STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505296	A. BUILDING _____ B. WING _____	09/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST FRANCIS OF BELLINGHAM	3121 SQUALICUM PARKWAY BELLINGHAM, WA 98225

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 -** 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 ensure two of two residents (#2 and #3) were free from physical and sexual abuse. The facility failed to ensure allegations of abuse were reported timely, a thorough investigation was conducted, residents' behavioral interventions were followed and residents were adequately supervised. These failures constituted an Immediate Jeopardy (IJ) on 08/17/2020. An IJ was called on 08/17/2020 at 2:00 PM. The facility removed the IJ on 09/01/2020 at 3:23 PM, after the facility completed all staff training on Abuse and Neglect, reporting and investigation process including interviewing all staff involved, working with residents with abusive behaviors, parameters and expectations of supervision and following the resident care plans, placed the identified resident on a one to one supervision at all times, reassessed residents for abusive behaviors that affected other residents, and reviewed identified residents for appropriate interventions. Findings included . Review of the facility policy titled, Abuse Prevention Policy and Procedure, with a revised date of 07/01/2020, included: Each resident has the right to be free from abuse; Residents must not be subjected to abuse by anyone; Abuse may include any physical injury to a resident, and sexual contact; All incidents, including injuries of unknown origins such as bruising, resident to resident contact will be identified and incident reports in order to initiate an investigation; The interdisciplinary care plan process shall be used to target those residents with needs and behaviors that might lead to conflict; Staff are responsible for monitoring secluded areas of the building to ensure that abuse does not occur; As soon as a report of alleged or suspected abuse is received, the investigation shall begin in order to rule out or identify abuse; The investigation would include identification of the parties involved, identification of witnesses, and interview of all parties involved; and Mandated Reporters are to immediately report to their onsite supervisor and the State Hotline when they have reasonable cause to believe abuse has occurred. RESIDENT #1 Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's Care Plan showed the following focus problems. The resident was dependent on staff for activities, cognitive stimulation, and social interaction related to physical limitations, dementia, and language barrier and wandering, revised on 06/23/2020. The interventions included the resident was to not be left alone with female residents. The resident also had a communication problem related to language barrier problem dated 02/10/2020. The interventions included arranging for a Spanish translator as necessary to communicate with the resident, assign a Spanish speaking male caregiver when available. RESIDENT #2 Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the 04/22/2020, Quarterly MDS assessment showed the resident was cognitively intact and able to communicate without difficulties. RESIDENT #3 Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly MDS dated , 07/01/2020, showed the resident was assessed to have severe cognitive impairment but able to understand others and make herself understood. RESIDENT #1 TO RESIDENT #2 ALLEGATION OF PHYSICAL ABUSE Review of Resident #1's progress notes showed the following: On 07/02/2020 at 12:49 PM, the resident was on alert monitoring for threatening and aggressive gestures; On 07/03/2020 at 10:11 PM, the resident was on alert for wandering and intrusive behavior; On 07/04/2020 at 11:04 PM, Staff A, Registered Nurse (RN), documented that male Resident #1 became agitated with female Resident #2, when she did not want him to be sitting too close to her while she was listening to her iPad music. (This incident occurred on 07/04/2020 at approximately 8:30 PM, per witness statements.) Review of Resident #2's progress note dated 07/04/2020 at 10:59 PM, documented by Staff A, showed Resident #2 became agitated with Resident #1, when she felt he was sitting to close to her while she was listening to her iPad music. (This incident occurred on 07/04/2020 at approximately 8:30 PM, per witness statements.) Review of Resident #1's progress note dated 07/05/2020 at 3:18 AM, documented by the Director of Nursing Services, (DNS), showed that another resident (resident was not identified) made an allegation of unwanted touching toward Resident #1. The note indicated that the incident was reported to the Department of Social and Health Services (DSHS), implying the State Hot Line was notified. The Power of Attorney, the Advanced Registered Nurse Practitioner (ARNP), DNS and Administrator were notified of the incident. Additionally, Resident #1, was placed on alert to monitor for behaviors. (This incident occurred on 07/04/2020 at approximately 8:30 PM, per witness statements.) Review of Resident #2's progress note dated 07/05/2020 at 4:15 AM, documented by Staff B, Licensed Practical Nurse, (LPN), showed that Resident #2 had reported to her assigned Certified Nursing Assistant, (CNA), at 2:00 AM, that Resident #1 touched her arm while she was sitting outside her room in the evening while listening to music. Staff B went to take Resident #2's statement but she was asleep. Staff B documented that the CNA had reported that Resident #1 had touched Resident #2 without hurting Resident #2, and Resident #2 asked Resident #1 to not touch her three times but Resident #1 did not stop. Resident #2 was concerned that another resident (resident was not identified) always stares at her and would speak something in Spanish.(This incident occurred on 07/04/2020 at approximately 8:30 PM, per witness statements.) Review of Resident #2's progress note dated 07/05/2020 at 9:04 AM, documented by Staff C, LPN, RCM, showed that Staff C instructed the dayshift nurse to place Resident #1 on one on one supervision until further notice from the management team on Monday 07/06/2020. Review of Resident #1's progress note dated 07/05/2020 at 12:12 PM, documented by Staff C, RCM, showed that the RCM, immediately instructed that Resident #1 was placed on one on one supervision (even though Staff C documented the resident was placed on one to one supervision three hours prior) due to alleged sexual assault and inappropriate touching of female resident (female resident was not identified). Review of Resident #2's progress note dated 07/05/2020 at 5:26 PM, showed the resident was noted to have dark purple in color bruises on her left arm above her elbow and she reported that Resident #1 grabbed her left arm. Resident #2 noted that she believed the bruises were caused from the incident from the prior day. Review of Resident #2's Incident Report which was initiated on 07/05/2020 at 3:50 AM, showed on 07/08/2020 the facility was unable to substantiate the allegation of physical abuse or unwanted touching. Additionally, bruising to Resident #2's left arm was noted to be unclear of the origin (an injury of unknown source), even though Resident #2 stated she felt the bruise was caused by Resident #1. Review of the Witness Statements from Resident #2's Incident Report dated 07/05/2020, showed the following: Staff D, CNA, reported that she was told to watch Resident #1 around Resident #2 as he was fighting with her. Resident #2 reported to her on 07/05/2020 at 2:00 AM, that Resident #1 came by her door and would stare at her, He watches everything going on in my room. Resident #2 reported that Resident #1 kept touching her arm, he touched her three times even though she told him not to and to stop. Staff A, RN noted that on 06/04/2020 at approx. (approximately) 2030 (8:30 PM), Resident #1 was sitting behind and to the left of Resident #2, listening to Resident #2's iPad which was playing music. Resident #2 was heard to tell Resident #1 to move that she did not want him there and he was too close to her. Staff A attested that she did not witness nor receive a report from Resident #2 that Resident #1 had grabbed her arm. Staff A's witness statement had a signature date of 04/05/20. Additionally, further residents' interview statements and what appear to be staff interview

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

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) statements with only staff first names had no date or time of the statements. Review of Resident #1's Incident Report initiated on 07/05/2020 at 3:50 AM, showed on 07/08/2020, the facility was unable to substantiate the allegation of unwanted touching as the incident was not witnessed and previous interaction was witnessed and residents were redirected of which no physical touching occurred. In a continued observation on 08/10/2020 starting at 12:08 PM to 12:17 PM, Resident #2 was sitting in the hallway, talking on her cell phone across from room [ROOM NUMBER]. Resident #1 was observed to be sitting in his wheelchair slightly behind Resident #3, no staff were observed in the area. In an interview and continued observation on 08/10/2020 at 12:17 PM, Resident #2 stated that she had a problem with the resident who was sitting behind her (Resident #1) who just left. Resident #2 stated that Resident #1 got right in her face and she told him not to and he grabbed her arm. She stated the staff had to come and help her, including a nurse that was working and a couple of CNAs. The resident stated that it had been a month or so ago and occurred in the late afternoon when she played her music. Resident #2 stated that he would come and sit and look at her. She recalled a time she was fixing her underpants and did not know Resident #1 was directly behind her. She stated that he was not supposed to be down here, they moved him but he comes down here about once a day. Resident #2 stated that she did not feel real safe as the facility was always short staffed and had new staff that were not used to taking care of her. Resident #2 stated that the staff were there when Resident #1 touched her and that he took his hand and made a fist at her as she demonstrated making a fist with her left hand. In a phone interview on 08/11/2020 at 3:59 PM, Staff A, RN, stated that on 07/04/2020, Resident #2 was listening to country music and Resident #1 was sitting behind her listening to her music. She stated that she thought he might have been looking at her iPad and she got irritated and told him to go away and get away which in turn agitated him. Staff A stated that Resident #1 got into Resident #2's personal space, I think she said he grabbed her but did not see that, one of the NACs (CNA) saw it start to escalate but unsure . no one told me they saw him grab her. In a phone interview on 08/11/2020 at 5:47 PM, Staff F, CNA, stated that she knows the care needs of the residents per their Care Plans and Kardex (a care guide for direct care staff). Staff F stated that she was familiar with Resident #1, he had dementia and he had been on one on one supervision for a while. Staff F stated that she thought he was on one on one supervision because he had been wandering into other residents rooms. Staff F was asked if she recalled the incident which occurred on 07/04/2020. Staff F stated, Oh yeah, I remember, it was right before he (Resident #1) was put on one to one. The staff came and got me to translate. Staff F stated that Resident #2 had been playing her music and Resident #1 had his hand on her shoulder, and she was telling him to not touch her. Staff F stated that she told Resident #1 in Spanish to not touch Resident #2 and he became aggressive and rude and said in Spanish do you want me to hit her and he put his arm back as if to hit her. Staff F stated that she translated in the moment to the nurse, Staff A, RN, what Resident #1 said. Staff F stated that Staff A was aware that Resident #1 touched Resident #2. Staff F stated that she did not witness the incident but she guessed she should have reported the incident but thought Staff A was going to do it. Staff F stated that she was not asked to provide a witness statement of the incident. In a phone interview on 08/13/2020 at 4:00 PM, Staff G, CNA, stated that Resident #1 was slightly independent and they had to keep an eye on him and supervise him so he did not go into another resident's room. Staff G stated that they changed Resident #1's room when he grabbed another resident's arm. Staff G stated that he was there when it happened but did not see the incident. Staff G stated that Resident #1 was sitting by his room and Resident #2 had a tablet and was listening to music. Staff G stated that Resident #1 went closer to listen to her music and Resident #2 told Resident #1 to go away. Staff G stated that Resident #1 insisted on being there. Staff G stated that Resident #2 told the nurse (Staff A), that Resident #1 grabbed her and Staff A asked Staff G if he witnessed the incident which he had not. Staff G stated that they had Staff F translate for Resident #1 and after that Resident #1 was on one on one supervision. Staff G stated that it was the end of his shift that night and recalled reporting off that Resident #1 was on supervision and to check on the resident every 15 minutes. Staff G stated that if they were to notice anything out of the ordinary they were to report, and he did report to the nurse. Staff G stated that the nurse (Staff A), reported that Resident #2 insisted that Resident #1 grabbed her but the nurse was not there and she did not know if that actually happened and neither did Staff G. In a phone interview on 08/14/2020 at 1:58 PM, Staff C, LPN (Licensed Practical Nurse), RCM, stated that she was the On-Call Manager on 07/04/2020. She said she directed Staff H, RN, the dayshift nurse on 07/05/2020, to place Resident #1 on one on one supervision. Staff C was asked why Resident #1 did not have one on one supervision later on in the afternoon on 07/05/2020. Staff C stated that she was not in the facility and directed Staff H, on the morning shift, to place Resident #1 on one on one supervision. In a phone interview on 08/14/2020 at 3:23 PM, the DNS stated that there were no staff who were aware of the 07/04/2020 incident between Resident #1 and Resident #2. She stated that Resident #1 self-propelled in his wheelchair and the facility tried to provide the best supervision. She stated that Resident #1 came out of his room and was attracted to the music Resident #2 was playing. The DNS stated that Resident #1's Care Planned Intervention, to not to be left alone with female residents was not realistic. The DNS stated that Resident #1 was not placed on one on one supervision until Monday, 07/06/2020, and was unable to speak to the progress note that indicated that the resident was placed on one on one supervision prior, as it did not make sense to her. The DNS stated that the conversation that she had with Staff A, RN, did not substantiate the incident between Resident #1 and Resident #2 and was not able to speak to why Staff A did not report Resident #2's allegation of abuse on the evening of 07/04/2020. RESIDENT #1 TO RESIDENT #3 ALLEGATION OF SEXUAL ABUSE Review of Resident #1's progress note dated 07/05/2020 at 2:15 PM, showed the nurse went to the location where she heard someone say, Hey Stop. The nurse observed that there were two nurses and two CNAs in the hallway where Resident #3 was sitting in her wheelchair eating her lunch and Resident #1 was sitting in his wheelchair in front of Resident #3. The CNAs' reported that Resident #1 was seen rubbing Resident #3's chest area. Resident #1 was noted to be agitated and was noted to be currently on one on one staff supervision. Review of Resident #3's progress note dated 07/05/2020 at 6:24 PM, showed the nurse heard a CNA screaming in the hallway and went to the hallway and observed a CNA separating Resident #1 from Resident #3. The CNA reported that Resident #1 was observed to be rubbing his hand on Resident #3's chest area. Resident #1 was currently on one on one supervision. (This incident occurred on 07/05/2020 at approximately 2:00 PM, per witness statements.) Review of Resident #3's Incident Report dated 07/05/2020 at 3:15 PM, showed CNAs reported that Resident #1 was observed using his hands to rub the chest area of female Resident #3. Resident #1 was on one on one supervision. (This incident occurred on 07/05/2020 at approximately 2:00 PM, per witness statements.) Review of the witness statement dated 07/05/2020, showed Staff E, CNA, noted on 07/05/2020, that around 2:00 PM, she turned onto the 140 Hallway and witnessed Resident #1 touching Resident #3's chest. Review of Resident #1's Incident Report dated 07/05/2020 at 2:15 PM, showed CNAs reported that male Resident #1 was seen using his hand to rub the chest area of female Resident #3. Resident #1 was currently on one on one supervision. Review of the one to one supervision documentation showed the one to one supervision began on 07/05/2020 at 3:00 PM, six hours after it was documented the resident was to be on one to one supervision after the first abuse allegation. The facility failed to follow Resident #1's Care Plan Intervention to not be left alone with female residents, failed to timely report Resident #2's allegation of abuse, failed to ensure Resident #1 was placed on one to one supervision after the evening on 07/04/2020 as directed by the On Call Manger, Staff C, failed to ensure Resident #1 was adequately supervised and failed to conduct a complete and through investigation of the incident on 07/04/2020. Reference: (WAC) 388-97-0640 (1)(5)(a)(6)(a)(b)(7)(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 observation, interview, and record review, the facility failed to ensure non-medication interventions were attempted prior to administration of an anti-psychotic medication (medications that affect the mind or behavior), and failed to ensure there was an adequate indication for usage of an anti-psychotic medication for one of three resident's (#1) reviewed for unnecessary medications. This failure placed the resident at risk for potential serious adverse side-effects from unnecessary medication use and unmet psychosocial needs. Findings included . Review of the facility's policy titled, [MEDICAL CONDITION] Management Guideline, dated 10/2015, showed the purpose was to improve the resident's quality of life with non-pharmacological interventions and if indicated medication interventions at the lowest effective

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F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) dose. Notify Physician of behavior/s indicating possible need for medication intervention, rule out pain, and include in the Physician order [REDACTED]. Review of the facility's policy titled, Behavior Management, revised on 09/2017, showed the purpose was to ensure resident behaviors are tracked, trended and analyzed to determine the most effective resident specific interventions. If Resident is exhibiting signs of aggressive behavior that continues or escalates despite resident specific interventions . places others at risk for harm, staff should respond timely to protect other residents. Staff should stay with resident and attempt to escort away from others. Resident #1 was admitted to the facility on [DATE] and received [DIAGNOSES REDACTED]. Review of the Care Plan showed the resident had the following Focus Problems and Interventions which included: A communication problem related to language barrier initiated on 02/10/2020, interventions were to arrange for a Spanish translator as necessary to communicate with the resident, assign a Spanish speaking male care giver when available, and resident can communicate in both English and Spanish, understands English; Alteration in cognition and/or communication related to Dementia initiated on 03/30/2020, interventions included if the resident does not seem to understand paraphrase and repeat, and listen closely and monitor body language; Dependent on staff for activities, cognitive stimulation and social interaction related to physical limitations, dementia, language barrier and wandering revised on 06/23/2020, interventions included should not be left along with female residents, often wanders the facility, staff will redirect with crafting materials, assist in arts craft one to one; History of behaviors of joking with other residents, acting like he is going to trip them, run into them with his chair and joking that can be perceived as aggressive. Resident can become upset if he feels other residents are telling him what to do initiated on 08/17/2016, interventions included the resident likes to visit female Resident #3, visits need to take place in a common area and redirect resident if he attempts to visit in room; redirect resident if joking is perceived unsafe or aggressive; History of stopping outside female residents rooms, stalling and peering inside initiated on 02/08/2020, interventions included redirection and remind of boundaries; and History of inappropriate sexual behavior initiated on 02/24/2016. Review of the Quarterly [MEDICAL CONDITION] Medication Review, dated 06/09/2020, showed the resident was on [MEDICATION NAME] for Depression, with no noted last GDR (Gradual Dose Reduction). The [MEDICATION NAME] Target Behaviors were as follows: A) inappropriate touching of female staff - no indication occurred, B) Exposing or touching of genitals in public spaces - no indication occurred and C) Sexual comments and [MEDICATION NAME] at female staff noted to have occurred 12 times. Non Pharmacological Interventions were to: 1) ask resident to be respectful, 2) redirect and distract with activity, 3) remove from activity / room and remind room is an appropriate / private place for such activities, 3) alert SS if behavior continues or increases. 1 and 2 are effective. The resident's weight was noted to be stable, wandering behaviors still present, non-intrusive and never exit seeking. The resident had refused housekeeping in his room at times and would still cat call to staff and [MEDICATION NAME] at females, but very easy to redirect. The resident loves activities such as ball 1:1, coloring and gardening. No significant changes in health. The IDT (Interdisciplinary Team) recommendations were the resident's behaviors were still evident but easy to redirect, at times had to re-approach several times. The resident was just started back on the [MEDICATION NAME] in March with success to reducing behaviors. No changes were recommended. Review of the June 2020, Behavior Monitoring Record (BMR), showed the resident was monitored for depression ([MEDICATION NAME]) for the following target behaviors: A) Inappropriate touching of female staff, B) Exposing or touching of genitals in public spaces, C) Sexual comments and [MEDICATION NAME] at female staff. Interventions 1) Ask resident to be respectful, 2) Redirect and distract with activity, 3) Remove resident from activity/room and remind room is an appropriate/private place, 3) Alert SS (Social Services) if behavior continues or increases. Outcome codes +) Improved, -) Worsened, 0) Unchanged. On 06/06/2020 the resident had two episodes of C) Sexual comments which improved with interventions and on 06/16/2020 10 episodes of C) Sexual comments which was unchanged with interventions. Review of the June 2020, Behavior Symptom Review, from the Point of Care, CNA, documentation showed the resident had rejection of care on 06/22/2020 at 4:59 AM, 06/23/2020 at 1:41 AM, 06/29/2020 at 1:06 AM, and on 06/30/2020 at 10:19 PM, had an episode of threatening behavior and at 1:49 AM another episode of rejection of care. (No interventions were documented in the Behavior Symptom Review.) Review of the June 2020, Progress Notes showed the resident had three days of behaviors of which did not constitute the requirement for an antipsychotic medication: - 06/08/2020 at 2:53 PM, the resident was verbally aggressive toward a housekeeper, stating that his room was clean and he did not want his room cleaned on that day; - 06/29/2020 at 11:23 AM, the CNA (Certified Nursing Assistant), found several hydration pitchers full of what was believed to be apple juice, but in fact was urine. The resident stated that when he needed to go he would look for the nearest available vessel; and - 06/30/2020 at 23:33 PM, the resident became very agitated and combative making threatening gestures with cane when LN (Licensed Nurse) tried to give the resident his bedtime insulin and the resident refused. Review of the July 2020, MAR indicated [REDACTED]. Review of the July 2020 BMR showed the following: 07/01/2020 through 07/09/2020 showed monitored for depression ([MEDICATION NAME]) behaviors, A) Inappropriate touching of female staff, B) Exposing or touching of genitals in public spaces, C) Sexual comments and [MEDICATION NAME] at female staff, D) Urinating in hydration cups. Interventions 1) Ask resident to be respectful, 2) Redirect and distract with activity, 3) Remove resident from activity/room and remind room is an appropriate/private place, 3) Alert SS (Social Services) if behavior continues or increases. - 07/01/2020 three episodes of C) Sexual comments and [MEDICATION NAME] at female staff, unchanged with interventions; - 07/05/2020 one episode of A) Inappropriate touching of female staff which was improved with interventions. On 07/10/2020, the monitor showed a change for depression ([MEDICATION NAME]) Behaviors, A) Refusing care, B) Depressive Statements, C) Self isolation. Interventions 1) Redirect with activity, 2) Change position, 3) Offer snack, 4) Leave room and return, 5) 1 on 1. No behavioral episodes were noted from 07/10/2020 through 07/31/2020. Beginning on 07/11/2020 through 07/31/2020, a monitor was added to monitor for [MEDICAL CONDITION] ([MEDICATION NAME], an antipsychotic medication) behaviors, A) Inappropriate touching of female staff, B) Exposing or touching of genitals in public spaces, C) Sexual comments and [MEDICATION NAME] at female staff, D) Urinating in hydration cups. Interventions 1) Ask resident to be respectful, 2) Redirect and distract with activity, 3) Remove resident from activity/room and remind room is an appropriate/private place, 3) Alert SS (Social Services) if behavior continues or increases. No behavioral episodes were noted from 07/11/2020 through 07/31/2020. Review of the July 2020, Behavior Symptoms Review, showed the resident had threatening behavior on 07/04/2020 at 9:58 PM, an episode of abusive language on 07/07/2020 at 10:12 PM, an episode of kicking/hitting on 07/10/2020 at 10:16 PM and 07/28/2020 at 10:06 PM, and two episodes of rejection of care on- 07/13/2020 at 2:16 AM and 07/14/2020 at 1:56 AM. (No interventions were noted as attempted) Review of the July 2020, Progress Notes showed the following documented episodes of resident behaviors: 07/01/2020 at 1:54 PM, twice when the nurse walked by, the resident made inappropriate and sexual comments directed toward the nurse, the resident was redirected but later in the shift continued to make inappropriate comments; 07/04/2020 at 11:04 PM, the resident became agitated with Resident #2 when she did not want him sitting too close while listening to music on her iPad; 07/05/2020 at 12:12 PM, the resident was placed on 1:1 supervision for allegation of inappropriate touching of female Resident #2; 07/05/2020 at 2:15 PM, the resident was observed touching female Resident #3 chest; 07/06/2020 at 10:57 AM, the Administrator and the rest of the management team okayed the resident for a room move; 07/06/2020 at 5:38 PM, the resident returned from eye appointment and was upset that he was moved to a new room. The resident cornered the nurse while helping him move the last of his stuff; 07/07/2020 at 12:54 PM, the resident currently on every 15 minute checks, needed re-directed to his room after using the bathroom, Spanish translation from CNA, and the resident was doing fine in his new room and sleeping well; 07/07/2020 at 6:08 PM, the resident was redirected from nurse's medication cart, refused his medications, wandered toward another hall, redirected and the nurse noted aggression, placed on one to one supervision; 07/08/2020 at 12:25 AM, monitored resident every 15 minutes, became briefly agitated when CNA went to clock out at the end of her shift and tried to follower her, afterwards the resident went to bed without complications; 07/08/2020 at 11:34 AM, Geriatric Mental Health Specialist noted that the resident had been moved to a new room closer to the nurse's station away from some of the women residents whom he had been intrusive. Staff reported he was much more agitated of late and earlier in the week he hit a staff with a stick and on 07/07/2020 he had gotten some rocks and was poised to throw them at staff who were in his room while he sat in the doorway. Up and down the halls last PM agitated, He remained on 1:1 supervision, the resident's ability to communicate in English was pretty much gone now. When the resident sits in the hall now a days he often looks the women up and down and [MEDICATION NAME]. Suspect the resident was becoming more disinhibited as his dementia progressed. Not having new behaviors just more of them. Will review status with Psych MD and have plan Thursday AM; 07/08/2020 at 2:23 PM, the resident fell while trying to get something from his closet when he lost his balance. Blood Pressure was noted at 70/45 initially; 07/08/2020 at 5:54 PM, the resident was on one to one with staff, no noted behavior till around 3:30 PM, noted getting harder to re-direct; 07/09/2020 at 1:52 PM, medication review completed. Due to on-going behaviors, ARNP has added [DIAGNOSES REDACTED]. The CNA was able to speak to the resident in Spanish and was able

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) to redirect the resident. The Resident Care Manager and Leadership staff were informed of the episode of aggression as the resident had just been released from being on one on one monitoring and now was suddenly displaying more behaviors as he was not getting the attention he had been from the one on one staff; 07/29/2020 at 3:29 AM, the resident was on 10 minute checks, started to propel self in wheelchair around the unit, when he was headed down the incorrect hallway the LN intervened and tried to redirect the resident back to his room. The resident became agitated and pushed against the LN with his wheelchair and hit the LN twice with an open hand until a CAN was able to speak with him in Spanish and direct him to his room. Review of the Staff I, RN, Geriatric Mental Health Specialist, (GMHS), hand written note dated 07/09/2020, showed, Reviewed status with a Dr. (one initial abbreviation), thinks sounds psychotic recommended trial of [MEDICATION NAME], message left with the DNS. Review of the ARNP (advanced registered nurse practitioner) Progress Note dated 07/14/2020, showed that some of the resident's confusion and/or behaviors may be related to his English as a second language, Resident is Spanish speaking. Physical Exam, Psychiatric review noted judgement/insight was appropriate .We will continue to follow and offer distractions. Review of Progress Note dated 08/03/2020 at 10:07 AM, showed the resident had issues with wandering this review month, had a substantiated episode of abuse with another resident when he wandered down the incorrect hallway .Resident can be redirected when the Spanish language is able to be used to communicate with the resident. In an observation on 08/10/2020 at 10:20 AM, the resident was sitting by himself, in his wheelchair in the main hallway, at 10:33 AM, the resident was self-propelling in the hallway, a staff member walked by and engaged the resident in a ball toss activity of which the resident actively engaged in, at 12:08 PM, the resident was sitting in the 120 Hallway directly behind Resident #2, no staff were in the area. In a phone interview on 08/14/2020 at 1:58 PM, Staff C, LPN (Licensed Practical Nurse), RCM (Resident Care Manager), stated that Staff I, RN, GMHS, talked with the doctor she worked with and discussed the resident's behaviors and made recommendations. Staff C, stated that the PCP (Primary Care Provider) was informed of the recommendations and they made the decision to okay the medication recommendation. Staff C, stated that they reviewed the resident in the Psych Meeting prior to starting the [MEDICATION NAME] for [MEDICAL CONDITION] symptoms of aggressive behaviors, hitting, yelling, and throwing things. Staff C, stated that Social Services placed the indication and behaviors on the BMD, and she should have placed more than what was on the BMD, there should have been the resident's aggressive behaviors. In a phone interview on 08/14/2020 at 3:23 PM, the Director of Nursing Services (DNS), stated that the resident was identified as someone who wanders in the halls and there was some intrusive wandering. The DNS stated that since May he had no behaviors till the two recent incidents he had not had any behaviors for potential resident to resident behaviors that were negative. She stated that he was doing well, we took him off some of his medication but she was unable to indicate which medications and stated, I might have misspoke. The DNS stated that the resident had a Mental Health visit and he was deemed to have [MEDICAL CONDITION]. The DNS was asked what the resident's symptoms of [MEDICAL CONDITION] were and she stated that she had no comment, and stated, I am not the provider, I am not the specialist. The DNS confirmed the target behaviors for the [MEDICATION NAME] had been the prior target behaviors for the [MEDICATION NAME], and stated that [MEDICAL CONDITION] presented different in different residents. The DNS stated that was how the resident presented. Reviewed the note from Staff I, RN, GMHS, dated 07/08/2020, the DNS stated that she was unsure where that came from and was unaware where the Mental Health Nurse got that information. Review of an addendum made on 08/16/2020, to the ARNP Progress Note dated 07/14/2020, (a month later) showed [MEDICAL CONDITION]: Meeting and care recommendation in July 2020 after multiple, well documented sexual behaviors toward other resident, repeatedly, after redirection and instruction that behaviors were inappropriate, [MEDICATION NAME] was begun for [MEDICAL CONDITION] . his inability to follow instructions, lack of insight concerning self-care and agitation. It is suspected that he is experiencing [MEDICAL CONDITION] in the setting of [MEDICAL CONDITION]. In a phone interview on 08/18/2020 at 10:49 AM, Staff J, ARNP, stated that she sees the resident every 30 days and if anything acute comes up she sees him earlier. She stated that the resident's language could be a barrier, if there was a Spanish speaking aide nearby, could utilize to translate but did not like to utilize the facility aides to translate and a translator was not always available. She stated that if there was a Spanish speaking aide available it calmed the resident down. She stated that it was her impression that if he was not able to communicate in his native language it frustrated him and his dementia was pretty far advanced. Staff J, stated that she was unaware of an interpretive service available at the facility and had not utilized one when assessing the resident. Staff J, stated that she was asked to place the addendum to her 07/14/2020 Progress Note. Staff J was unable to provide information regarding the resident's [DIAGNOSES REDACTED]. stated that she was not included in the resident's Care Plan to include non-pharmacological interventions for the resident prior to the resident starting on an antipsychotic medication. In a phone interview on 08/20/2020 at 11:53 AM, Staff I, RN, GMHS, stated that she provided a mental health consultation for the facility based on a mental health model from the 1980's. She stated that was what she had provided for Resident #1. She stated that the resident had a language barrier, there was limited Spanish interpreters and the resident loved the women which was nothing new. She stated that she did not think you could stop sexual behaviors with an antipsychotic. Staff I stated that for a couple of weeks he had not seemed his happy self, his demeanor had changed and it was out of character for him to be threatening. She stated that he had looked paranoid but was uncertain who told her about the resident being aggressive. She stated that her initial thought was his dementia was progressing but after review with the psychiatrist maybe he had developed [MEDICAL CONDITION] with depression. In a phone interview with the resident's daughter on 08/20/2020 at 2:13 PM, the daughter stated that she was unaware that the resident had been started on an antipsychotic medications, only thought he was on his regular diabetes medication. She stated that the facility had called about the facility's recent COVID testing, the resident being moved to another room and they asked if it was a good time to look for a dementia building. She stated, They have not called us back. In an interview on 08/26/2020 at 11:50 AM, Staff K, Social Service Coordinator, stated that Staff I had evaluated the resident and made suggestions which goes to the DNS and it then is between the ARNP. Staff K was asked about the resident's behaviors associated with his [DIAGNOSES REDACTED]. In a phone interview on 08/24/2020 at 2:22 PM, Staff L, Psychiatrist, stated that Staff I, RN, GMHS, would come to him for consultation, she would describe the situation and he would make suggestions for behavioral interventions or possible medications for the attending physician to consider. Staff L, stated that Resident #1 did not ring a bell for him, and he may or may not have talked about Resident #1. Staff L, stated that he did not have documentation of the consultation that he provides and was unable to answer any further questions. Reference: (WAC) 388-97-1060 (3)(k)(i)