STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505362	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VIEW RIDGE CARE CENTER	5129 HILLTOP ROAD EVERETT, WA 98203

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F 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain resident/representative informed consent regarding risks/benefits/alternatives of [MEDICAL CONDITION] medications for one of three residents (#4) reviewed for medications. Failure to provide information and to obtain consent placed the resident at risk for not being informed of the expected/unexpected consequences of treatment with [MEDICAL CONDITION] medications and for potential medication-related adverse effects. Findings included . Review of the facility's [MEDICAL CONDITION] medication policy, undated, revealed prior to initiation of the medication, a consent must be obtained from the resident or their legally responsible party. The resident admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. On 07/23/2020, a review of the resident's clinical record revealed no informed consent documentation could be found for the treatment of [REDACTED]. In a phone interview on 07/28/2020 at 2:03 PM, the Administrator confirmed that the facility had not documented an informed consent was done for the treatment with [MEDICATION NAME]. Reference: (WAC) 388-97-0200 (2)(3)
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their policy regarding identifying and investigating potential allegations of abuse/neglect for one of six residents (#4) reviewed for investigations and grievances. The failure to recognize potential abuse, to timely report an allegation of potential abuse, and to do a timely and thorough investigation placed the resident at risk for further potential abuse. Additional failed practice included an incomplete investigation that did not include a witness statement from the involved resident (#4). Findings included . The resident admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. Review of the July 2020 Grievance Log, revealed an entry for Resident #4, dated 07/04/2020, and the documented concern was regarding Personal care. Review of the grievance/concern investigation, dated 07/04/2020, revealed the resident's daughters alleged the nursing assistants assisting the resident to the bathroom on the night of 07/03/2020 were rough with her. In an interview the facility did with the resident regarding her care 07/03/2020, the resident had stated the nursing assistants had jerked me around in bed. The summary/findings of the grievance/concern investigation were that the resident was increasingly confused over the course of her admission to the nursing home, and that her perception was that she could not control her anxiety related to things like having a roommate instead of having a private room. This allegation was not converted to an incident investigation and fully investigated, or logged as a potential abuse allegation until 07/23/2020. Review of the July 2020 incident reporting log revealed this allegation was not logged until 07/23/2020. Review of the Complaint Resolution Unit Online Incident Report, dated 07/23/2020, revealed this allegation was not reported until 07/23/2020, or approximately 19 days after the allegation first became known by facility staff. Review of the incident investigation, dated 07/23/2020, revealed the facility was unable to determine abuse and neglect, and that the resident had been on cares in pairs (which meant two staff would go into the resident's room when providing care), had a history of [REDACTED]. In an interview on 07/28/2020 at 2:03 PM, the Administrator stated they did call the incident in to the complaint resolution unit, but that it was late. She stated the incident reporting log had not been accurate because the allegation had not been timely logged. The Administrator agreed the investigation was late. Review of an incident investigation report, dated 07/29/2020, revealed there was an investigation for Resident #4 that did not include a witness statement at all from the involved resident. The facility ruled out abuse/neglect, but without a witness statement from the resident, this investigation was not thorough. Reference: (WAC) 388-97-0640 (2)(b)(5)
F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to plan for and ensure an orderly discharge for one of three residents (#1) reviewed for discharge plans. Failure to ensure adequate and necessary in-home caregiver coverage resulted in the resident's needs not being met at home after discharge and ultimately resulted in the resident being readmitted to the hospital pending readmission to a skilled nursing facility. Additional failed practice included a failure to ensure transfer equipment was coordinated and available on discharge, and to ensure the discharge summary was accurate. Findings included . RESIDENT #1 The resident admitted to the facility on [DATE], then discharged home on[DATE]. The resident had [DIAGNOSES REDACTED]. According to the Admission Minimum Data Set (MDS) assessment, dated 04/16/2020, the resident required extensive 2-person assist with bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS also indicated the resident weighed 290 Lbs. In a phone interview on 07/01/2020 at 11:37 AM, the resident's husband stated his wife needed 24-hour care because she could not provide care for herself because she was immobilized. He stated he was going to have to take his wife to the hospital and put her in their care because she couldn't get proper care at home. He stated they did have one caregiver arranged when she left the nursing home, but she had quit after a couple days. The husband stated he was going on the road as a trucker later that day and he was taking his wife to the hospital prior to leaving. He stated he was at a loss and worried sick. In a phone interview on 07/01/2020 at 11:37 AM, the resident stated there were no other family members in the area except for her husband who was headed out of town for work. The resident stated she had used friends for help to get out of bed to the wheelchair as she couldn't get out of bed by herself, but she has exhausted her friends' help. The resident stated she really needed two good healthy caregivers to take care of her. She stated she had met one caregiver prior to leaving the nursing home, and the other was supposed to start after she got home, but that didn't happen. She said she met that one caregiver through a window, but couldn't really ask a lot of questions through the window. The resident stated since she had been home she had a little sponge bath, but not an actual bath. She stated she had a friend come over to help her put her pills in pillboxes. The resident stated while at the nursing home she used a hoyer (a mechanical lift used to transfer a person in and out of bed), she stated she had also used a slider board (a flat board-like device used to transfer a person between two surfaces, the person is pulled from one surface to the other over the slider board) at the nursing home also, but primarily she needed a hoyer. The resident stated when she went home she used the hoyer a couple times, with her friends help, then when the caregiver started, she taught them how to use it. The resident stated when she was at home she used a bedpan and briefs for toileting, when she had help. In a phone interview on 06/30/2020 at 8:20 AM, a social worker with Home and Community Services (HCS), stated the facility had not provided accurate information about the resident's abilities at discharge as she was led to believe the resident needed only one caregiver. This social worker stated that facility staff had told her the resident was transferring with a slider board, but actually she needed a hoyer to transfer, and hoyer transfers required two persons to be safe. The social worker said she thought there would be a family member that could help mornings and evenings to get the resident in/out of bed,

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

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F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) but the problem was there was no help for the solo caregiver that had been arranged. The social worker stated there had been one caregiver already set up at discharge, and another caregiver pending, but that second caregiver did not actually happen, and the resident ended up being heavier care than the facility had indicated. The social worker stated the discharge had not been safe, because the hoyer transfers the resident required actually required two staff to be safe, not one. In an interview on 06/30/2020 at 12:30 PM, the Administrator stated she had gotten a call from Resident #1 just that morning, and the resident stated she had been left alone seven to eight hours a day. The administrator stated from their perspective the discharge had not been safe because there had not been two caregivers set up by the HCS Social Worker. The administrator stated the hoyer equipment had not been delivered to the resident's home until the day after her discharge from the nursing facility. The administrator stated it was a mixed bag whether the resident used the slider board or the hoyer lift while she was a resident in the nursing home. The administrator was asked whether the facility had confirmed the two caregivers' availability prior to the discharge, she stated they had received an email from the HCS Social Worker that everything was set up. Review of an email, dated 06/26/2020, from the HCS Social Worker, addressed to the nursing home social worker (Staff A), revealed the email read Received approval for (caregiver name) to begin working today for Resident #1 name. In an interview on 07/08/2020 at 11:30 AM, the Administrator stated they had been told that the caregiver set up by the HCS Social Worker was going to be joined by her sister and be the second caregiver. The Administrator stated when Resident #1 was in the nursing home, she was not transferring, she was incontinent and was using a brief, and the resident was super anxious to go home. In a phone interview on 07/01/2020 at 12:44 PM, Staff A, Social Services, stated the caregiver interview between the caregiver and Resident #1 had happened prior to discharge, through a window, and they talked on the phone. Staff A stated the caregiver had said her sister was also a nursing assistant and would be helping. Staff A stated the resident's family had stated they would be helping fill in, because there was a concern her allotted hours would deplete rapidly. In a phone interview on 07/01/2020 at 1:14 PM, Resident #1's sister stated the caregiver that had been arranged decided she couldn't handle the resident by herself. The residents' sister stated she had made it clear Resident #1 needed two caregivers to take care of her, which is why she had insisted that the allotted hours be increased. The sister said Resident #1 was happy with the caregiver after their interview and she was impressed with her, but once the caregiver started, she couldn't do it by herself, and then the caregiver's sister couldn't do it either. In a phone interview on 07/08/2020 @ 2:45 PM, Resident #1's husband stated his wife was still in the hospital, while they were trying to find another nursing home to place her in. He stated he really wasn't comfortable sending her back to the original nursing home because of the way she was discharged last time. The husband was asked if the original plan had included family members from out of state to come take care of his wife, he stated No way. In a phone interview on 07/09/2020 at 10:10 AM, Staff A, Social Services, stated the facility doesn't confirm caregiver needs on discharge, that they left that up to the HCS Social Worker and the resident. Staff A was asked if the facility had confirmed any family members coming in to take care of the resident, she stated she spoke with some family members. Review of a Discharge Summary, dated 06/25/2020, revealed: -Reason for discharge: caregivers located, -Social Services Summary Caregivers were finally located ., -Fall Risk: No. -Functional Status: --Bathing, dressing, toileting, transfers, walking, stairs, locomotion in wheelchair all indicated her assistance needed was : Extensive assistance (Weight-bearing support), -Equipment ordered/needed: included commode, slider board and hospital bed. Review of the care plan, print date 06/30/2020 (current care plan as of resident's discharge date), revealed the resident was care planned for: -discharge plan was to return home with spouse and caregiver assistance, and a barrier to discharge had been Setting up caregivers for discharge . -Activity of daily living self-care performance deficit related to her stroke, decreased mobility and pain: --for bathing the care plan stated she needed a bed bath or hoyer with two people, --for bed mobility the care plan stated she needed maximum assistance with two to three people to complete bed mobility, --for dressing the care plan indicated for the lower body she needed maximum assist of two to three people, --for transfers the care plan indicated she needed a hoyer with two people. -for falls, the care plan indicated she was at risk for falls related to a need for extensive assist with transfers and mobility, fall history, generalized weakness and recent stroke, it stated her transfer status was mechanical lift with two staff. Review of the Kardex (care directives for nursing assistants), print date 06/30/2020 (current Kardex as of the resident's discharge date), revealed: -for bathing, the Kardex indicated she needed a bed bath or hoyer to reclining bath chair with two people, -for dressing/splint care, the Kardex indicated she needed two to 3 people for lower body maximum assistance, -for mobility, the Kardex indicated Not at this time, -for transferring, the Kardex indicated hoyer with two people, -for bladder/bowel, the Kardex indicated total assistance with two people assist, -for bed mobility, the kardex indicated maximum assistance with two to three people for complete bed mobility. Review of Activity of Daily Living documentation, from 06/01/2020 to discharge on 06/26/2020 showed: -for transferring, the resident required support of two staff for every transfer documented, -for urinary continence and toilet use, the resident required two person physical assist the majority of the documented toileting. Reference: (WAC) 388-97-0080 (6)(7)(c) .
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure they acquired all ordered medications for one of three residents (#4) reviewed for medications. Failure to acquire [MEDICATION NAME] from the pharmacy resulted in Resident #4 not receiving eight doses of the medication. This failure placed the resident at risk for medication-related complications. Findings included . The resident admitted to the facility on [DATE] with multiple medical diagnoses. According to the admission Minimum Data Set assessment, dated 06/18/2020, the resident had no cognitive impairment. Review of the June and July 2020 Medication Administration Records (MARs), revealed the resident had an order, dated 06/12/2020, to receive [MEDICATION NAME] every Tuesday and Friday for post-menopausal symptoms. According to the MARs, the resident received one dose, and missed eight doses. In an interview on 07/28/2020 at 2:03 PM, the Administrator stated the resident had not received any doses of the [MEDICATION NAME] as the order did not ever get filled by the pharmacy. The Administrator stated the staff that documented that the resident received one dose had received corrective action. Reference: (WAC) 388-97-1300 (1)(A)
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three residents (#4) remained free of unnecessary [MEDICAL CONDITION] medications due to lack of monitoring. Failure to monitor target behaviors and for adverse side effects placed the resident at risk for medication-related adverse side effects. Findings included . Record review of the facility's [MEDICAL CONDITION] medication policy, untitled and undated, revealed: 1) routine monitoring for adverse side effects of the [MEDICAL CONDITION] medications should be documented on the Medication Administration Records (MARs); 2) when hypnotic medications were ordered, resident's hours of sleep would be documented on the MARs, and when [MEDICATION NAME] (antidepressant medication) was given for [MEDICAL CONDITION], hours of sleep were to be documented as described for hypnotics; 3) behavior monitoring would be documented when antipsychotic, antianxiety or mood stabilizing medications were ordered. The resident admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. Review of the June and July 2020 MARs revealed no adverse side effect monitoring was documented for the treatment with [MEDICATION NAME] (antianxiety medication), and no target behaviors monitoring was documented for the treatment with [MEDICATION NAME] (antipsychotic medication) or [MEDICATION NAME], and no hours of sleep monitoring was documented for the treatment with [MEDICATION NAME] for [MEDICAL CONDITION]. In a phone interview on 07/28/2020 at 1:55 PM, the Administrator confirmed no adverse side effect monitoring for the treatment with [MEDICATION NAME] had been documented, no target behavior monitoring for the treatment with [MEDICATION NAME] or [MEDICATION NAME] had been documented, and no hours of sleep had been documented for the

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F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) treatment with [MEDICATION NAME] with [MEDICAL CONDITION]. Reference: (WAC) 388-97-1060 (3)(k)(i)(4) .
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure clinical records were complete and accurate for one of four residents (#4) reviewed for skin issues. The failure to include skin issue assessment documentation that included measurements and descriptors made it impossible to determine which bruising may have occurred at the nursing facility, or what may have occurred prior to the resident's admission to the facility. Findings included . Resident #4 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. (a disorder of the nervous system that affects movement), a need for assistance with personal care, impaired functional mobility, balance, gait, and endurance, diabetes, [MEDICAL CONDITION] (a disorder involving excessive body fat that increases the risk of health problems, and [MEDICAL CONDITION] (a condition characterized by widespread muscle pain and tenderness). Review of a Medical Hospitalist Team Progress Note, dated 06/10/2020 (day prior to admit to View Ridge), indicated under skin, no rash on exposed areas excepting many ecchymosis (discoloration of skin resulting from bleeding underneath, typically caused by bruising). Review of the Admission Note, dated 06/11/2020 (day of admit to the facility), revealed under the skin section an entry to describe skin condition present Bruising throughout body and skin tear to LLE (left lower extremity). There were no measurements, descriptors, or locations documented to describe the bruising throughout the body, or the skin tear. Review of an Admit and Quarterly Assessment, dated 06/11/2020, revealed under the Integumentary (organ system consisting of skin, hair, nails) revealed documentation ecchymosis throughout, and a front right lower leg skin tear that was scabbed over. No documentation was made about measurements, descriptors, or locations of the ecchymosis. Review of an emergency department encounter note, dated 07/15/2020, revealed Resident #4s family was concerned about abuse for which they hospital had the forensic team examine the resident. The emergency physician's note indicated I do not see anything distinctive but she does have quite a bit of bruising on her arms and legs. Review of the forensic nurse's notes, dated 07/16/2020, revealed the resident had extensive bruising of her arms and legs on both sides, and bruising on her coccyx which that was difficult to see due to pain, bruising on the breasts and abdomen. The note indicated the bruising was in various stages of healing. The note indicted the skin on the forearms and hands was blotchy and mottled and paper thin. In an observation on 07/14/2020 at 8:35 AM, the resident had two small light purple bruises on her right buttocks, and a small, light purple bruise on her right upper leg. The resident thought those had occurred when she had used a bedpan. Additionally, the resident was observed to have large, skin abnormalities on both lower legs. The leg skin abnormalities were reddish/purplish/dry scaly skin that was intact, but looked to be very fragile, there appeared to be slight [MEDICAL CONDITION]. In a phone interview on 07/20/2020 at 3:28 PM, the residents' daughter stated her mother had had the lower extremity [MEDICAL CONDITION] for a long time. In a phone interview on 07/28/2020 at 10:10 AM, the hospital forensic nurse examiner stated she had not actually visualized the resident's coccyx during her exam, as the resident was in pain. In a phone interview on 07/28/2020 at 1:57 PM, Resident #4 stated she had bruising everywhere on her body which she said was due to having low platelets (blood components that help in clotting to stop bleeding). The resident stated she bruised easily. The resident was asked if she had bruising like that when she admitted to the facility, she stated Yes. Resident #4 denied she was abused while at the facility. In an interview on 07/28/2020 at 2:03 PM, the Administrator was asked about the lack of documentation regarding skin descriptors for the resident's skin issues, she stated she was disappointed and they were doing staff education on that. In a phone interview on 07/31/2020 at 3:18 PM, the residents' daughter stated her mother had bruising from her elbows to hands, and from her knees down to her feet which she stated was due to [MEDICAL CONDITION] (skin that appeared swollen and red and can be painful to the touch), and that she'd had bruising for a long time. In summary, due to the lack of documentation of measurements and descriptors, it was impossible to determine which skin abnormalities were new and which were old. There was documentation the resident admitted with bruising, but the specifics remained undocumented during her admission. Reference: (WAC) 388-97-1720 (1)(a)(i)(ii)