STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505513	A. BUILDING _____ B. WING _____	**07/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STAFFORD HEALTHCARE	**2800 SOUTH 224TH STREET, DES MOINES, WA 98198**

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 -** Actual harm **Residents Affected -** Few	**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 identify and prevent a pattern of abuse for two (#s 1 & 2) of four sample residents. The facility failed to identify abuse, and implement preventative measures to protect the residents. Failure to recognize and analyze a pattern of incidents of resident to resident altercations, provide adequate supervision and care planning with interventions, placed residents at risk of continued abuse and resulted in Resident #2 hitting Resident #1's face, causing redness and swelling which constitutes harm. Findings Included . Resident #1 was admitted to the facility on [DATE] and according to the 05/08/2020 Annual Minimum Data Set (MDS- an assessment tool), had multiple diagnoses, including Alzheimer's, and [MEDICAL CONDITION] with behavior disturbance. Review of the 02/02/2020 Care Plan (CP) showed Resident #1 will often yell, call people names, swear or tell people what to do. Interventions to prevent abusive behavior included: Re-direct, if needed suggest pleasant actions from resident, if she yells/swears/calls names/tells peers what to do during groups. Offer resident to sit out in the hallway with a word puzzle or book by nurses' cart when not watching television in her room or participating activities. Review of a facility Incident investigation dated 06/29/2020 showed, on 06/22/2020 at about 3:35 PM, Staff C Licensed Practical Nurse (LPN), and Staff D, LPN heard Resident #1 yelling, she hit me, she hit me from the hallway. The two nurses went out to the hallway and found Resident #1 seated in her wheelchair covering her right eye and saying she hit me, she hit me. Upon assessment, Resident #1 was noted with swelling and a red mark on her face over her right eye down to the right inner eye measuring 3.5 cm x 2.0 cm (centimeter). Resident#1 further stated that she thought that it was funny because she saw stars when hit. On 07/27/2020 at 12:05 PM, Resident #1 was observed seated in a wheelchair, in her room. Resident #1 was observed with no redness or swelling to the right area eye. During an interview at this time, when asked how the other residents treated her, Resident #1 stated that she had a problem with one lady who no longer lived on the floor. Resident #1 stated, I said some(thing) to her which she didn't like and she hit me on the face but now it's healed, as she pointed to her right eye. In an interview on 07/22/2020 at 3:12 PM, Staff D revealed that she heard a resident saying She hit me, she hit me. When she went out and found Resident #1 covering her face and Resident #2 had wheeled herself to her room. When asked what happened, Staff D stated that Resident #1 had called Resident #2 Black[***] , big[***] . When Staff D asked Resident #2 what happed, she revealed that she was tired of being verbally insulted by Resident #1 and being called names. The investigation conclusion dated 06/29/2020 revealed, Resident #2 admitted to hitting Resident #1 in the face as she stated 'I'm sick of her calling me an[***] . I wasn't even talking to her, I was just trying to get by.' On 07/27/2020 at 11:45 PM, Resident #2 was observed seated in a wheelchair, in the second floor hallway. During an interview at this time, when asked if staff treated her well, Resident #2 stated, Yes. When asked about other residents, Resident #2 stated, I had a problem with one lady upstairs calling me names and I got tired and reacted, I hit her and feel sorry and that is not right. Review of the investigation conclusion dated 06/29/2020, showed facility staff concluded no abuse or neglect occurred. During an interview on 07/27/2020 at 12:20 PM Staff B, Director of Nursing (DNS) confirmed Resident #2 hit Resident #1. Further review of the incident investigation dated 06/29/2020 showed a witness statement by Staff E, Registered Nurse (RN), who documented that earlier in the morning of 06/22/2020 Staff E, heard Resident #1 cursing/calling out names while passing morning medication in the hallways. Resident's #1's needs were attended to but the resident continued to be loud. Resident #2 was pissed off and said to her shut up which other resident didn't like to hear and started cursing her answering back. Immediately both residents were separated to avoid further altercation. Both residents were in the hallway before lunch and both appeared to be calm and quiet. In an interview on 07/22/2020 at 2:42 PM, when asked about Resident #1 and Resident #2's morning altercation, Staff E revealed that Resident #1 was calling for help and being loud, then Residen t#2 said to Resident #1 Shut up. Resident #1 responded with a vulgar word back to Resident #2. Staff E intervened and separated the two residents without further abuse until later that afternoon. When asked if he reported the abuse to anyone, Staff E said No, that's her normal behavior and nothing really happened. Staff E further indicated that Residen t#1 had a behavior of cursing at anyone around her when she needed help. Review of the facility incident log showed no documentation the 06/22/2020 morning shift resident to resident verbal altercation. In an interview on 07/22/2020 at 8:12 AM, when asked if the altercation in the morning shift 06/22/2020 incident was reported on incident/accident log, Staff B said No. When asked if it was investigated, Staff B stated no. The facility failed to investigate a resident to resident verbal altercation to rule out abuse and prevent recurrence of further altercations. Further review of the 06/29/2020 incident investigation revealed that Resident #1 had a known history of being directly and indirectly vulgar when she perceived that her needs were not met. Resident #1 had a previous history of verbal altercation with another resident in 02/02/2020 when she had a shouting match with another resident who is no longer a resident at the facility. In an interview on 07/22/2020 at 3:25 PM, Staff F, Nursing Assistant (NA), revealed that Resident #1 had behaviors of calling for help and cursing at anyone around her. When asked how often the resident called and cursed, Staff F stated, daily. When asked if she had reported these behaviors to anyone including the Administrator or the State Abuse Hotline, Staff F, said everyone know that's her behavior. During an interview on 07/22/2020 at 3:40 PM, Staff G, NA, confirmed that Resident #1 had behaviors of cursing and insulting other residents. When asked what happened when other residents got offended, Staff G said Resident #1 is re-directed with activities. In an interview on 07/22/2020 at 8:12 AM, Staff B stated Resident #1 was re-directed to her room or to activities whenever she started cursing. During an interview on 07/22/2020 at 3:50 PM, Staff H, NA revealed that Resident #1 had a pattern of calling for help and cursing at residents and staff. When asked how other residents reacted to Resident #1's abusive behavior, Staff H stated that they were, mad, but staff redirect (Resident #1) with activities. Further review of the 02/02/2020 CP showed there were no interventions that directed staff on how to intervene or prevent resident to resident altercations. Review of the March, April, and May 2020 Treatment Administration Records (TARs) showed no direction to staff to monitor cursing or verbally abusive behaviors by Resident #1 or to document interventions. Review of written statements dated 06/23/2020 by Staff F, Staff G, and Staff H all showed they had, witnessed Resident #1 verbally cursing at residents and staff on 3rd floor. In an interview on 07/22/2020 at 8:12 AM, regarding preventing mental and verbal abuse by Resident #1 to other residents, Staff B stated that Resident #1 sat at the nurse station so staff could keep an eye on her. When asked if there was staff witness to the physical abuse on the afternoon of 06/22/2020, staff B said No. REFERENCE: WAC 388-97-0640 (1) .

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.