STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505236	A. BUILDING _____ B. WING _____	03/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALDERCREST HEALTH & REHAB CENTER	21400 72ND AVENUE WEST EDMONDS, WA 98026

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on observation, interview and records review the facility failed to ensure active influenza was reported to the State. This failure prevented accurate epidemiological mapping and surveillance county and state wide, and placed residents at risk for receiving less than required care and services. Findings include. According to collateral interviews 03/05/2020 at 11:41 AM, 1:17 PM, 2:23 PM, and 2:40 PM, the facility identified active influenza and implemented infection control polices and procedures which were observed by collateral visitors. Staff were wearing personal protective gear and staff were observed to implement isolation precautions as early as 02/21/2020. Review of the February 2019 Infection Control Summary revealed six persons, five residents and one staff acquired Influenza A. In an interview on 03/06/2020 at 4:15 PM Staff A, the Administrator, and Staff B, the Director of Nursing, stated the facility did not report the Influenza cases to the State. Reference (WAC) 388-97-0640(5)(a) .
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to thoroughly investigate seven of seven Resident's (#1, #2, #3, #4, #5, #6 and #7) for allegations of abuse and/or neglect. This failure prevented the facility from identifying the cause of the resident's concerns, adequately preventing a recurrence, and placed all residents at risk for being abused or neglected. Findings include. RESIDENT #1 According to the [DATE] Minimum Data Set (MDS), an assessment, Resident #1 was able to make their own decisions, required extensive assistance of two staff for activities of daily living, and had suffered a fracture requiring rehabilitation. Resident #1 was discharged from the facility and not available for observation or interview. A collateral interview on 03/05/2020 at 5:33 PM, stated staff did not respond to call lights and Resident #1 sat in urine and feces for an extended period of time. Review of the facility's February 2020 incident log revealed staff logged Resident #1's concerns on [DATE]. A 02/13/2020 and 0[DATE] progress note indicated the resident's concerns were related to staff not answering the call light promptly, being left in a wet bed, not being toileted, food being cold, not receiving a replacement for the cold food and being left on a bed pan for an extended period of time. According to the facility investigation, the facility initiated investigation on [DATE] and completed the investigation on 03/15/2020. The facility did not provide any documentation to support the facility audited staff response to call lights, observed the provision of care or the lack of care, and did not address the lack of toileting. There were no pertinent witness statements from any staff or residents included in the investigation. The facility did not provide any documentation to support Resident #1 was assessed for injury, change in condition, or mental health status. The facility did not include or describe any factor that made this incident unavoidable. RESIDENT #2 Resident #2 was impaired for decision-making, had suffered a stroke, required extensive assistance of one staff for the provision of activities of daily living, was on scheduled pain medication but had no symptoms of pain, and had mental health [DIAGNOSES REDACTED]. Resident #2 was observed on 03/06/2020 siting in a chair in the resident's room. Interviewed at the same time the resident smiled and had no specific concerns. Review of the February 2020 incident log revealed a 02/09/2020 entry that indicated the resident had a concern about abuse/neglect. Review of the investigation documents revealed the incident was about missing narcotics which would be considered misappropriation. When asked for this investigation the facility provided two staff interviews, the January Controlled Substance Log, and Resident #2's January Medication Administration Record [REDACTED]. The Director of Nursing, Staff B, stated in an interview on 03/06/2020 at 1:26 PM, staff counted medication on the evening shift at 10:00 PM, there were four remaining tablets. Some time after this assessment two of the tablets were administered and two were missing. Staff B stated that nursing staff probably were not counting correctly and counted cards not pills. Staff B stated that nursing staff probably did not document administration correctly. Because there was not a thorough investigation these questions were not answered. It was clear narcotics were missing but the cause of the error was not know and not investigated. The facility requested a pharmacy audit according to Staff B, but as of 03/06/2020 the audit had not taken place, according to a collateral interview on 03/13/2020 at 4:00 PM. The facility did not know what happened, how the loss of narcotics occurred, if other residents were missing narcotics, if residents pain was being relieved, leaving every resident in the facility at risk for unrelieved pain and misappropriation of resident's narcotic medication. RESIDENT #3 According to the quarterly 02/01/2020 MDS Resident #3 was cognitively impaired, required extensive assistance of one staff for activities of daily living including transfers and toileting, and had [DIAGNOSES REDACTED]. The MDS did not address if Resident #3 had memory problems. Resident #3 was observed from the doorway related to isolation procedures, still in bed, and recovering from a [MEDICAL CONDITION] infection. The resident had no concerns at the time of the observation. According to the February 2020 incident log, Resident #3, experienced an unwitnessed fall on 02/20/2020. Review of the facility's investigation revealed Resident #3 had [MEDICAL CONDITION]. The facility documented the resident was educated as a solution to prevention but no other interventions were documented as being considered or listed in light of the resident's dementia [DIAGNOSES REDACTED]. The most recent, previous fall, being on 0[DATE] to determine if any variable would influence the plan to prevent further falls or injury. Fall assessments and care plans were requested but not provided. RESIDENT #4 AND RESIDENT #5 Resident #4 was admitted to the facility on [DATE] according to the admission [DATE] MDS. Staff assessed this resident as being cognitively aware and able to make their own decisions, demonstrated behavior symptoms towards others, required extensive two person assistance for activities of daily living and had a [DIAGNOSES REDACTED].#4's only concern was the lack of a functional telephone. Resident #5 According to the [DATE] MDS, Resident #5 was able to make their own decisions, and presented with behaviors directed toward others such as hitting and kicking, and behaviors directed towards themselves such as scratching. Staff assessed Resident #5 to require extensive assistance of one staff for activities of daily living, and had a [DIAGNOSES REDACTED].#4 and #5 were alleging abuse/neglect. The investigation indicated both residents participated in a disagreement over toileting facilities. The investigation did not include either resident's known history of a pervious disagreement, what was done previously unsuccessfully or successfully, either resident's documented behaviors that might have, influenced the current incident, and/or assisted staff to determine how to proceed in providing a suitable plan for each resident's future as a roommate. RESIDENT #6 Resident #6 was admitted to the facility on [DATE], was discharged from the facility on 0[DATE]20 and not available for observation or interview. Staff B stated in an interview on 03/06/2020 at 12:25 PM that Resident #6 was hoarding sharp objects to harm Resident #6 and others, so Staff B notified the State of the findings. Review of the facility's February and March incident logs revealed no entry for Resident #6. The facility was asked for investigative documents but none were provided to answer any question about this incident. RESIDENT #7 Resident #7 had lived at the facility since 2017, recently experienced a planned discharged and was not available for observation or interview.

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 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) According to the 0[DATE] discharge MDS, Resident #7 was not able to make their own decisions, required extensive assistance for activities of daily living, and had multiple diagnoses. Review of the facility's January 2020 incident log revealed a [DATE] entry, that indicated Resident #7 was abused or abused another person. The investigation was requested on 03/06/2020 at 4:15 PM but no investigation was ever received. Reference (WAC) 388-97-0640 (6)(a)(b) .
F 0684 **Level of harm** - Minimal harm or potential for 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 observation, interview and record review, the facility failed to assess and treat, one (#8) of eight residents reviewed for nonpressure related skin issues, left lower leg skin issues. This failure prevented prompt [DIAGNOSES REDACTED]. According to the 01/04/2020 Minimum Data Set Resident #8 was able to make their own decisions, exhibited no behaviors, required extensive assistance of two staff for bed mobility, transfers and toileting and only supervision for locomotion. Staff documented on this assessment Resident #8 had kidney disease, diabetes, and no skin issues. Staff documented on the January 7, 2020 shower reporting sheet Resident #8's that staff observed new areas of redness. February and March 2020 Treatment Administration Records revealed staff assessed Resident #8 weekly for any change in skin condition, recording there were no changes. A collateral contact, interviewed on 03/05/2020 at 12:02 PM, stated that among many issues Resident #8 exhibited a red area on the lower left leg that was getting larger over an extended period of time. During an interview on [DATE]2 at 2:10 PM another collateral contact stated that Resident #8's left calf was red and the skin was flaky. Observation on 03/06/202 at 10:10 AM revealed Resident #8 in bed. Resident #8 presented with left leg redness. Observation and interview of Resident #8, with Staff B, on 03/06/2020 at 1:20 PM, revealed a right leg more [MEDICAL CONDITION] than the left, and areas on the left legs suggestive of [MEDICAL CONDITIONS] or scratching according Staff B. Staff B stated that the facility was not aware of the redness to the left leg. Refer to WAC 388-97-1060(1) .
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to identify weight loss, assess the resident for causative factors, or develop a plan to prevent weight loss for one (Resident #1) of two sampled residents reviewed for weight loss. This failure placed the resident at risk for continued weight loss. Findings include. Resident #1 was admitted to the facility on [DATE] according to the [DATE] Minimum Data Set (MDS) an assessment. Staff assessed Resident #1 to be able to make their own decisions, require extensive assistance of two staff for activities of daily living, have a wound infection, kidney disease and mental health diagnoses, and weighed 236 pounds. Resident #1 discharged from the facility on 02/07/2020. According to the discharge MDS of the same date, staff recorded Resident #1's weight as 219. A weight loss of 17 pounds. Resident #1 was discharged from the facility and not available for observation or interview. A collateral interview on 03/05/2020 at 5:33 PM, indicated Resident #1 had many concerns about the care at the facility, including weight loss. Weight records, meal monitors, and registered dietitian notes, and other data, were requested on 03/06/2020 at 4:15 PM and again on 03/11/2020. None were received. The facility provided no records supporting staff identified Resident #1 with weight loss (desired or undesired), assessed causative factors, or created or implemented a plan to prevent further loss. Reference (WAC) 388-97-1060 (3)(h) .
F 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident must receive and the facility must provide necessary behavioral health care and services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed for two (#1 and #4) of seven residents reviewed for mental health services, to ensure mental health services were provided. This failure delayed mental health treatment and had the potential to affect quality of life. Findings include. RESIDENT #4 According to the admission [DATE] Minimum Data Set (MDS) , an assessment, Resident #4 had [DIAGNOSES REDACTED]. Staff documented on this assessment that no Preadmission Screening and Resident Review was performed. Staff developed a care plan dated [DATE] addressing the anxiety and personality disorder. According to a 03/05/2020 at 12:45 PM collateral interview the facility did not provide mental health services. Resident #4 had no complaints during the investigation. Mental Health Service records were requested from the facility on 03/06/2020 at 4:15 PM and again on 03/11/2020. No documentation to support mental health services were received. RESIDENT #1 Resident #1 was admitted to the facility in December 2019 according to the [DATE] admission MDS. Staff documented on this assessment the resident had a [DIAGNOSES REDACTED]. No other data was received from the facility. Resident #1 was discharged for m the facility and not available for observation and interview. No associated WAC. .
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** Based on observation, interview and record review, the facility failed to maintain complete and accurate records for each resident. Failure to ensure clinical records were complete and accurate placed residents at risk of not having their needs met. Findings included. Refer to CFR: 483.12(c)(1)(4) F-609 Timeframe: Abuse Reported to State Agency 483.12(c)(2)-(4) F-610 Investigate Abuse 483.25 F-684 Quality of Care 483.25(g), F-692, Nutrition/Hydration Status Maintenance 483.40 F-740 Behavioral Health Services Records were incomplete, or nonexistent, did not contain accurate information, and were not readily accessible. REFERENCE: WAC 388-97-1720 (1)(a)(i-iv)(b) .