained a second fracture to the left hip, four days after admission to the facility. SIMILAR FINDINGS RESIDENT #5 Review of the medical record showed Resident #5 readmitted to the facility on [DATE] for multiple care needs, including dementia, and had a history of [REDACTED].#5 was assessed to require limited assistance of one staff member for walking in her room and in the corridor. Review of the resident's Fall Risk CP included the intervention, dated [DATE], Provide supervision with ambulation out of room but allow her to wander at will. Do not startle her when bringing her FWW to her. Tends to lose balance when she stops walking and when she turns while walking. Reveiw of the resident's record showed the resident had a witnessed fall on [DATE] at 4:00 PM. A progress note dated [DATE] at 9:24 PM showed, the Res (resident) was walking to the dining room from her room lost balance and fall (sic). The root cause of the fall was stated as Res (Resident) was using the walker but when she lost balance she tried to grape (sic) the sit to stand machine but the machine moved and res end up of the floor. This fall resulted in a large bruise to the left hip. An Investigation Summary (IS), dated [DATE], stated the resident is very high risk for fall related to h/o (history of) . poor safety awareness, does not always use FWW (front wheeled walker). Walks independently to supervision with FWW (needs cues to use FWW and watch path) per care plan. The IS did not address that the resident ambulated independently at the time of the fall, even though staff identified she was assessed to need supervision with ambulation. Further review of the resident's record showed Resident #5 had a second witnessed fall on [DATE] at 6:00 AM that resulted in a bruise over her right eye. According to the undated IS the resident was ambulating in the hallway without her FWW and tripped over a parked walker in the hallway. The root cause of the fall was identified as, Bathroom seeking without her FWW. Further review of the IS showed, Fall Assessment: very high risk for falls related to h/o (second fall this year), poor safety awareness .Walks supervised, as tolerated with FWW, needs cues to use FWW and watch path . Under the Action Taken section of the IS it showed .staff assist her when she is walking and transferring as tolerated however she still gets up on own per care plan and resident rights. The IS did not address the resident's need for supervision when ambulating to ensure the use of her walker and prevent falls. On [DATE] at 7:30 AM Staff T stated, (the resident) has the right to be free of movement. We do not provide 1:1 supervision . REFERENCE: WAC [DATE] (3)(g).
F 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the Administration failed to effectively and efficiently monitor and sustain facility compliance with federal regulatory requirements. The Administrator failed to ensure previous citations were not repeated, including reporting allegations, care planning revisions, consistent use of professional standards of practice were used; Failed to ensure the facility maintained an effective Infection Control Program, and Quality Assurance program, ensure compliance related to the prevention of abuse and neglect which resulted in psychological harm, and continued failed practice related to accidents. An immediate jeopardy (IJ) situation related to resident to resident abuse was identified on 06/23/2020. Findings included . On 06/24/2020, a removal plan was submitted to the department by the Director of Nursing. The plan was incomplete and lacked enough information to show the immediacy was removed, even though the facility alleged removal by 07/03/2020. The Department was unable to remove the immediacy until 07/13/2020, 10 days after the day the facility alleged removal of the immediacy. The Administrator failed to ensure that all staff were aware of the organizational structure in the facility, who to report to. In a review of two different facility Organization Charts both were dated January 2020. One was submitted by the DNS and one was submitted by Staff C, Risk Management Specialist. Both Charts showed the Administrator was accountable for all nursing departments. The first Chart showed that all nursing staff including education and training department were accountable to the Administrator. The second Organization Chart showed the same except, the Education and Training department was now moved under the DNS. The only nursing department the DNS was responsible for was infection control and Safety, Risk and Compliance. In an interview on 08/04/2020 at 3:00 PM, Staff II, Neighborhood Coordinator, stated that when it came to reporting, she reported to the DNS. In an interview on 08/04/2020 at 3:10 PM, Staff F, Neighborhood Coordinator, stated that when it came to reporting, she reported to the Administrator. In an interview on 08/04/2020 at 3:30 PM, Staff G, Neighborhood Coordinator, stated that when it came to reporting, she reported clinical issues to the DNS, and non-clinical issues to the Administrator. The Administrator failed to intervene as the Director of Nursing (DNS) and other staff refused to be interviewed, causing delays in completing investigations; refused to let department staff interview line staff without interference; refused to timely submit paperwork when requested. Failed to educate staff to survey processes and protocols and failed to have, completed removal plans in place, delaying the review and approval from the department. In a telephone meeting on 6/15/20 at 1:00 pm, the Assistant Administrator stated that she had worked with a department staff and proceeded to use derogatory remarks about the surveyor in front of the facility line staff, creating a tense meeting environment. F-600, CFR 483.12, Freedom from Abuse, Neglect, and Exploitation; The Administrator failed to identify, recognize, and act upon repeated resident to resident altercations, leading to physical and psychological harm. In a telephone conversation with the Administrator on 06/23/2020 at 4:00 PM, the Administrator was informed of an immediate jeopardy, due to recurring resident to resident abuse. While discussing the immediate need to act, the Administrator failed to recognize, that when a resident yells at other residents, intimidates residents with his walker, grabbed the arm of another resident that caused a skin

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F 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 8) tear, it was considered abusive behavior. The Administrator stated, It was a minor skin tear. In a previous citation at F 600 on 09/25/2018, the Administrator documented on the plan of correction that the Administrator would be the person to ensure correction and ongoing compliance. F-609, CFR 483.12(c)(1)(4), Reporting of Alleged Violations - Repeated Deficiency from 08/20/18 The Administrator failed to ensure the reporting of alleged abuse, resident to resident altercations, and falls with serious injury were reported to the department. F-657, CFR 483.21(b)(1) Care Plan Timing and Revision - Repeated Deficiency from 08/20/2018 and 11/04/2019. In the previous citations for resident centered care plans not being revised. The Administrator documented on the plan of correction, that the Administrator would be the person to ensure correction, ongoing compliance, and ensuring care plans were resident centered, revised as necessary to meet the needs and preferences of residents. In addition, action plans to correct any problems would be developed, implemented, and evaluated through the QAPI process when indicated. F-658, CFR 483.21, Services Provided Meet Professional Standard - Repeat deficiency from 08/20/2018 and 11/04/2019. The Administrator documented on both plans of corrections that, the Administrator would be the person to ensure correction and ongoing compliance. In addition, Audits would be completed by the Director of Clinical Services or designee, and reviewed. Action plans to correct any problems would be developed, implemented, and evaluated through the QAPI process when indicated. F-684, CFR 483.25, Quality of Care The facility Administrator failed to ensure nursing staff recognized, comprehensively assessed, monitored, or treated disturbed sleep patterns for one resident #9. Resident #9, experienced continuous pacing and lack of sleep, resulting in a diminished quality of life and sustaining a fall with substantial injury to the left hip, and requiring hospitalization for a surgical procedure to fix the [MEDICAL CONDITION]. F-689, CFR 483.25(d)(1)(2), Free of Accidents/Hazards/Supervision/Devices, Repeat deficiency from, 08/20/18, 10/10/18, & 11/4/19 The Administrator failed to ensure preventative measures for falls including increased supervision was implemented, this resulted in actual harm. For all of the past citations, the Administrator documented to ensure compliance the facility would continue weekly evaluations of falls, by the Risk Manager, Staff C and the Director of Clinical Services, Staff B and the Administrator would be responsible for ensuring compliance. F-867, CFR 483.87, Qapi/qaa Improvement Activities The facility Administrator failed to implement an effective Quality Assessment and Assurance (QA&A) program that identified potential, past system deficiencies and sustained compliance to prevent failed practice from reoccurring even though on past citations the facility administrator documented that all audits for past non-compliance would be monitored through Qapi and the Administrator would ensure compliance. F-880, CFR 483.80 Infection Prevention & Control The facility Administrator failed to ensure there was a process for infection surveillance that included complete information to facilitate an accurate analysis of infections in the facility for five months (January through May 2020) of Infection Control (IC) documents reviewed. In addition, the Administrator failed to ensure consistent social distancing between residents on three of the five floors. This failure placed the residents at risk for COVID-19 (Coronavirus - an illness caused by [MEDICAL CONDITION] that can spread from person to person) infection. F-881, CFR 483.80, Antibiotic Stewardship Program The facility Administrator failed to set up and have staff follow an established Antibiotic Stewardship Program (ASP) to ensure the appropriate use of antibiotics (ABOs) for five (between January 2020 and May 2020) of five months of Infection Control (IC) documents reviewed. The facility Administrator failed, despite awareness of previous and continued failed practice, to ensure adequate revision of care plans, reporting of alleged abuse, resident altercations, and falls, and investigate and implement preventive measures for recurrent falls and resident to resident altercations, and allowed staff to create an adversarial relationship with department staff. REFERENCE: WAC 388-97-1620 (1).
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** Based on interview and record review, the facility failed to implement an effective Quality Assessment and Assurance (QA&A) program that identified potential or addressed corrected system deficiencies related to care plan revision and falls. This failed practice disallowed facility staff the opportunity to analyze potential and actual system deficiencies and develop/implement corrective action for deficiencies that led to resident harm in the areas of abuse and falls. Findings included . Refer to: CFR 483.12, F600 - Freedom from Abuse, Neglect and Exploitation CFR 483.21(b)(2), F657 - Care Plan Timing and Revision CFR 483.25(d)(2), F689 - Accidents FALLS Review of falls investigative reports for Residents #5, #8, and #9 showed the facility did not conduct a root-cause analysis to identify factors associated with falls or develop and implement interventions to address recurrent falls. Please refer to F689 which resulted in actual harm to a resident. In a joint interview with Staff V (Assistant Administrator/QAA Coordinator) and Staff W (Interim QAA Coordinator) on 07/02/2020 at 11:44 AM, Staff V described incident management was under the oversight of (Staff C, Risk and Compliance Specialist) and then (Staff B - Director of Clinical Services), who has oversight of Staff C. Staff V also stated, I review the incidents, but as far as the workflow, it goes from the originating neighborhood, then to (Risk and Compliance Specialist), then (Director of Clinical Services). If it reaches a threshold of concern then (the Administrator) is included. (The Administrator) is always informed of those types of things because of the daily meetings. In this continued interview, when asked how the facility addressed falls to prevent recurrence, Staff W stated, We do a stand up meeting every day and it is reported and we look at it on a daily basis; we have a monthly meeting - a summary of what we had for that month, and rounds. In addition to stand up, the falls are being reported daily by staff. Weekly reports for falls are generated. Neighborhood Coordinators, Therapy Services and Activities Department get those reports as well. When asked how the QAA Committee knew when a negative trend occurred, Staff W stated, Through visual review of graphs, we look at the data, and whatever or whoever triggers we set up an audit system. If we see deviation then we talk about it with the Neighborhood Coordinator. We have a weekly nurses meeting and we discuss it there. When asked how the QAA committee decided which issues to work on, Staff W stated, We have to prioritize . falls is one of them. In an interview on 07/10/2020 at 10:05 AM, when asked for documentation that showed the QAA Committee evaluated falls between 01/2020 and 06/2020, Staff V provided a blank copy of a Morning Stand up form, a 2020 YTD (Year to Date) form showing location and number of falls between 2019 and 2020, and a Fall Team Work Sheet January 2020 for Resident #37. These documents did not show the facility evaluated falls, what trends were identified, and how the facility addressed those trends. When asked for documentation that showed the facility evaluated the data reflected in the documents provided, Staff V stated, The evaluation of the data is related to the QAPI (Quality Assurance Performance Improvement) plan. QAPI (team) reviews falls monthly. When asked what the QAPI Team concluded about the falls reviewed between 01/2020 and 06/2020, Staff V stated, The IDT (InterDisciplinary Team) Huddle meets to discuss the people and those who were at risk that (Staff C) has identified or tracked. When asked if there were any meeting minutes to show this occurred, Staff V stated, No. When asked if there were any Fall Team meeting minutes, Staff V stated, I can't tell you there is a weekly summary of the incidents. The work is daily, weekly, monthly, it happens in different ways. They meet as needed for the Falls Team. We know we have an issue. We identified we have an issue with falls. No further information was provided to show the QAA Committee analyzed falls over a six month period or developed interventions based on the analysis. CARE PLANS Review of medical records for Residents #1, #8, and #9 revealed Care Plans (CPs) were not updated to show interventions to prevent recurrence of falls and resident to resident altercations. These findings were shared with Staff A, Administrator on 06/23/2020 at 12:04 PM (Please refer to F600, which resulted in an Immediate Jeopardy, F689 which resulted in actual harm, and F657 which showed failed practice with CP revision). Review of the facility's 2019 Annual State Survey results showed the facility failed to revise CPs in a timely fashion. This document showed the facility would review CPs plans monthly, . and then quarterly until ongoing compliance is assured. Action plans to correct any problems will be developed, implemented, and evaluated through the QAPI process when indicated. Administrator will be responsible for ensuring compliance by 12/19/19. Review of a January 2020 Care Plan Review form showed the facility audited one resident's care plan from the SJR floor, one out of five floors. A February 2020 review form showed the same. No monthly audits were provided for the month of March. A quarterly June audit was provided for one resident on the third floor, Resident #1, on 06/23/2020, the day the facility was found in Immediate Jeopardy for resident to resident altercations involving this resident. In an interview on 07/10/2020 at 10:05 AM, when asked if a sample of one resident was sufficient to assure sustained compliance with an identified issue, or if the facility conducted a monthly audit in March 2020 and a quarterly audit in June 2020 prior to 06/23/2020, Staff V stated, What we have is what we have. We are in the middle of a pandemic. No further information was provided to show the facility reviewed care plans and

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F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) subsequently developed, implemented, and evaluated through the QAPI process. REFERENCE: WAC 388-97-1760(1)(2). .
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure its infection surveillance process included complete information to facilitate an accurate analysis of infections in the facility for five (January through May 2020) of five months of Infection Control (IC) documents reviewed. This failure detracted from staff's ability to identify trends and implement interventions, and placed residents at risk for infections. In addition, based on observations and interviews, the facility failed to consistently implement social distancing between residents in three of five floors. This failure placed the residents at risk for COVID-19 (Coronavirus - an illness caused by [MEDICAL CONDITION] that can spread from person to person) infection. Findings included . Refer to CFR 483.80(a)(3), F881 - Antibiotic Stewardship INFECTION SURVEILLANCE Review of the January 2020 to March 2020 IC documents showed a pattern wherein the facility answered as NA (Not Applicable) or did not provide an answer to the questions: Diagnostic Tool Used?, Criteria met? Date Test Ordered, Signs & Symptoms, Ordering Provider, follow-up Notes, Organism involved with the signs & symptoms, or the Type of Infection. In addition, review of the IC documents showed a lack of the onset date (the date the resident first started to have symptoms) for infections. Establishing an onset date for an infection helps determine incubation time, period of communicability, and may inform other ways to limit transmission. Review of the above IC Documents showed no documentation the facility identified, as part of their surveillance process, whether a Urinary Tract Infection [MEDICAL CONDITION] was Catheter-Associated (CAUTI) or not. Identifying this information would facilitate the development of specific interventions to address IC practices with UTIs. In addition, the McGeer Criteria (a national standard for defining infections) established signs and symptoms (S/SX) specific to UTI or a CAUTI, which helped determine whether the S/SX met the definition of an infection. Furthermore, review of the above IC documents showed the facility did not include as part of their surveillance process which infections were House Acquired Infections (HAI - infections acquired in the nursing home) or Community Acquired Infections (CAI - infections acquired out of the nursing home). This information is important to track as a resident can expose other residents to CAIs upon admission, placing them at risk of an infection outbreak. In an interview on 06/22/2020 at 9:07 AM, when asked if knowing the onset date of signs and symptoms was relevant for infection surveillance, Staff E, Infection Preventionist/Registered Nurse, answered, Yes. When asked if the facility was tracking and evaluating UTI differently from CAUTI, or CAI from HAI, Staff E stated, No, not currently. To be honest, I don't always put them in those categories. I haven't been able to get to that surveillance level at the moment. Staff E acknowledged the information should be part of the infection surveillance process and stated, Absolutely, it would lend to a more accurate infection surveillance. Staff E acknowledged incomplete information detracted from accurate infection surveillance and stated, Very incomplete line listing (IC documents). COVID-19 SOCIAL DISTANCING According to the Centers for Disease Control (CDC), COVID-19 is thought to spread mainly from person to person - between people who are in close contact with one another (within about 6 feet). The CDC recommends, Put 6 feet of distance . stay at least 6 feet (about 2 arms' length) from other people. The CDC also recommends that when six feet of distancing is difficult to maintain, a face mask is to be used, but is not a substitute for social distancing. THIRD FLOOR An observation on 06/18/2020 at 11:47 AM in the Third Floor North Dining Room showed Resident # 3 seated less than six feet apart from Resident # 4's left side. No masks were observed being worn by the residents. A similar observation was noted on 06/22/2020 at 8:15 AM, when Resident #4 was observed to be seated less than 2 feet apart between a male and female resident. These residents were observed not to wear masks. In an interview on 06/22/2020 at 8:15 AM, when asked if the residents maintained social distancing, Staff P, Registered Nurse (RN), stated, No, and acknowledged the residents should be six feet apart from each other. Another observation at 11:01 AM showed Resident #1 less than six feet apart from a female resident in a wheel chair. In another observation at 2:53 PM, Resident #3 was seated next to Resident #4, less than 6 feet apart. When Staff P was asked what the distance was between the residents, she stated, Closer than six feet, and acknowledged that social distancing was not maintained. These residents were also not observed to wear masks. SJR FLOOR DINING ROOM Observations on 6/22/20 at 10:45 AM showed three residents watching the television and sitting less than six feet apart from each other. Three residents were also observed sitting at a table, less than six feet apart. When asked if the residents maintained social distancing, Staff Y (RN) did not answer and proceeded to separate the residents. A staff nearby, Staff X (RN) stated, The residents keep moving around. When asked who was responsible for ensuring social distancing to prevent COVID-19 transmission per CDC recommendations, Staff X stated, It's all of us. FOURTH FLOOR SOUTH DINING ROOM An observation on 06/17/2020 at 12:15 PM showed several residents eating in the dining room, but not 6 feet apart from each other or wearing a mask. When asked if the residents maintained social distancing, Staff S, Licensed Practical Nurse (LPN) stated, No, the space is not enough to maintain residents 6 feet apart. Another observation on 06/22/2020 at 11:47 AM showed a female and male resident seated next to each other holding hands, but not 6 feet apart from each other or wearing a mask. REFERENCE: WAC 388-97-1320 (2)(b). .

F 0881 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Implement a program that monitors antibiotic use.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow an established Antibiotic Stewardship Program (ASP) to ensure the appropriate use of antibiotics (ABOs) for five (between January 2020 and May 2020) of five months of Infection Control (IC) documents reviewed. This failure placed the residents at an increased risk for [MEDICAL CONDITION] (MDRO: germs that are resistant to many antibiotics) and had the potential for adverse outcomes associated with inappropriate and/or unnecessary use of antibiotics. Findings included . Review of a 05/2018 facility policy titled Antibiotic Stewardship Program showed the facility would perform ongoing assessment and monitoring of ABO use and develop evidence-based processes that lead to accurate [DIAGNOSES REDACTED]. According to the McGeer Criteria, a Urinary Tract Infection [MEDICAL CONDITION] not associated with a catheter (a flexible tube that passes through the urethra and into the bladder to drain urine) was defined by (1) dysuria (painful or difficult urination), or fever or leukocytosis (elevated white blood cell count in the blood) associated with at least one [MEDICAL CONDITION] (GU) symptom, and (2) a urine culture (test to find germs that can cause an infection) of at least 100,000 cfu/ml (colony forming units/milliliter) of no more than 2 species of microorganisms in a voided urine specimen, or 100 cfu/ml of any number or organisms in a specimen collected by in-and-out catheter. This Criteria also showed that in the absence of fever or leukocytosis, two or more GU symptoms and the accompanying urine culture were required to define a UTI. JANUARY 2020 IC DOCUMENTS Review of the January 2019 IC documents showed: Resident #13 was treated with an ABO intramuscularly (IM) for seven days for a UTI, had S/SX of red, cloudy urine, foley cath (catheter). This document showed, > (greater than) 2 organisms recovered. Review of a UA test dated 01/16/2020 showed, The specimen submitted does not meet the laboratory's criteria for acceptability and Please submit another sample if clinically indicated. This test did not show results for CFUs, required in defining a UTI per McGeer Criteria. When asked if the S/SX met McGeer Criteria for the definition of a UTI, Staff E acknowledged it did not and stated, She had no growth. She did not have a complete culture. Resident #14, #15, #16, #17, and #18 were treated with ABOs for non-UTIs. This document did not show the S/SX associated with the infections. When asked if the IC document reflected S/SX to support the use of an ABO, Staff E stated, No, it does not reflect. Resident #19 was treated for [REDACTED]. This document showed no answers to identify S/SX or Organism associated with the UTI. When asked if the record showed the infection identified met McGeer Criteria for the definition of a UTI, Staff E acknowledged it did not. Resident #20 was treated with two ABOs for a UTI. This document showed no S/SX and that the Organism identified with the UTI was mixed flora of 10-25k CFU. Staff E acknowledged the UTI did not meet McGeer Criteria for the definition of a UTI. Resident #21 was treated with an ABO for R (right) heel. This document did not identify the type of infection the ABO was required for. In addition, this document did not show any S/SX associated with the infection or that the facility addressed if it met the McGeer Criteria for an infection. Resident #22 was treated with ABOs for a UTI, and the S/SX were pre-op? This document showed gram negative rods (bacteria) >100 cfu. When asked if the infection met the McGeer Criteria for a UTI, Staff E stated, Not based on this line listing. Resident #23 had a UTI with S/SX of immune compromise and no growth. When asked if immune compromise met S/SX for a UTI according to McGeer Criteria, Staff E stated, It did not, and acknowledged the infection was inaccurately identified. FEBRUARY 2020 IC DOCUMENTS Review of the February 2020 IC DOCUMENTS showed: Resident #20 was treated with ABOs for a UTI. This document did not show any S/SX. This document also showed results of Mixed flora 10 - 25 CFU, which did not meet diagnostic criteria according to McGeer. Similarly, Resident #24 was treated with ABOs for a UTI, no S/SX were identified, and showed, Organism - Escherichia coli (a bacteria) >100k cfu. When asked if the infections met the McGeer Criteria without S/SX of a UTI, Staff E stated, No. Resident #25 was treated for [REDACTED].>100K

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505182	A. BUILDING _____ B. WING _____	**08/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PROVIDENCE MOUNT ST VINCENT	**4831 35TH AVENUE SOUTHWEST SEATTLE, WA 98126**

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 0881 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 10) cfu. No answer was provided to the categories S/SX and Criteria Met? When asked if the McGeer Criteria was met for the definition of a UTI, Staff E stated, I can't say. The line listing does not show the symptoms for an infection. Review of Resident #26's medical records revealed a 02/19/2020 progress note that showed, Pt (Patient) due to discharge home today, c/o (complained of) dysuria last evening . UA w/ (with) C&S will be sent prior to discharge. [MEDICATION NAME] (an ABO) 100 mg BID (twice a day) started x (for) 5 days. Will check urine results as they are available and contact pt (patient) and/or PCP (Primary Care Provider) if need for Abx (antibiotic) change. Review of the February 2020 IC documents showed the facility identified Resident #26 had a UTI with the Organism - Serratia marcescens (a bacteria) >100k CFU. When asked if the facility followed up as instructed to, contact pt and/or PCP if need for Abx (antibiotic) change, Staff E stated, Not that it was documented, and acknowledged an analysis of ABO appropriateness with the PCP did not occur. Resident #27 was treated for [REDACTED].? When asked if the document showed criteria was met for a UTI, Staff E stated, Not evident on the line list. Resident #28 was treated for [REDACTED].? When asked if the infection met McGeer Criteria for a UTI, Staff E stated, Without signs and symptoms, we don't know, and acknowledged, Yes, it should have been evaluated. Resident #29 had a UTI, no identified S/SX or assessed if Criteria met?, and was treated with an ABO. This IC document identified two Organisms that were less than 100, 000 cfu. When asked if the infection met the McGeer Criteria for a UTI, Staff E stated, It's not reflected. Resident # 30 was treated with an ABO for a UTI, with S/SX identified as ?, Criteria met? was answered as NA, and the Organism identified as ?. When asked if the facility accurately identified the S/SX met the definition for a UTI, Staff E stated, No. Resident #31 was treated with an ABO IM for UTI/PNA (pneumonia). Under S/SX the document showed elevated WBC. While the IC document showed under Organism, [DIAGNOSES REDACTED] pneumonia (a bacteria) > 100, 000 cfu, it did not show any GU S/SX. Staff E acknowledged the S/SX did not meet the McGeer Criteria for a UTI. When asked which infection the ABO was prescribed for, Staff E stated, the ABO was for the elevated white blood cell count and fever, and acknowledged, It should be clear (in the IC document) for what the antibiotic was used for. Resident #32 was identified to have a UTI, with the S/SX of [MEDICAL CONDITION], retention. It also identified the organism mixed flora >100 CFU. Staff E acknowledged the S/SX did not meet the McGeer Criteria for a UTI which required two or more GU S/SX in the absence of fever or leukocytosis. MARCH 2020 IC DOCUMENTS Review of the March 2020 IC Documents showed: Resident #5 was treated with an ABO for a UTI, and the S/SX showed fall. This document identified a UA was ordered but did not show the results of the UA. When asked if fall met the S/SX criteria for a UTI, Staff E stated, No, and acknowledged the incorrect identification of a UTI. Resident #33 was treated with an ABO for a UTI. Under S/SX it showed Fever/ N/V (nausea/vomiting), LLS (sic) crackles diminished. This document did not identify any GU S/SX for a UTI. Under Organism the IC document showed ? Escherichia coli. When asked if the S/SX met McGeer Criteria for a UTI, Staff E stated, No. Resident #34 was treated for [REDACTED]. Review of culture results dated 03/23/2020 showed, >100K [DIAGNOSES REDACTED] pneumonia (a bacteria). When asked if the infection met the definition for a UTI in the absence of fever or leukocytosis, Staff E stated, Not based on that. APRIL 2020 IC DOCUMENTS Review of the April 2020 IC Documents showed: Resident #35 was treated with an ABO for a UTI. The S/SX identified included temp. (sic) rare cough. This document showed no GU S/SX, and identified the organism associated with the UTI was [DIAGNOSES REDACTED] pneumonia >100k cfu. When asked if the S/SX met McGeer Criteria for a UTI, Staff E stated, No, it did not. MAY 2020 IC DOCUMENTS Review of the May 2020 IC Documents showed: Resident #36 was treated for [REDACTED]. The S/SX identified were, Fever, anorexia, loose stools. This IC document showed no GU S/SX, and identified the organisms associated with the UTI was Escherichia coli >100k cfu (and) Proteus mirabilis (a bacteria) 10-25k cfu. When asked if the S/SX identified met McGeer Criteria for a UTI, Staff E stated, I don't have urinary symptoms to support it. In this continued interview on 06/18/2020 at 9:07 AM, Staff E acknowledged the facility did not follow their ASP as there was inadequate and incomplete analysis of symptoms required to define an infection with ABO usage. REFERENCE: No Associated WAC. .