STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505519	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BENSON HEIGHTS REHABILITATION CENTER	**22410 BENSON ROAD SE KENT, WA 98031**

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 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 ensure one (#49) of five residents reviewed for unnecessary medications consented to the use of a [MEDICAL CONDITION] medication. This failure placed the resident/resident representative's right to make informed decisions at risk. Findings included . RESIDENT #49 Resident #49's annual MDS (Minimum Data Set-an assessment tool) dated 01/03/2020 showed the resident admitted on [DATE] with multiple complex medical and cognitive conditions. The assessment showed the resident received an antidepressant medication. Review of Resident #49's February 2020 Medication Administration Record [REDACTED]. This medication was originally started on 1[DATE]19, and resumed 01/13/2020 after a hospitalization . Review of Resident #49's medical record did not reveal the resident/resident representative had received information about the risks and benefits of [MEDICATION NAME]. There was also no evidence in the medical record that the resident/resident representative was presented with a choice about use of this medication or possible alternatives, or consented to its use. On 03/01/2020 at 12:44 PM, the above findings were discussed with Staff I, Registered Nurse. Staff I was asked if the facility obtained consents for antidepressant medications, and she replied they did. Staff I acknowledged Resident #49 did not have a consent for [MEDICATION NAME]. On 03/04/2020 at 8:23 AM, Staff B, Director of Nursing, said she was aware of the above finding. Staff B acknowledged the lack of consent for [MEDICATION NAME] said she thought the failure to obtain consent for [MEDICATION NAME] was because it was prescribed to increase Resident #49's appetite. REFERENCE WAC 388-97-0260 .
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 identify, protect, assess, report and prevent a pattern of resident to resident abuse. This included identifying a known pattern of aggressive behaviors by Residents #42, #49 and #77, three of 19 sample residents. Abusive behaviors identified by staff included hitting, punching, kicking, ramming into other residents with a wheelchair (w/c), verbal abuse, threats and intimidation of other residents. The facility failed to recognize these incidents as abuse, even though staff identified immediate responses to instances of abuse. The facility did not analyze the circumstances of these abusive behaviors or implement plans for prevention or recurrence. Failure to recognize multiple incidents of resident to resident altercations as abuse placed residents at risk of serious injury or harm. This failure resulted in an Immediate Jeopardy (IJ) related to abuse on 02/28/2020. The facility reassessed residents #42, #49 and #77 and provided training for all staff regarding recognizing and reporting abuse, which led to the removal of the IJ on 03/03/2020. Findings included . A July 2018 facility policy titled, Accidents/Hazards/Devices, showed the facility recognized that resident to resident altercations could be a situation of abuse, and that reasonable precautions would be taken when the risk of resident to resident altercations was present. In addition, interventions would be implemented to minimize or control incidents of disruptive or intrusive behavior to minimize altercations. RESIDENT #42 Resident #42 admitted on [DATE] with care needs related to depression, dementia and other chronic illnesses. According to the resident's Care Plan (CP), revised on 01/30/2020, he had the potential to be verbally and physically aggressive towards others. On 02/27/2020 at 10:25 AM, four staff were observed in Resident #42's room. He was seated on his bed, while a staff member told him he would need to take some time in his room and calm down, and she would check back with him when he was calmer. At 10:30 AM, Staff J, Social Service Assistant (SSA), was asked why Resident #42 was needing time to calm down. According to Staff J, as she exited a room on the South Hall, she observed two staff in the hallways attempting to separate Residents #42 and #49 who were both agitated. Staff J stated Resident #42 was making threatening comments to (Resident #49). Three staff who were present separated the residents. Resident #42 was escorted back to his room by staff. A 02/27/2020 progress note by Staff J after this incident described Resident #42 as agitated and striking Staff J's arm. The note did not identify any threatening behavior towards Resident #49. Threats or intimidation are included in the definition of mental abuse, which staff have a responsibility to recognize and report to the Administrator and the State Agency (SA). On 02/28/2020 at 10:22 AM, Staff J was interviewed about her response to the resident to resident altercation on 02/27/2020. When asked to clarify what type of threats Resident #42 made to Resident #49, Staff J said she recalled Resident #42 saying I'm gonna kick your a** as the two residents moved towards each other in their wheelchairs. At this point, staff separated the residents. When asked who was notified of this incident after the residents were separated, Staff J said she talked to Staff B, Director of Nursing (DON). When Staff J was asked if she had notified the Administrator, she said she did not remember. When asked if she considered the altercation between Residents #42 and #49 as abuse, she said it was not. When asked to clarify why it was not abuse, Staff J replied, Because there was no resident to resident contact and (Resident #49) said he was okay. When Staff J was asked if it was acceptable for one resident to threaten another resident, she replied, No. As the current definitions of mental abuse, mistreatment, threats and intimidation were reviewed, Staff J acknowledged the behavior she observed on 02/27/2020 met the definition of mental abuse. The incident was not reported to the Administrator. ADDITIONAL INTERVIEW: On 03/03/2020 at 9:35 AM, Staff C, Social Service Director, was interviewed regarding her recent training about abuse and resident to resident altercations. When asked about her understanding of when abuse occurred, she replied, When there is physical or emotional harm. Her response failed to identify the occurrence of abuse as one or more defined behaviors, whether or not a resident reported or sustained some type of harm. After further discussion to clarify this definition, Staff C said she did see the difference and the need to focus on the resident's behavior at the time of an incident to determine abuse, with efforts to later determine if harm had occurred after the incident. RESIDENT #49 Resident #49's 01/03/2020 Annual MDS (Minimum Data Set-an assessment tool) showed the resident admitted on [DATE] with multiple complex medical and cognitive conditions. The assessment showed the resident had verbal behaviors directed toward others for one to three days in the look-back period. The resident's care plan, last revised 0[DATE]20, showed the resident could be .verbally and physically aggressive . and had .Potential for injury to self or others . Review of progress notes for Resident #49 showed that on 10/20/2019 the resident exhibited .many inappropriate behaviors, one resulting in a (sic) aggressive confronting with another resident. A note, dated 10/22/2019, showed, Resident blocked another resident in the hallway and grabbed her hand and arm, then hit her. A note of 11/23/2019 showed the resident attempted .to run into ambulating resident with his w/c and grabbed a hold of another resident's w/c and

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) pulled her backwards. The note also said the resident .attempted to kick another resident in her w/c as she was passing by. A note of 11/24/2019 showed the resident was noted to be hitting (unidentified person's initials). The note also showed staff tried to move Resident #49 away from the other unidentified person when Resident #49 .grabbed a hold of (unidentified person's initials) w/c. A note of 01/08/2020 showed Resident #49 was witnessed .yanking on (unidentified person's initials) arm in entryway . A note of 02/16/2020 showed Resident #49 was .heard cussing at his roommate. On 02/28/2020 at 12:05 PM, the above findings involving Resident #49 were discussed with Staff B. No further information to show the facility developed and implemented interventions to prevent future altercations or abuse between Resident #49 and other residents was received. RESIDENT #77 Review of the medical record showed Resident #77 was admitted to the facility on [DATE] with multiple medical and psychiatric diagnoses. Review of a CP, initiated and revised on 01/25/2020, showed, (Resident) is/has potential to be physically aggressive r/t (related to) Poor impulse control, with the goal of, (Resident will not harm self or others, and (Resident) will verbalize understanding of need to control physically aggressive behavior through the review date. Interventions, also initiated 01/25/2020, identified triggers for physical aggression and what to do when the resident became agitated, such as intervening before agitation escalated, guiding away from source of distress, engaging calmly in conversation, and to re-approach later. Additionally, the resident's CP showed an intervention dated 02/23/2020 to get a case manager or charge nurse to assist if the resident is continuously yelling and is bothering others. Review of a progress note dated 12/06/2019 at 1:33 AM, showed, Res (Resident) has been up and about in the facility. He has been loud . He has been coming to the NS (Nursing Station) making verbal threats, fire-ring (sic) staff, then wheels away quickly . has been out in the smoking patio with another male res (Resident #13) making threats, which are becoming more explosive, more difficult to redirect. Call placed to MD for a PRN (as needed medication) or to review his current meds (medications), for possible med change. Awaiting C/B (call back). A subsequent 12/06/2019 progress note showed, At ~(approximately) 0200 (2:00 AM) (Resident) is seen talking to himself loudly outside the porch near another res (Resident #13), who told him to shut the f*** (expletive) up: (Resident #77) retorted You have no right to tell me what to do which enraged Resident #13; the two engaged in a shouting match, got closer to each other and almost engaged in a physical fight; we broke them up in time. (Resident #77) then made provoking statements such as 'Let me go say one last word to him' 'I'll make sure he's in jail'. A subsequent progress note of 12/06/2019 and timed at 2:37 PM showed, Once outside could hear both (Resident #13) and (Resident #77) yelling at each other, (Resident #77) yelling at (Resident #13) 'I'm going to kill you!' As staff separated the two . A) (Assessment) (Resident #77) had several verbal altercations with others this shift, easily agitated P) (Plan) Will place on alert for increased agitation. The above findings were shared with Staff J on 02/28/2020 at 8:41 AM. When asked how the interventions were changed or what precautions were taken to prevent future altercations between Residents #77 and #13, or other residents, Staff J stated, I will find out. When asked if the record showed who were the others Resident #77 had verbal altercations with, Staff J stated, I honestly don't know the answer to that. I can try to dig some information for this. When asked if it was relevant that Resident #77's CP showed he had altercations with Resident #13, Staff J stated, Absolutely, so we can all protect. When asked if the above resident to resident altercations represented abuse, Staff J stated, That would depend on how the other person responded. When asked what kind of abuse yelling was, Staff J stated, It can be verbal and can cause psychological harm and how the other person perceives it. When asked what kind of abuse the words, I'm going to kill you! represented, Staff J stated, That is a threat and is verbal abuse. No further information was provided to show the facility developed and implemented interventions to prevent future altercations or abuse between Residents #77 and #13, or other residents. Review of a progress note dated 12/07/2019 showed, At approximately 0615 (6:15 AM), resident was propelling w/c from outside through day room. Resident #13 was blocking (Resident #77) way out of day room and refused to move. (Resident #77) pushed Resident #13 w/c to move him. (Resident #13) reached around and punched (Resident #77). (Resident #77) started to punch back. LN (Licensed Nurse) got in between the two residents and moved (Resident #77) to south end of building. This LN held (Resident #13's) w/c to prevent him from following (Resident #77). All other residents removed from the area. (Resident #13) continued to yell and scream profanities at (Resident #77) and staff, using threatening language. (Resident #77) responded with threatening language when being escorted to south. Another 12/07/2019 note showed, Resident will be monitored very closely. In this continued interview with Staff J, when asked what kind of abuse punching represented, Staff J stated, Physical. When asked if interventions changed to show how staff would monitor Resident #77 closely, Staff J stated, I will find out. No further information was provided to show the facility developed and implemented interventions to prevent future altercations or abuse between Residents #77 and #13, or other residents. Review of a progress note dated 12/07/2019 at 2:41 PM, showed Resident has been quite labile throughout the day. Had another minor verbal altercation with another resident today. In this continued interview, when asked if the record showed who the other resident involved in the verbal altercation was, Staff J stated, I don't know. I think it would be important to pass on (that information). No further information was provided to show the facility developed and implemented interventions to prevent future altercations or abuse between Residents #77 and the other resident. Review of a progress note dated, 12/08/2019 at 4:25 PM showed, .this afternoon, kicked at another resident's wheelchair that was in front of him. The med (medication) nurse was right there when this occurred and she states that the other resident had been quietly sitting there when he kicked out at the chair with his foot will remain on alert for behavior towards others. Additionally, a 12/08/19 progress note timed at 5:21 PM showed, (Resident #77) has had behaviors in the facility that are aggressive, disorganized and seemingly out of control . his grabbing at other residents the last two days is unclear. Review of a progress note dated 12/08/2019 and timed at 7:51 PM showed, Res has had aggressive behavior during this shift, and kicked at another residents wheel chair (Resident #46) when (Resident #46) came to this writer for meds. NO visible injury noted. Kept away from each other . will cont to monitor. In this continued interview, when asked if the record showed the facility identified who the other residents were that Resident #77 was grabbing at, Staff J stated, Not in this note. When asked if Resident #46's record showed he was involved in a resident to resident altercation with Resident #77, Staff J stated, No. When asked what she expected to happen for the alleged victim in a resident to resident altercation, Staff J stated, A note reflecting whether he felt safe or ruling out psychological harm. When asked what kind of abuse kicking represented, Staff J stated, Kicking can also be considered physical abuse. When asked if the facility developed and implemented interventions to prevent future altercations or abuse between Residents #77 and #46, or other residents, Staff J stated, I will find out. No further information was provided. Review of a [DATE] progress note for Resident #77 showed, He continues to exhibit unpredictable behavior exacerbated by mood lability, and During this shift he was hitting and ramming people with his wheel chair. He mentioned that I should call the police. I told him if he continued with this bx (behavior) I might. Since he was all for me calling the police I changed the direction of the conversation and nurse gave him a prn. He kept going in and out of his room as in defiance. I told him it was okay to come out of his room if he was calmer and stopped threatening both residents and staff. In this continued interview, when asked if the record showed who the people were Resident #77 was hitting and ramming, Staff J stated, It does not say. When asked what kind of abuse ramming and hitting people represented, Staff J stated, Physical abuse. When asked what kind of abuse threatening residents represented, Staff J stated, It can be psychological harm. When asked what the facility did to protect the residents from recurrence of resident to resident physical or mental abuse, Staff J stated, I'll try to find out what I can. When asked if interventions changed to prevent future resident to resident altercations, Staff J stated, I will find out. No further information was provided. A 12/14/2019 progress note showed, It was reported to this writer that the resident was up most of the night. When this writer arrived, resident was yelling at everyone around . Social service team will continue to monitor this resident. A 12/15/2019 progress note showed, (Resident) tried to ram into me with his wheel chair but instead he hit another resident's wheel chair. This writer then stopped him from ramming into us again and took him to his room . I asked him if he planned to hit anyone else and he said maybe . is impulsive and aggressive. He focuses on staff but is unaware when other residents are near. He stated he feels he cannot control his anger. A subsequent 12/15/2019 progress note showed, Resident has been on alert for agitation, also for hitting staff, and other residents . In this continued interview, when asked who everyone Resident #77 yelled at on 12/14/2019 was, and if the staff followed up on the potential effects of the yelling on other residents, Staff J stated, I will find out. I think again it's a matter of investigating and doing our work. When asked if staff re-evaluated interventions to prevent future resident to resident altercations or abuse, Staff J stated, I will find out. No further information was provided. A 01/25/2020 progress note showed, I have intervened a few times this shift with (Resident #77) and (Resident # 71). The first being outside where Resident #71 was screaming at her (sic) and he was yelling at her to Stay away from me

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) or I'll hit you! That incident I was able to separate w/o (without) any contact. Then later during dinner (Resident #71) had sat near the dining room and as (Resident #77) was rolling by she began yelling at him to not steal from her and raised her fist, he then struck her on the right shoulder. The two were separated before any further incidents happened . appears to be responding to other residents agitation . will place on alert for increased agitation. In this continued interview, when asked if the record showed what interventions were put in place to prevent recurrences of resident to resident altercations or abuse between Resident #77 and Resident #71, Staff J stated, No. When asked why it took 51 days to develop interventions to manage recurring resident to resident altercations and abusive behaviors identified since 12/06/2019, Staff J stated, I would have to look and see what we have. When asked if the record showed the facility put measures in place to protect Resident #77 and other residents from recurring verbal and physical abuse, Staff J stated, I will look for that. No further information was provided. The above findings were shared with Staff B on 02/28/2020 at 11:39 AM. Staff B stated, Resident to resident altercations are interesting here. It depends. If there's any indication the residents physically harm one another or psychological harm happened then we follow the abuse protocol. When asked if she recognized Resident #77's behaviors as abuse, Staff B stated, Sure, and I would only know about them if I had received an incident report. The above findings were shared with Staff A, Administrator, on 02/28/2020 at 10:30 AM. Staff A stated he was unaware of the resident to resident altercations and recurring abusive behaviors and stated, I don't dispute, it's resident to resident altercations. Staff A identified punching, kicking, ramming into others with a wheel chair, hitting, and threatening others as abuse, and stated, There definitely is some retraining needing to be done right here. Do they (staff) really know abuse and neglect? These were examples of abuse and of not investigating it properly which we should be. Our system needs to be worked on. REFERENCE: WAC 388-97-0640. .
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 policies and procedures regarding recognizing, reporting and investigating incidents of resident to resident abuse. The facility failed to identify altercations involving Residents #42, #49 and #77, and involving other unidentified resident as abuse. The facility failed to ensure staff reported and investigated abusive acts by residents, as specified in their current policy. This failure did not ensure residents were protected from abuse. Findings included . RESIDENT #42 As previously documented in F600 (above), on 02/27/2020 at 10:25 AM, an altercation occurred between Residents #42 and #49 in the facility. During the altercation, a staff member reported Resident #42 threatened Resident #49, saying I'm gonna kick your ass. Three staff were needed to separate the residents. On the morning of 02/28/2020, during an interview with Staff J, Social Service Assistant, she acknowledged she had not identified the altercation as mental abuse. She stated the incident did not need to be reported because there was no physical contact between the two residents. Failure to recognize the different types of abuse as defined in current regulations, resulted in minimizing the impacts of such actions on residents and did not protect them from all forms of abuse. RESIDENT #49 Resident #49's 01/03/2020 annual MDS (Minimum Data Set-an assessment tool) showed the resident admitted on [DATE] with multiple complex medical and cognitive conditions. The assessment showed the resident had verbal behaviors directed toward others for one to three days in the look-back period. The resident's care plan, last revised 0[DATE]20, showed the resident could be .verbally and physically aggressive . and had .Potential for injury to self or others . Review of progress notes for Resident #49 showed that on 10/20/2019 the resident exhibited .many inappropriate behaviors, one resulting in a (sic) aggressive confronting with with another resident. A note of 10/22/2019 showed, Resident blocked another resident in the hallway and grabbed her hand and arm, then hit her. A note of 11/23/2019 showed the resident attempted .to run into ambulating resident with his w/c and grabbed a hold of another resident's w/c and pulled her backwards. The note also said the resident .attempted to kick another resident in her w/c as she was passing by. A note of 11/24/2019 showed the resident was noted to be hitting (unidentified person's initials). The note also showed staff tried to pull Resident #49 away from from the other unidentified person when Resident #49 .grabbed a hold of (unidentified person's initials) w/c. A note of 01/08/2020 showed Resident #49 was witnessed .yanking on (unidentified person's initials) arm in entryway . A note of 02/16/2020 showed Resident #49 was .heard cussing at his roommate. The above incidents were not logged in the facility's incident log. On 02/28/2020 at 12:05 PM, the above findings involving Resident #49 were discussed with Staff B, Director of Nursing, who stated she would look for additional information. Staff B said generally if an incident was not in the incident log, or did not have an incident report, she didn't know about it. Staff B said potentially the facility needed to tighten up what was written on incident reports. No further information was received. RESIDENT #77 Similar findings were identified for Resident #77 during the survey, as previously cited in F 600 (above). Record review for Resident #77 found a pattern of resident to resident altercations since his admission, when staff documented this resident was swearing and making threats to kill other residents, punching, shoving or ramming into other residents in his wheelchair. On 02/28/2020 at 8:41 AM, the pattern of resident to resident abuse was reviewed with Staff J, who identified a series of incidents involving Resident #77 and other residents as physical, verbal or mental abuse (making threats,swearing). Review of the facility's incident log reviewed the incidents were not documented by staff. REFERENCE: WAC 388-97-0640(2). .
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure incidents of resident to resident altercations were reported to the State Agency (SA) and the Administrator within the required timeframe for three (#42, #49 and #77) of three residents reviewed for abuse/neglect. Failure to complete required reporting of incidents did not ensure interventions were in place to protect the residents and/or prevent future occurrences. Findings included . A May 2018 facility policy titled Freedom from Abuse, Neglect and Exploitation showed the facility would report allegations including abuse, neglect, exploitation or mistreatment, to the SA, the Administrator, and to other officials according to State Law. RESIDENT #42 As previously documented in F600, Resident #42 was involved in an altercation with Resident #49 on 02/27/2020. While at least three staff (Staff J, Staff V and Staff U) were present during the altercation, none of these staff identified the incident as abuse. When Staff J was interviewed on 02/28/2020 and asked if she had reported the incident to the Administrator (Staff A), she said she couldn't recall if she had. From an interview with the facility's Administrator on 02/28/2020, he acknowledged staff were not routinely notifying him of resident to resident altercations, even when resident behaviors met current definitions of abuse. RESIDENT #49 Resident #49's 01/03/2020 Annual MDS (Minimum Data Set-an assessment tool) showed the resident admitted on [DATE] with multiple complex medical and cognitive conditions. The assessment showed the resident had verbal behaviors directed toward others for one to three days in the look-back period. The resident's care plan, last revised 0[DATE]20, showed the resident could be .verbally and physically aggressive . and had .Potential for injury to self or others . Review of progress notes for Resident #49 showed that on 10/20/2019 the resident exhibited .many inappropriate behaviors, one resulting in a (sic) aggressive confronting with with another resident. A note of 10/22/2019 showed, Resident blocked another resident in the hallway and grabbed her hand and arm, then hit her. A note of 11/23/2019 showed the resident attempted .to run into ambulating resident with his w/c and grabbed a hold of another resident's w/c and pulled her backwards. The note also said the resident .attempted to kick another resident in her w/c as she was passing by. A note of 11/24/2019 showed the resident was noted to be hitting (unidentified person's initials). The note also showed staff tried to pull Resident #49 away from from the other unidentified person when Resident #49 .grabbed a hold of (unidentified person's initials) w/c. A note of 01/08/2020 showed Resident #49 was witnessed .yanking on (unidentified person's initials) arm in entryway . A note of 02/16/2020 showed Resident #49 was .heard cussing at his roommate. The above incidents were not seen as logged in the facility's incident log. On 02/28/2020 at 12:05 PM, the above findings involving Resident #49 were discussed with Staff B, Director of Nursing, who stated she would look for additional information. Staff B said generally if an incident was not in the incident log, or did not have an incident report, she didn't know about it. Staff B said potentially the facility needed to tighten up what was written on incident reports. No further information was received.

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) RESIDENT #77 Review of 12/06/2019 progress notes showed, He (Resident) has been coming to the NS (Nursing Station) making verbal threats . has been out in the smoking patio with another male res (Resident #13) making threats, which are becoming more explosive, more difficult to redirect . At ~(approximately) 0200 (2:00 AM) (Resident #77) is seen talking to himself loudly outside the porch near another res (Resident #13), who told him to shut the f*** (expletive) up . the two engaged in a shouting match, got closer to each other and almost engaged in a physical fight; we broke them up in time . and Once outside could hear both Resident #13 and Resident #77 yelling at each other, (Resident #77) yelling at Resident #13 'I'm going to kill you!' as staff were separated the two . Review of the facility's incident log did not show these incidents were reported to the SA. Review of the medical record showed no documentation the staff reported these incidents to the Administrator. Review of 12/07/2019 progress notes showed, (Resident #13) was blocking (Resident #77) out of the day room and refused to move, (Resident #77) pushed (Resident #13) wc (wheel chair) to move him. (Resident #13) reached around and punching (Resident #77), (Resident #77) started to punch back . (Resident #13) continued to yell and scream profanities at (Resident #77) and staff, using threatening language, and Had another minor verbal altercation with another resident today . Review of the facility's incident log did not show these incidents were reported to the SA. Review of the medical record showed no documentation the staff reported these incidents to the Administrator. Review of a 12/08/2019 progress note showed, This afternoon kicked another resident's wc that was in front of him. The med (medication) nurse was right there when this occurred and she states that the other resident had been quietly sitting there when he kicked out at the chair with his foot . and . has had behaviors in the facility that are aggressive, disorganized and seemingly out of control . his grabbing at other residents the last two days is unclear. Review of the facility's incident log did not show these incidents were reported to the SA. Review of the medical record showed no documentation the staff reported these incidents to the Administrator. Review of a [DATE] progress note showed, Hitting and ramming people with his wheel chair . threatening both residents and staff. Review of the facility's incident log did not show this incident was reported to the SA. Review of the medical record showed no documentation the staff reported this incident to the Administrator. In an interview on 02/28/2020 at 9:36 AM, when asked who she reported resident to resident altercations to, Staff O, Certified Nursing Assistant (CNA) stated, The nurse, the charge nurse. In an interview on 02/28/2020 at 8:29 AM, when asked what was the procedure she followed for reporting a resident to resident altercation, Staff J, Social Services Assistant, stated, If injured, and not ok it would be a State call. When asked if a resident to resident altercation was documented anywhere else, Staff J stated, We have incident reports for injuries or 'show of support', any time we have to support another resident to redirect them away from the other resident. When asked what the intent was for completing an incident report, regardless of injury, Staff J answered, To track any kinds of incidents and injuries and for the resident's wellbeing. When asked if non-injury altercations required an incident report, Staff J stated, If it's a non injury, then no, unless we think there is psychological harm. If verbal to verbal and everybody seems to be ok, we do not do an incident report. It depends on the situation. If harm of any type, my understanding is we are to report via the hotline and, of course, nursing supervisors and administration. When asked if resident to resident interactions can be abusive, with or without injury, Staff J answered, Of course, I think it can be. Any situation is a potential. On 02/28/2020 at 11:39 AM, the above findings were shared with Staff B. When asked what the process was for reporting resident to resident altercations to the SSA, Staff B stated, If an incident report had been completed it would have been logged. If others documented that a resident struck someone I would have liked to have an incident report for that. The incident report then triggers the logging (reporting to the SA). When asked if resident to resident to resident altercations, with or without harm, should be reported to the SA via the log, Staff B stated, It should be on the log. The above findings were shared with Staff A, Administrator, on 02/28/2020 at 10:27 AM. When asked what he expected from staff when residents were verbally or physically abusive to each other, Staff A stated, Report and investigate and document. When asked who should staff report to, Staff A stated, The supervisor and then it comes up all the way to me. When asked if the above resident to resident altercations were reported to him, Staff A stated, No, they didn't call me. That's one of the things where I feel the system fails here. They have to follow the protocol. That is not being done. I expect them to report. If it's a resident to resident altercation we should call it in (to the SA). I was unaware. I can see the broken system right here. You opened my eyes to something here. These were examples of abuse and of not investigating it properly, which we should be. Our system needs to be worked on. Staff should know how to report abuse. When asked what the purpose was of logging incidents in the log, Staff A stated, It's so we can look at what's going on, and what to do to prevent it from happening again. If the data is not there we can't do anything. 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 observation, interview and record review, the facility failed to ensure all allegations of abuse, neglect or mistreatment identified by staff were investigated for two (#49 and #77) of three residents reviewed for abuse/neglect. This failure placed the residents at risk for unrecognized abuse and neglect, and did not ensure interventions were in place to protect the resident and/or prevent future incidents. Findings included . RESIDENT #49 Resident #49's 01/03/2020 Annual MDS (Minimum Data Set-an assessment tool) showed the resident admitted on [DATE] with multiple complex medical and cognitive conditions. The assessment showed the resident had verbal behaviors directed toward others for one to three days in the look-back period. The resident's care plan, last revised 0[DATE]20, showed the resident could be .verbally and physically aggressive . and had .Potential for injury to self or others . Review of progress notes for Resident #49 showed that on 10/20/2019 the resident exhibited .many inappropriate behaviors, one resulting in a (sic) aggressive confronting with with another resident. A note of 10/22/2019 showed, Resident blocked another resident in the hallway and grabbed her hand and arm, then hit her. A note of 11/23/2019 showed the resident attempted .to run into ambulating resident with his w/c and grabbed a hold of another resident's w/c and pulled her backwards. The note also said the resident .attempted to kick another resident in her w/c as she was passing by. A note of 11/24/2019 showed the resident was noted to be hitting (unidentified person's initials). The note also showed staff tried to pull Resident #49 away from from the other unidentified person when Resident #49 .grabbed a hold of (unidentified person's initials) w/c. A note of 01/08/2020 showed Resident #49 was witnessed .yanking on (unidentified person's initials) arm in entryway . A note of 02/16/2020 showed Resident #49 was .heard cussing at his roommate. The above incidents were not seen as logged in the facility's incident log. On 02/28/2020 at 12:05 PM, the above findings involving Resident #49 were discussed with Staff B, Director of Nursing, who stated she would look for additional information. Staff B said generally if an incident was not in the incident log, or did not have an incident report, she didn't know about it. Staff B said potentially the facility needed to tighten up what was written on incident reports. No further information was received. RESIDENT #77 Review of 12/06/2019 progress notes showed, He (Resident) has been coming to the NS (Nursing Station) making verbal threats . has been out in the smoking patio with another male res (Resident #13) making threats, which are becoming more explosive, more difficult to redirect . At ~(approximately) 0200 (2:00 AM) (Resident #77) is seen talking to himself loudly outside the porch near another res (Resident #13), who told him to shut the f*** (expletive) up . the two engaged in a shouting match, got closer to each other and almost engaged in a physical fight; we broke them up in time . and Once outside could hear both Resident #13 and Resident #77 yelling at each other, (Resident #77) yelling at Resident #13 'I'm going to kill you!' as staff were separated the two . Review of the facility's incident log or the residents' medical record did not show these incidents were investigated. Review of 12/07/2019 progress notes showed, (Resident #13) was blocking (Resident #77) out of the day room and refused to move, (Resident #77) pushed (Resident #13) wc (wheel chair) to move him. (Resident #13) reached around and punching (Resident #77), (Resident #77) started to punch back . (Resident #13) continued to yell and scream profanities at (Resident #77) and staff, using threatening language. Had another minor verbal altercation with another resident today . Review of the facility's incident log or the residents' medical record did not show these incidents were investigated. A 12/08/2019 progress note showed, This afternoon kicked another resident's wc that was in front of him. The med (medication) nurse was right there when this occurred and she states that the other resident had been quietly sitting there when he kicked out at the chair with his foot . and . has had behaviors in the facility that are aggressive, disorganized and seemingly out of control . his grabbing at other residents the last two days is unclear. Review of the facility's incident log or the residents' medical record did not show these incidents were investigated. Review of a [DATE] progress note showed, Hitting and ramming people with his wheel chair . threatening both

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) residents and staff. Review of the facility's incident log or the residents' medical record did not show these incidents were investigated. On 02/28/2020 at 11:39 AM, the above findings were shared with Staff B. Staff B stated she became aware of resident to resident altercations if staff completed an incident report, which would then be logged and an investigation completed. The above findings were shared with Staff A, Administrator, on 02/28/2020 at 10:27 AM. When asked what he expected if staff identified a resident to resident altercation, Staff A stated, We are gonna' do an investigation. That's something we do, and we need to get the facts. Do a thorough investigation because we don't take things at face value. When asked if the above incidents should be investigated, Staff A stated, Absolutely it warrants an investigation. All incidents and accidents should be investigated. These were examples of abuse and of not investigating it properly which we should be. I can see the broken system right here. Our system needs to be worked on. If the data is not there we can't do anything. REFERENCE: WAC 388-97- 0640 (6)(a)(b) .
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the office of the State Long-Term Care Ombudsman (LTCO) received required resident transfer information for three (#64, #6 and #44) of six residents reviewed for hospitalization s. Failure to ensure required notification was completed, prevented the LTCO from educating and advocating for residents regarding their rights. Findings included . RESIDENT #64 Resident #64's quarterly MDS (Minimum Data Set-an assessment tool) dated 01/24/2020 showed the resident readmitted for m the hospital on [DATE] with multiple complex medical and cognitive conditions. The assessment showed the resident originally admitted to the facility on [DATE]. Review of progress notes showed Resident #64 was hospitalized from [DATE] until 11/27/2019. Review of the resident's record did not reveal evidence that the LTCO was notified of the hospitalization . On 03/01/2020 at 11:03 AM, Staff C, Director of Social Services, was asked the facility procedure of notifying the LTCO for residents who were admitted to the hospital. Staff C said on discharge, the facility was to fax a form to the LTCO. Staff C was asked for documentation that the LTCO was notified for Resident #64's above hospitalization . On 03/02/2020 at 6:41 AM, Staff C acknowledged the facility did not notify the LTCO regarding Resident #64's above admission. RESIDENT #6 Review of the progress notes showed Resident #6 was transferred to the hospital on an emergency basis on 08/14/2019. Review of the residents' medical records did not show documentation wherein the facility notified the LTCO of the transfer. In an interview on 03/02/2020 at 6:49 AM, when asked if the LTCO was notified of the hospital transfer, Staff C stated, No. RESIDENT #44 Review of the progress notes showed Resident #44 was transferred to the hospital on an emergency basis on 10/11/2019. Review of the residents' medical records did not show documentation wherein the facility notified the LTCO of the transfer. In an interview on 03/02/2020 at 6:49 AM, when asked if the LTCO was notified of the hospital transfer, Staff C stated, No. REFERENCE WAC 388-97-0120(2)(a-d). .
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide bed hold notice in writing at the time of transfer to the hospital for three (#49, #64 and #73) of six residents reviewed for hospitalization . This failure placed residents at risk for lack of knowledge regarding the right to hold their bed while they were at the hospital. Findings included . RESIDENT #49 Review of Resident #49's annual MDS (Minimum Data Set-an assessment tool) dated 01/03/2020 showed the resident admitted on [DATE] with multiple complex medical and cognitive conditions. Review of Resident #49's progress notes showed the resident was hosptalized on [DATE] and re-admitted on [DATE]. Review of the resident's record did not show evidence notice of the facility's bed hold policy was given to the resident at the time of his hospitalization . On 03/02/2020 at 6:41 AM, Staff C, Director of Social Services, acknowledged the bed hold policy was not given to Resident #49 at the time of the above hospitalization . RESIDENT #64 Resident #64's quarterly MDS (Minimum Data Set-an assessment tool) dated 01/24/2020 showed the resident readmitted for m the hospital on [DATE] with multiple complex medical and cognitive conditions. The assessment showed the resident originally admitted to the facility on [DATE]. Review of progress notes showed Resident #64 was hospitalized from [DATE] until 11/27/2019. Review of the resident's record did not reveal evidence that the resident/resident representative received notice of the bed hold policy at the time of this hospitalization . On 03/02/2020 at 6:41 AM, Staff C acknowledged Resident #64 did not received notice of the bed hold policy at the time of the above hospitalization . RESIDENT #73 Review of progress notes showed Resident #73 transferred to the hospital on [DATE] and re-admitted to the facility on [DATE]. Review of the medical record showed no documentation staff provided Resident #73 or the Resident Representative (RR) a written bed hold notice at the time of, or shortly after, the transfer. In an interview on 03/02/2020 at 6:48 AM, when asked if the facility provided the bed hold notice to Resident #73 or their RR as required, Staff C stated, No. REFERENCE: WAC 388-97-0120 (4). .
F 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Pre-admission Screening and Resident Review (PASRR - an assessment for mental health needs) Level II recommendations were implemented for one (#77) of five residents reviewed for unnecessary medications. This failure placed the resident at risk to not receive the necessary individualized care or mental health services. Findings included . RESIDENT #77 Review of Resident #77's medical record showed he was admitted on [DATE] with multiple care needs and [DIAGNOSES REDACTED]. Review of the Electronic Health Record (EHR) showed a PASRR Level I, dated 11/07/2019, was uploaded into the resident's medical record on the day of admission. This Level I evaluation showed the resident had the [DIAGNOSES REDACTED]. (Patient) was seen by local PASRR evaluator on 11/7/19 (sic) determined appropriate for SNF discharge on this day. Pt will have SMI follow with clinical providers upon discharge. Additional review of the medical record showed a PASRR Level II evaluation was scanned into the resident's EHR on 02/25/2020. This Level II evaluation showed, . remains on a very high dose (over max (maximum) recommended) of [MEDICATION NAME] (antipsychotic). Obtain records from outpt. (outpatient) psychiatric provider to obtain additional psychiatric history and establish rationale for various medications. Refer for psychiatric consult, neurology consult. In addition, this evaluation also showed, Recommendations for nursing facility . Ancillary Services: Vision. Review of the medical record showed no documentation the facility followed up with the PASRR Level II recommendations for a neurology or vision evaluations, or obtained psychiatric history to explain an over the maximum dose of an antipsychotic. In an interview on 03/02/2020 at 7:07 AM, when asked when the PASRR Level II was requested, Staff C, Director of Social Services stated, I had to call and ask for the Level II. When asked when did she call to obtain the Level II evaluation, Staff C stated, Recently, in February. When asked if waiting over three months was an acceptable timeframe to procure the Level II recommendations, Staff C acknowledged the delay in processing the Level II recommendations and stated, Within 30 days it (the recommendations) should usually be here. REFERENCE WAC 388-97-1915(4) .
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 ensure care plans were accurate/current for three (#42, #49 and #36) of 19 sample residents whose care plans were reviewed. This failure placed residents at risk for care

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) errors. Findings included . RESIDENT #42 Resident #42 admitted on [DATE] with care needs related to depression, dementia and other chronic illnesses. Review of the resident's Care Plan (CP), last revised on 01/30/2020, included problems such as: 1. the presence of a skin-tear on his right forearm, first identified on 08/2019. Review of recent weekly skin checks for the month of February 2020 found his skin was intact. 2. A second problem identified 11/06/2019, said the resident was a new admit and was adjusting to his recent placement in the facility. At the time of survey, Resident #42 had lived in the facility for over 15 months. On 03/03/2020 at 1:30 PM, the above information was reviewed with Staff B, Director of Nursing (DON), who acknowledged these issues were not current and the CP needed revision. RESIDENT #49 On 02/29/2020 at 8:57 AM, Resident #49 was observed to have several missing lower teeth. Resident #49's annual MDS (Minimum Data Set-an assessment tool) dated 01/03/2020 showed the resident admitted on [DATE] and had a cavity or broken teeth. The MDS showed the resident was seen by the dentist the previous (NAME)and the dentist recommended having all upper teeth removed, as well as a few on the bottom, but the resident had declined this at that time. Review of Resident #49's Medication Administration Record [REDACTED]. Documentation by an outside-facility dental agency on 08/26/2019 showed a dental recommendation to make a full upper denture and a lower partial denture On 03/01/2020, review of Resident #49's care plan, last revised 0[DATE], showed the resident had broken and missing teeth, but did not include information about the recommended dental recommendation as above. The care plan also showed the resident was administered [MEDICATION NAME] ([MEDICATION NAME]) which had been discontinued. On 03/01/2020 Staff I, Registered Nurse (RN) acknowledged Resident #49's care plan had to be updated to remove the [MEDICATION NAME], as well as to include the recommendations for dental follow-up. RESIDENT #36 Review of a 09/27/2019 Significant Change MDS showed Resident #36 had a Stage 3 pressure ulcer, and used a pressure reducing device for the chair and bed. An observation on 03/01/20 at 8:30 AM showed Resident # 36 sitting in a wheel chair in his room, with a cushion underneath him. An overlay mattress was observed on the bed. Review of a 02/26/2020 wound consult note showed the resident had a right hip pressure ulcer since 09/10/2019. Review of a Skin CP, initiated on 05/26/2019 and revised on 04/22/2019, showed the resident, has potential for impairment to skin integrity r/t urinary incontinence, [MEDICAL CONDITION] (lung disease), lung CA (cancer), [MEDICAL CONDITION] (low blood pressure), [MEDICAL CONDITION]. This CP had the interventions to apply barrier ointment after each incontinent episode (initiated 05/26/2016), diet snacks supplements as ordered (03/06/2017), weekly skin check (05/26/2016), and observe skin during routine care (05/26/2016). This CP showed no additional revision to reflect the resident's current pressure ulcer, or interventions that addressed the management and prevention of additional pressure ulcers. In an interview on 03/02/2020 at 8:56 AM, when asked if the CP should be revised to reflect the presence of a pressure ulcer, including interventions to manage and prevent future pressure ulcers, Staff K, Charge Nurse, replied, Yes, of course. REFERENCE: WAC 388-97-1020(2)(c)(d) .
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 interview and record review, the facility failed to ensure one (#66) of one residents reviewed for [MEDICAL TREATMENT] had consistent monitoring of the [MEDICAL TREATMENT] site by Licensed Nurses (LNs) as ordered. For one of one residents (#8) reviewed for tube feeding and one (#49) of five residents reviewed for unnecessary medications, the facility failed to have clear/complete orders. These failures placed residents at risk for care errors or omissions. Findings included . RESIDENT #66 Resident #66 admitted [DATE] with care needs related to dementia and kidney disease. Since her admission, she received [MEDICAL TREATMENT] three times per week. Her current care plan, last revised on 01/30/2020, identified her ongoing need for [MEDICAL TREATMENT] at a community [MEDICAL TREATMENT] center. Review of her current physician orders [REDACTED]. Review of monitoring by LNs documented during February 2020, found six shifts when staff on duty did not document they had completed monitoring of the shunt as ordered. The absence of this information was discussed with Staff B, Director of Nursing, on 03/03/2020 at 1:40 PM. RESIDENT #8 Resident #8's 02/19/2020 quarterly MDS (Minimum Data Set-an assessment tool) showed the resident re-admitted on [DATE], and received nutrition by enteral feeding (a tube in the stomach). Review of Resident #8's February 2020 Treatment Administration Record (TAR) showed a 08/26/2019 order, Enteral Feed Order every 3 hours Document the amount water 175 ml (milliliters) q (every) 3 hours (sic). On 02/28/2020 at 9:06, Staff L, Licensed Practical Nurse (LPN) was asked the meaning of the above order, which appeared unclear. Staff L said, Yes it is very confusing and Im going to fix it. Review of Resident #8's February 2020 TAR also showed a 08/26/2020 order to check the residual amount in the resident's stomach before administering feeding, flush and medications, but the amounts of the residuals were not recorded. On 02/28/2020 at 9:06 AM, Staff L was asked if the amounts of the residuals should be documented, and she replied they should. RESIDENT #49 Review of Resident #49's February 2020 Medication Administration Record [REDACTED]. Although check marks indicated administration of the supplement, the amount consumed by the resident was not documented. On 03/01/2020 at 12:51 PM, this finding was discussed with Staff I, Registered Nurse (RN) who acknowledged amount of supplements consumed should be documented in the MAR. Review of Resident #49's February 2020 TAR showed a 02/13/2020 order to administer oxygen at one to four liters by nasal cannula .as needed for SOB (shortness of breath)/low sat (oxygen saturation). The order did not specify what level of oxygen saturation constituted a low level. On 03/01/2020 at 12:36 PM, this finding was discussed with Staff I, who acknowledged the order needed clarification and said, We're supposed to write the parameters. REFERENCE WAC 388-97-1620(2)(b)(i)(ii), (6)(b)(i) .
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.** Based on interview and record review, the facility failed to follow bowel interventions for one (#73) of five residents reviewed for unnecessary medications. This failure placed the resident at risk for unmet care needs and discomfort. Findings included . RESIDENT #73 Review of a bowel movement (BM) flow sheet showed Resident #73 did not have a BM for five days, between 02/03/2020 and 02/07/2020. Review of the February 2020 Medication Administration Record [REDACTED]. This order did not show when to administer the MOM when staff identified constipation. This MAR indicated [REDACTED]. This MAR indicated [REDACTED]. Review of the MAR indicated [REDACTED]. The MAR indicated [REDACTED]. In an interview on 03/01/2020 at 12:11 PM, when asked how licensed nurses initiated the bowel protocol, Staff T, Licensed Practical Nurse (LPN), stated, It depends on their orders. I think your standard policy is three days without a BM. When asked if staff followed the bowel protocol for Resident #73 between 02/03/2020 and 02/07/2020, Staff T stated, No. When asked if Resident #73 should have received PRN laxatives when the record showed she had a BM hours preceding the PRN laxative administration, Staff T stated, No. REFERENCE: WAC 388-97-1060(1) .
F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	**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 develop, implement and re-evaluate interventions to prevent recurrence of falls or fall-related injuries for one (#77) of five residents reviewed for unnecessary medications. This failure resulted in harm to Resident #77, who had 12 falls between 11/11/2019 and 02/27/2020, sustained small lacerations to his head, eye or cheek, and required two hospital transfers due to lacerations incurred with falls. For one of the other five residents reviewed (#49), the facility failed to complete root cause analysis of five falls, one of which resulted in an injury. This failure resulted in staff inability to prevent recurring falls related to not completing assessments or revising care plans. Findings included . A July 2018 facility policy titled Accident Hazards/Supervision/Devices showed the facility would evaluate potential causative factors to help in the development and implementation of relevant, consistent and individualized interventions to

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 6) reduce the likelihood of recurrent falls. This policy showed the facility would determine what caused or contributed to the fall, including what the resident tried to do before the fall, and the resident's care plan or facility practices would be revised as needed to reduce the likelihood of another fall. RESIDENT #77 Review of the medical record showed Resident #77 admitted to the facility on [DATE]. An 11/19/2019 Care Assessment Area (CAA) note showed, The resident has had several falls at his prior living situation, AFH (Adult Family Home). He has had two falls here, one at the bedside at 7 in the morning trying to transfer without assistance. He lost his balance and fell on his bottom. He had a second fall in the mens (sic) room, trying to transfer himself, this occurred at 915 in the morning. He is impulsive and still wants to be independent. He is at risk for falls due to dementia, [MEDICAL CONDITIONS] (lung disease). He is currently working with PT (Physical Therapy) and OT (Occupational Therapy) for improved mobility, ADL's (Activities of Daily Living), balance and safety. He is not safe walking on his own. He is able to use the w/c (wheel chair) independently but still needs help with transfers. Review of an 11/09/2019 OT Evaluation showed, Patient Goals: patient stated, I want to get stronger and not fall. Review of a Falls CP, with a date initiated and revised of 11/11/2019, identified contributing factors of Poor communication/comprehension. Interventions, also dated 11/11/2019, showed staff were to monitor changes in mental status, pain or bruises and to take vital signs one time in the first 24 hours. The resident's CP showed no additional interventions after 11/11/2019 to prevent further falls. Another Falls CP, dated 11/20/2019, showed, The resident is at risk for falls, and identified contributing factors of, Confusion, Gait/ (and) balance problems, incontinence, Poor communication/comprehension, psychoactive drug use, unaware of safety needs, vision/hearing problems. This CP showed interventions, dated 11/20/2019, which included, Anticipate and meet the resident's needs, Be sure the call light is within reach and encourage the resident to use it for assistance as needed, Bed against the wall, Ensure commonly used items are within reach of resident prior to leaving room, Ensure the resident is wearing appropriate footwear (non skid shoes, non-skid socks, etc.) prior to transfers or ambulating, PT to evaluate and treat as ordered, and to, Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter (or) remove any potential causes. The resident's CP showed no additional interventions after 11/20/2019 to prevent further falls. Review of an 11/11/2019 progress note timed at 7:15 AM showed, noted resident was sitting on the floor and facing his bed. He denies hitting his head but he did fall to the floor. Review of an 11/11/2019 Incident Report (IR) showed, He (Resident) stated he tripped on the ft. (foot) rest of w/c (wheel chair) - He was not wearing shoes, only socks on ft (feet). This investigation showed the Plan to Prevent Recurrence was to Encourage resident to ask for assist. Frequent checks. Ensure w/c breaks (sic) are on. This investigation showed the facility discussed the fall with therapy services during Stand Up (an interdisciplinary meeting). In an interview on 03/01/20 at 8:39 AM, when asked if the interventions showed how often staff would frequently check on Resident #77, that staff should ensure his wheel chair brakes were on, or how staff would anticipate the needs of a resident identified with cognitive and communication impairments, Staff B, Director of Nursing, stated, I don't know how. It's a generic or canned intervention. Review of an 11/12/2019 progress note timed at 9:48 AM showed, found (Resident) on the floor, middle stall, sitting on the foot rests of his w/c, the back of his w/c was leaning over him. Resident was holding on to the bathroom rail with his right hand . Resident was fully dressed but only wearing socks. Resident had PT/OT eval but they are currently not working with him. Will discuss with SS (Social Services) and DNS (Director of Nursing Services) for room change closer to the NS (Nursing Station) r/t (related to) his impulsive behavior . Review of the 11/12/2019 IR showed, He was up using restroom, and Bathroom is too sm (small) space, for his w/c & (and) him to use. This report showed the plan to prevent recurrence was, Move to room [ROOM NUMBER]B . for closer observation, and Let resident know he can he can use alternate bathroom (shower room). cont (continue) with PT/OT for transfer, standing balance, and ADLS. This investigation showed the facility discussed the fall with therapy services. Review of an 11/13/2019 PT note showed, Pt (Patient) educated and instructed to safety with using call light and wait for assist before getting up . Pt has had two falls in this week, in his room and in his BR (bathroom). When asked if the facility assessed Resident #77's toileting pattern to assist staff to anticipate the resident's self-transfers associated with toileting needs, Staff B stated in this continued interview, His short term memory is not great and he is totally incontinent. He doesn't self-initiate going to the bathroom. When asked if the fall interventions directed staff to an alternate toileting location that would accommodate the resident's wheel chair, Staff B stated, I'd have to look. No further information was provided by Staff B. A progress note dated 11/14/19 and timed at 11:58 AM showed, Res. (Resident) was attempting to transfer himself from bed to w/c. The w/c rolled back. When res attempted to sit back on the bed, he was further away and sat on the very edge. He was able to lower himself to the floor as writer made it to him. An 11/14/2019 IR showed, Resident trying to go to WC, as the resident's intent. The staff identified the plan to prevent recurrence was to, Encourage resident to ask for assist. Encourage resident to lock brakes. This IR's summary showed the resident, Forgot to lock brakes was the root cause of this fall. This investigation showed the facility discussed the fall with therapy services during Stand Up. Review of an 11/14/2019 PT note showed, Instruction and education on safety awareness with transfers and use of call light. An 11/15/2019 PT note showed, Pt instructed on brakes and safety awareness. Pt encouraged to use call light. An 11/18/2019 PT note showed, Pt is encouraged to use call light to remove risk for falls. In this continued interview, when asked if the facility established why Resident #77 wanted to get out of bed, Staff B stated, I don't know that we would have looked at that. I don't see it. When asked if establishing why the resident wanted to get out of bed would help to anticipate his needs, Staff B stated, I don't think the etiology of why he was trying to get up was looked at. When asked if the investigation showed when was the last time staff checked on Resident #77 prior to the fall, Staff B stated, I don't see it. Review of a 12/04/2019 progress note showed, At 00:20 (12:20 AM) patient fell on the floor while transferring himself from wheel chair to bed. he pressed the call light to get our attention, he landed on his right hip, tried to catch himself by grabbing wheel chair and bed . his pants were around his ankles, wearing socks, wheel chair was locked . stated he lost his balance . Review of a 12/04/19 IR showed the resident's intent was, Attempting to transfer to bed. This report also showed the resident was referred to therapy and the plan to prevent recurrence was, Re-educated him (Resident) on asking for assistance . Continue with POC (Plan of Care) to continue to improve transfers and calling for help. Record review showed no results from the therapy referral. In this continued interview, when asked how staff compensated for and anticipated the needs of an impulsive resident with cognitive and communication impairments, Staff B answered, They just took his wheel chair and kept it out at night. When asked if the investigation showed what Resident #77 was doing prior to the attempted transfer from wheel chair to bed, Staff B stated, I can't speak to that. When asked if the investigation showed why the resident's pants were found around his ankles, Staff B stated, I don't see it. When asked if the interventions to prevent recurrence of falls changed, Staff B stated, I don't see it. Review of a 12/05/2019 progress note showed, Still cont (continues) to self transfer, occ (occasionally) forgetting to lock his w/c brakes. Review of a 12/11/2019 progress note showed, At 3 am writer heard noise from room & (and) checked, Resi (Resident) was on floor in lying left position close to the bed. Resident did not press his call light for help. Not hit his head . found small skin scrape on his left cheek. Resident did not verbalize how he was on the floor. He was more sleepy and confused. An IR dated 12/11/2019 showed the assigned care giver was not identified. This IR also showed the staff identified the medications [MEDICATION NAME] (antipsychotic) and [MEDICATION NAME] (anticonvulsants) had been increased on 12/07/2019 and 12/10/2019 respectively. In addition, this IR showed the plan to prevent recurrence included, Educate resident to press call light for help, and to, Instruct na-c (Nursing Assistant Certified) to make round frequent to check for toileting/transfer. This IR's summary showed, . appear to be secondary to attempting to transfer himself in a confused state. In this continued interview, when asked if the IR showed why the resident transferred on his own, what he was doing before the fall, or if the assigned care giver was interviewed, Staff B stated, No. When asked if the facility followed up on the identified sleepiness and its potential impact on falls, Staff B stated, No. When asked if the interventions to prevent or decrease falls changed to reflect frequent checks on the resident in order to anticipate toileting and transfer needs, Staff B stated, Don't see it. When asked if the facility put measures in place to compensate for the resident's impaired cognition, Staff B stated, No. When asked if educating a cognitively impaired and impulsive resident was a realistic intervention when the resident continued to show he did not alert the staff to assist him with toileting needs or transfers, Staff B stated, Probably not. Review of a 12/11/2019 progress note showed, Around 3:30am resi (resident) fell again on the floor and hit his head. Unknown how or what he hit when he fell . Writer noted to have blood on his right side of his head into his hairline. Resident was not responding to question, he turned to look at this writer and noted he has a deep laceration . Called 911 . sent to the VA hospital for further assessment. A 12/11/2019 IR showed the assigned care giver was not identified. This IR showed a referral was made to PT. This IR's summary showed, He is incontinent and does not appear to be responding to needs to toilet. Record review showed no results from the therapy referral. In this continued interview,

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F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 7) when asked if the interventions changed to prevent falls associated with self-transfers or injury from falls, Staff B stated, No. When asked if the CP changed to address toileting needs as the facility identified he does not appear to be responding to needs of toilet, Staff B stated, I'd have to find out. When asked what the result of the therapy referral was, Staff B stated, I'd have to check with Staff E (Therapy Director). No further information was provided. Review of a social services note dated 12/11/2019 showed, It is unclear what his baseline is but his AFH (Adult Family Home) caregiver did tell this writer that he always got up in the middle of the night to smoke and had many falls at the time. He even broke his nose falling in his home at one point. When asked if the facility modified interventions to show Resident #77 had a pattern of falling at night, Staff B stated, I don't know. Have to ask the case manager that charted it. No further information was provided. A [DATE] progress note timed at 1146 PM showed, Res found on floor lying on his abdomen side in his room small lacerations in his left eye brow hairline. basic first aid provided. And assisted back him to W/C. A 12/13/19 IR showed, Resident didn't verbalized (sic) how he fell from bed, and that wc was standing outside the room. This IR also showed the plan to prevent recurrence was to, Educate the resident to press the call light when he needs help. Ensure with CNA to make frequent rounds in this shift. This IR showed the resident's blood pressure dropped from lying to sitting position from 141/67 to 121/69, which reflected postural [MEDICAL CONDITION], a risk factor for falls. This IR showed the facility discussed the fall with therapy services during Stand Up. In this continued interview, when asked if the record showed the facility addressed the assessment of postural [MEDICAL CONDITION], Staff B stated, I will look if nurse reassessed. When asked if staff determined why the wheel chair was found outside of the room, what the resident was doing before the fall, and when was the last time Resident #77 was checked on, Staff B stated, No. When asked if staff determined why the resident got out of bed or his intent, Staff B stated, No. When asked how the interventions changed to prevent falls associated with self-transfers or injury from falls, Staff B stated, I'm not sure. I don't know. When asked if the repeated intervention of educating the resident to use the call light was appropriate after seven falls, Staff B stated, I have no answer for that. Review of a 01/07/2020 progress note, timed at 12:12 PM showed, Res found lying on the floor next to his bed .noting small puddle of blood on the floor under his head. Resident was fully dressed, but wearing no nonskid socks . Small superficial laceration on the back of his head . CNA reported that she helped him into his wc and it appeared that he was trying to get back into bed and fell towards the left side of his wc. Record review showed no documentation staff conducted a review of this fall. On 03/01/2020 at 09:15 AM, Staff B acknowledged the facility did not conduct an analysis of this fall or addressed interventions to prevent falls or falls with injury. Review of a 01/12/2020 progress note timed at 6:50 AM showed, Writer called by med (medication) nurse to assess resident in room [ROOM NUMBER]A. He was lying on the floor next to his bed. He has laceration to his head, little bit of blood noted. No need of dressing, and that Resident #77 told the nurse, I was trying to transfer to the w/c and fell down. Review of the IR report dated 01/12/2020 showed, He (Resident) was trying to transfer himself from bed to w/c as per his usual bx (behavior). This IR showed the plan to prevent recurrence was, Encourage him to use call light. Keep the w/c out of his room. Call light within reach. The report's summary showed, Too impulsive to have WC @ (at) bedside. Reminded to call us for assist to get up. In this continued interview, when asked if it was a realistic intervention to expect an impulsive and cognitively impaired resident to consistently use the call light or call staff for assist, or if those interventions were effective in decreasing falls, Staff B stated, No, and acknowledged the facility did not develop and implement interventions to decrease a pattern of falls or falls with injury since 11/20/2019. Review of a progress note dated 01/18/2020 showed, At 2130 (9:30 PM) CNA (Certified Nursing Assistant) notified writer that res is on the floor. Upon arrival, res was sitting next to the bed. Res states he sat down Review of the IR dated 01/18/20 showed, Res was trying to put himself in bed but when he couldn't get in, he sat down next to bed looks like res was trying to put himself in the bed. The report showed the plan to prevent recurrence was, educated on the need for call light use when needing help with transfers, keeping bed in lowest position, and watching out for surrounding furniture/environment/loose cords to prevent future falls. This investigation showed the facility discussed the fall with therapy services during Stand Up. This report's summary showed, (Fall) Appears related to self transfer from w/c to bed. Continue reminders to request assist. When asked how staff determined the fall was related to environmental factors, like surrounding furniture or loose cords, Staff B stated, I just assumed. I don't think it has anything to do with the fall. Review of a progress note dated 01/19/2020 at 1:04 PM showed, . Res is on the floor in fetal position facing toward the door; asked res what happened and stated 'I don't know i fell ' noted smear of blood near edge of the right side of the dresser . small laceration noted 1 cm right side of his head . This writer asked him again what happen (sic) and stated that he wants to transfer to his w/c. Record review showed no documentation staff conducted a review of this fall. On 03/01/2020 at 09:15 AM, Staff B acknowledged the facility did not conduct an analysis of this fall or addressed interventions to prevent falls or falls with injury. Review of a 02/27/2020 progress note showed, Called to room [ROOM NUMBER] to find res lying on his back in the door way Had no shoes on . When res lifted his head, noted active bleeding. Res stated he was attempting to get into his wc, lost his balance, fell backward and hit the floor, Res has a 1 (inch) deep laceration on the back of his head. drsg applied to stop the bleeding . call to (ambulance service) for ER (emergency room) visit for poss (possible) sutures. In an interview on 02/28/2020 at 12:12 PM, when asked about therapy's involvement with Resident #77's falls, Staff E stated, With Resident #77 it was his cognition that was an issue. He is unable to remember when to use the call light and lock his brakes and wait for assistance. When asked what was implemented to compensate for Resident #77's cognitive and impulse deficits, Staff E stated, I don't know how we would work with someone unable to follow directions or has memory deficits for those types of things. It would be nursing, it's not a PT situation. Review of the above falls showed Resident #77 fell a total of 12 times between 11/11/2019 and 02/27/2020, and continued to fall nine times after 11/20/19, the date of the last CP revision for fall interventions. On 12/11/2019, [DATE], 01/07/2020 and 01/19/2020, the staff assessed the resident sustained [REDACTED]. In addition, on 12/11/2019 and 02/27/2020, the resident required a hospital transfer to address a deep laceration to the head associated with a fall. When asked if the facility evaluated factors, and developed and implemented relevant and individualized interventions, to reduce future occurrences of falls or injuries from falls between 11/21/2019 and 02/27/2020, Staff B stated, No. Obviously not well enough. RESIDENT #49 Resident #49's Annual MDS (Minimum Data Set-an assessment tool), dated 01/03/2020, showed the resident admitted on [DATE] with multiple complex medical and cognitive conditions. Review of progress notes for Resident #49 showed the following falls: 11/04/2019: Found on floor, 11/09/2019: .found screaming on floor ., 11/14/2019: found resident .sprawled on the floor ., 11/23/2019: found .on the ground outside. A note of 01/08/2020 showed the resident was found on the floor and had bleeding from the forehead. Record review, including the IR log, showed no indication the facility completed reviews or root cause analyses of the falls noted in the progress notes above. Resident #49's care plan, last revised 0[DATE]20, showed the resident was at risk for falls. The plan instructed to review past falls, .attempt to determine cause of falls and Record possible root causes. The care plan listed the dates of nine falls which occurred 04/17/2019 to 01/08/2020. The corresponding interventions section had not been updated since 04/17/2019, the date of the resident's first fall. There was no indication the facility made ongoing care plan revisions to prevent recurring falls. On 03/02/2020 at 8:40 AM, the above findings were shared with Staff B, who said she would research the findings. No further information was received. REFERENCE: WAC 388-97-1060(3)(g). .
F 0700 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to use other alternatives to side rails, recognize or protect one resident (#74) of six, a dependent resident for bed mobility, from the dangers of entrapment after gathering information and completing assessments; failed to have a system in place to monitor and or maintain bedrails; failed to assess and provided risk information for side rail use, for two residents (#8 and #22) of six residents. These failures placed the other residents at risk for harm, such as entrapment. This failure resulted in an Immediate Jeopardy (IJ) related to side rails on 02/23/2020. The facility re-evaluated and modified Resident #74's side rails and provided training for all licensed staff, which led to the removal of this IJ on 02/25/20. Findings included . Review of a February 2018

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F 0700 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 8) facility policy titled Quality of Care Bed Rails showed the facility would attempt to use alternatives prior to installing a bed rail. It also stated, prior to implementation, the facility would assess each resident for risk of entrapment. The policy showed that if a bed rail was implemented, the resident would be re-assessed at routine intervals to verify its need. RESIDENT #74 A 02/07/2020 quarterly MDS (Minimum Data Set-an assessment tool) showed Resident #74 was admitted to the facility on [DATE] with multiple complex conditions including a neurological condition with symptoms of muscle spasms affecting movement and posture, a [MEDICAL CONDITION] disorder, muscle weakness and severe intellectual disability. The assessment showed the resident did not speak, rarely/never understood others, and had short term and long term memory problems. The assessment also showed the resident had severely impaired cognitive skills for daily decision making and had physical behaviors directed toward others. The assessment showed the resident was totally dependent on two persons for bed mobility, did not walk, and had range of motion (ROM) impairments of all extremities. The assessment endorsed the use of bed rails daily. Resident #74's 11/11/2019 admission MDS also showed daily bed rail use, and stated, .two side rails due to frequent [MEDICAL CONDITION], and He is always placed in the middle of the bed but he can occ (occasionally) scoot. The MDS said the resident could not sit up on his own, stand or bear weight. The MDS also showed the resident .may be appropriate for a low bed and mat next to bed, may approach family with this later. Review of an 11/07/2020 interdisciplinary care plan conference note showed Resident #74's parents indicated the resident, .has the capacity of a 7-9 month old. Resident #74's care plan (CP), last revised 02/20/2020, showed the resident had two assist rails for bed mobility. In another entry the CP said the resident had a half rail to allow the resident to, .move freely while in bed r/t (related to) [MEDICAL CONDITION] activity and (Resident #74's neurological diagnosis). The care plan said the resident had a behavior of hitting or biting himself if in pain, was at risk for falls, and was Unaware of safety needs. The care plan stated, The resident uses physical restraints r/t bilat (bilateral) rails. The plan instructed to Evaluate the resident's restraint at least quarterly. Review of a Medication Administration Record [REDACTED]. Review of a Physical Therapy (PT) evaluation dated 11/06/2020 for Resident #74 showed the resident had impaired ROM of all extremities, impaired strength in the lower extremities, and contractions in the right hand, both ankles and the right knee. The evaluation did not include a side rail evaluation. Review of a Fall Risk Evaluation dated 02/03/2020 showed the resident was not at risk for falls, and had decreased muscular coordination. Review of provider orders showed on 11/04/2019 a physician wrote an order, May have bedrails to assist with bed mobility and for [MEDICAL CONDITION]. Review of a Bed Rail Screen dated 11/04/2019 showed the rationale for bed rail use was Medical Condition, specified as [MEDICAL CONDITION] and a neurological disease, and the resident displayed impaired safety awareness. The question, Have alternatives to bed rails been attempted? was answered, NA (not applicable)-Resident/Family refuse (sic) alternatives to bed rails. The screen showed the document included comments by staff, Family very concerned of resident not having rails as he uses also for bed positioning and due to [MEDICAL CONDITION] activity and .no ability to understand safe or unsafe instructions. The screen showed the resident had spontaneous body movement and instability when sitting. The question, Is the resident able to move self in bed? was answered Yes. It also said the resident could move himself side to side, up and down in the bed, and could pull himself to a seated position. Progress notes dated 11/07/2019 showed Resident #74 was .restless throughout the night . On 11/08/2019 the resident had increased agitation. A note of 11/11/2019 showed the resident was .easily agitated . Review of [MEDICAL CONDITION] Episode forms showed Resident #74 had a three second [MEDICAL CONDITION] on 11/29/2019 which included jerking of his left arm and left leg. Another [MEDICAL CONDITION] Episode form showed on the same day the resident had a 30 second [MEDICAL CONDITION] which included jerking of his left arm and both legs. SURVEY OBSERVATIONS Initial observation on 02/23/2020 at 8:53 AM showed Resident #74 in a bed with side rails raised on both sides of the bed. The side rails were located along the middle two thirds of the bed. Both rails were uncovered metal about an inch and a half in diameter, and consisted of a top, middle and lower bar. On the same day at 12:54 PM, the resident was observed in bed with both side rails raised. The head of the bed was elevated, and the resident's head leaning to his left. On 02/23/2020 at 1:38 PM, the resident's right side rail was observed to have a four and a half inch space between the top and middle rail. The space between the middle and bottom rails was five inches. No padding or pillows were on or near the rails. At this time, Resident #74 was observed to be repeatedly lifting up and banging down his left arm on the mattress. INTERVIEWS On 02/23/2020 at 9:00 AM, Resident #74's representative was asked why the resident had side rails. The representative replied the resident had [MEDICAL CONDITION] at night, and the rails were there so the resident would not fall on the floor during a [MEDICAL CONDITION]. He was asked how long the resident had had the rails. He said since the resident's admission three to four months prior. The representative was asked if Resident #74 could use the rails to reposition himself, and he replied the resident could not. On 02/23/2020 at 11:58 AM, Staff H, Certified Nursing Assistant (CNA) was asked why Resident #74 had side rails on his bed. Staff H replied it was because the resident got excited and it helped him not to fall. Staff H was asked what she meant by excited and said this meant the resident curled himself up in bed and tried to roll over to the side. Staff H commented, Sometimes we find him over to the side, so the rail helps prevent him from falling. On 02/23/2020 at 1:01 PM, Staff I, Registered Nurse (RN) and charge nurse, was asked if she had ever observed agitated behavior by Resident #74. Staff I said she had, and she was asked what this behavior had looked like. Staff I described the behavior as hyper. When asked what she meant by hyper, Staff I demonstrated by moving her arms around in a chaotic manner. Staff I said the resident's family wanted a pillow inside each side rail so the resident, can't kick the side rail. Staff I said the resident was not capable of using a side rail and did not reposition himself. Staff I was then asked why Resident #74 had side rails, and replied, Just for the safety reason because sometimes he's hyperactive . so he wouldn't jump out or fall from the bed. Staff I was asked if she thought there was any risk of injury related to Resident #74's side rails and she said there was not. When asked why this was, Staff I said it was because the resident could not jump, never hit his head, and had no falls. Staff I concluded the resident's family wanted side rails in place, and we're just following them (their instructions). When Staff I was asked if the purpose of the side rails was to keep the resident in bed, she replied it was. INTERVIEW DIRECTOR OF NURSING On 02/23/2020 at 3:37 PM, Staff B, the Director of Nursing (DON) said side rails rarely were used at the facility, and they were usually used for positioning purposes. Staff B said it was the facility's practice to try everything before using a bed device. Staff B was asked if she was aware Resident #74 had side rails on his bed. Staff B said she remembered the resident's parents wanted side rails, and added, We were going to try to get rid of them. When asked the reason for this, Staff B said it was because the facility was going to try alternatives. Staff B said the staff told Resident #74's family the facility was not supposed to use side rails, .but I remember the family really wanting them. Staff B was asked if using side rails for this resident placed him at risk. Staff B replied the resident had no ability to get out or over the rails, and clinically had no risk because the rails did not restrict the resident from doing anything. Staff B said of Resident #74's side rails, they were there for safety and, They're there basically there to keep his family happy. Staff B then commented, I'm sure we're acquiescing to what they (his family) believe to be the safest, We've done what we've done with (Resident #74) because of his family, and his family was .very insistent that this (use of side rails) was what needed to be done. Staff B said she didn't know if anyone approached the family about removal of the side rails. A Bed Rail Screen done 02/23/2020 at 6:30 PM showed the indication for side rails for Resident #74 were documented as, Medical condition and Family Request, and that alternatives to bed rails had not been attempted. RECONFIGURED SIDE RAILS On 02/25/2020 at 9:30 AM, Resident #74 was observed in bed. The two side rails were raised, and had been padded with pillows on the inner aspect of each side rails. The pillows were held in place by pillow cases. FOLLOW-UP INTERVIEWS On 03/02/2020 at 7:43 AM, Staff E, Therapy Director, was asked if therapy had evaluated the resident's side rails. Staff E referenced the physical therapy assessment done on 02/27/2020. Staff E said staff needed to keep the side rails padded due to the potential for injury to the resident, since he could hit his head or slip an arm through a rail. On 02/25/2020 at 9:30 AM, during a follow-up interview with Resident #74's representative, he said he was still concerned about the resident falling out of bed during a [MEDICAL CONDITION]. The representative was asked what the resident did during a [MEDICAL CONDITION] and the representative replied the resident's hands and legs curled up, and when he did this, his body rolled away, which made him fear the resident would fall to the floor. The representative said during a [MEDICAL CONDITION], the resident's body would move side to side and the resident could not control his body. When asked if the resident could have gotten stuck in the rails during a [MEDICAL CONDITION], the representative said he could. The representative was asked what he thought of the padded side rail modifications. He replied it was good for the resident's safety. SIDE RAIL MONITORING On 03/03/2020 at 10:29 AM, Staff D, Maintenance Director, was asked if there was a system of inspection of beds, rails and mattresses for resident safety. Staff D replied this was something staff was working on but had not been assigned to him. When asked who was responsible for inspecting bed rails before safety issues were identified during survey, Staff D replied, I don't know who it would be. I assume it would

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F 0700 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 9) be nursing, right? Cause they're the ones that order the bed rails. Staff D said he had installed bed rails to Resident #74's bed. On 03/04/2020 at 9:18 AM, Staff A, Administrator, was asked what measure the facility used to ensure beds and side rails were inspected on a routine basis for safety. Staff A said he believed Staff D inspected side rails monthly and as needed. Staff A was asked if there was a record of regular bed/bed rail inspections and he replied Staff D logged the side rail inspections in a software program. At 10:14 AM, Staff A was asked for the side rail safety audit. Staff A said he did not have it, and that perhaps Staff D had not done it. RESIDENT #8 The 02/19/2020 quarterly MDS for Resident #8 showed the resident re-admitted on [DATE] with multiple complex medical and psychological conditions, including [MEDICAL CONDITION], hallucinations, delusions, and a progressive [MEDICAL CONDITION] condition of the nervous system. The assessment showed the resident had unclear speech, moderately impaired vision, and had short and long term memory problems. The assessment showed the resident had moderately impaired skills for daily life decisions and her behaviors included inattention, and intermittent disorganized thinking. The assessment also showed the resident was dependent on staff for bed mobility and transfers, and did not use restraints or bed rails. During the afternoon of 02/23/2020 Resident #8 was observed to have a raised side rail along the upper left side of her bed. On 03/04/2020 at 8:00 AM, the resident's bed was observed to have no side rails in use. Review of Resident #8's medical record did not reveal evidence of a safety evaluation for side rail use. Review of physician orders [REDACTED]. side rails on bed to aid in mobility and transfers per her request. Review of Resident #8's care plan, last revised 02/23/2020, showed that on 02/23/2020 the plan was revised to include the statement, Resident uses left side rails to aid on bed mobility per her request. On 03/04/2020 at 8:26 AM, Staff B said she thought side rails were initiated after Resident #8 changed rooms. Staff B said due to a change in rooms, a resident might be placed in a bed with side rails previously attached. Staff B said she saw the side rail on Resident #8's bed when a facility reassessment of side rail use was done. Staff B said, She (Resident #8) does not need a side rail and the side rail previously observed on Resident #8's bed was used by another resident. Staff B said after she observed the rail in use she asked Staff D to remove it. RESIDENT #22 Review of the medical record showed Resident #22 admitted to the facility on [DATE] with multiple care needs and [DIAGNOSES REDACTED]. A [DATE] Quarterly MDS showed Resident #22 was assessed to have moderately impaired cognition. Observations on 02/23/2020 at 1:00 PM and 03/04/2020 at 8:49 AM showed a raised quarter rail on the right side of Resident #22's bed. Review of Resident #22's care plan, revised on 0[DATE]20, showed The resident uses grab bar rail that is on the right side of bed to help with bed mobility, transfers, and sitting up in bed. Interventions included, Assess for appropriateness of the rail at least quarterly. Review of the medical record showed an order, dated 02/23/2020, which read, Quarter Rails that stands straight up on the right side of the bed to assist resident with mobility and with sitting self up in bed. In addition, review of the medical record showed a Bed Rail Screen completed 0[DATE]20. No previous Bed Rail Screens were found. In an interview on 03/04/2020 at 8:55 AM, when asked how long the quarter side rail had been in use for Resident #22, Staff O, Certified Nursing Assistant (CNA), stated, For a long time, more than three years 'cause she used to be independent. In an interview on 03/04/2020 at approximately 8:30 AM, when asked how long the quarter side rail had been in use by Resident #22, Staff P, Licensed Practical Nurse (LPN) stated, At least nine months ago she has had it. The above findings were shared with Staff K, Charge Nurse, on 03/04/2020 at 8:58 AM. When asked how long the quarter side rails had been in use by Resident #22, Staff K stated, I'm not sure . it's not been that long probably six months or so since she had had the rail. When asked how often bed rail screens were conducted, Staff K stated, Every three months, and acknowledged, We are in error, we should have done the assessment every three months. When asked if there was an order and care plan entry for the quarter rail prior to the 02/23/2020 date, Staff K stated he would, look to see. No further information was provided. REFERENCE: WAC 388-97-1060(3)(g) .
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 sufficient evaluation/monitoring of two (#35 and #49) of five residents reviewed for unnecessary medications. For Resident #35, the facility failed to provide a rationale for administerng multiple antipsychotic medications. For Resident #49, the facility failed to monitor a condition for which a [MEDICAL CONDITION] medication was prescribed. These failures placed the residents at risk to receive medications they did not require. Findings included . RESIDENT #35 Resident #35 was admitted on [DATE] with care needs related to [MEDICAL CONDITION] with delusions and behavioral symptoms and other medical conditions. A 12/23/2019 Admission Minimum Data Set (MDS - an assessment tool) identified the [DIAGNOSES REDACTED]. Resident #35's physician orders [REDACTED].#35 had been receiving four different antipsychotic medications ([MEDICATION NAME] and [MEDICATION NAME]) daily since admission. Review of an admission note by Resident #35's current physician (Staff W), did not provide a documented rationale that stated why the resident required four different antipsychotic medications. This note only identified one of the four medications, even though all four antipsychotic medications were prescribed over the past three months. Similarly, on 12/17/2019, Staff X, an Advanced Registered Nurse Practitioner (ARNP) who was a mental health consultant for facility residents, also reviewed Resident #35's care and medications. In her assessment, she identified each of the four different medications. While she identified a dose reduction for the medications was not indicated at the time, she did not document a rationale for continuing all four of the medications. Review of a facility policy, last revised May 2018, did not address the need for prescribers to provide a written rationale for any resident who was receiving more that one psychoactive medication of the same category (duplicative therapy), as specified in this regulation. On 03/02/2020 at 8:20 AM, Staff B, Director of Nursing (DON), was interviewed regarding the need for a rationale for prescribing four different antipsychotic medications for Resident #35. Staff B said medications were reviewed by the mental health ARNP, who had said Resident #35 wasn't a candidate for reducing any of his medications. When the need for a written rationale to address why a resident resident required duplicative psychoactive medications was reviewed (and had not been addressed in the facility's current policy), Staff B said she had provided all the information she had, and acknowledged it was not in the provided information. RESIDENT #49 Review of a 01/03/2020 Annual MDS showed Resident #49 admitted on [DATE] with multiple complex medical and cognitive conditions. Review of Resident #49's care plan, last revised 0[DATE], showed the indications for which the resident received sedative/hypnotic therapy included .not sleeping . Review of Resident #49's February 2020 Medication Administration Record [REDACTED]. Review of Resident #49's medical record did not reveal monitoring of Resident #49's sleep. On 03/01/2020 at 12:42 PM, the above findings were discussed and acknowledged by Staff I, Registered Nurse. Staff I said sleep monitoring was usually recorded in the Monitors section of a resident's medical record. REFERENCE: WAC 388-97-1060(3)(k)(i). .
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure expired or inactive medications were not stocked in two of three medication carts observed. These failures placed residents at risk to be provided expired medications or have medications diverted. Findings included . NORTH HALL MEDICATION CART In an observation on 02/23/2020 at 9:02 AM, a bottle of Sulfa (an antibiotic) eye drops, labeled for Resident #58, with a dispensed on date of 02/06/20, showed instructions to administer it daily for 10 doses. Observed also were oseltamavir ([MEDICAL CONDITION]) tablets for Resident #10, with a

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	505519	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BENSON HEIGHTS REHABILITATION CENTER	22410 BENSON ROAD SE KENT, WA 98031

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 10) dispensed on date of 02/16/2020, and a fluconazole (antifungal) tablet, with a dispense date of 06/05/19 for Resident #15. When asked if the medications were currently in use, Staff R, Registered Nurse, confirmed these medications were completed or no longer in use. When asked what staff did when medications were completed, Staff R stated, Yes, should be thrown out (discarded) when it gets done. In addition, one carton of honey thickened water and a carton of nectar thickened water, with a label instructing staff to, May be kept up to 7 days under refrigeration, were observed in the second drawer of the medication cart, unrefrigerated. Upon touch, the carton did not feel cold. When asked how long the cartons had been sitting unrefrigerated, Staff R stated, I got from the fridge this morning, 6:00 AM or so. They should be iced. SOUTH HALL MEDICATION CART In an observation on 02/23/2020 at 9:46 AM, an opened and unlabeled bottle of artificial eye drops and a nasal decongestant spray bottle were observed in the medication cart. In this observation, Staff S, Licensed Practical Nurse, acknowledged the eye drops and nasal spray should be labeled with a resident's name. In addition, a bottle of nasal moisturizing spray with an expiration date of 01/2020, and a tube of [MEDICATION NAME] ointment with an expiration date of 12/2019, were observed in the medication cart for Resident #14. Staff S stated, We should be throwing it away. An opened and undated bottle of liquid protein was also observed inside the medication cart. The label instructed staff it had a three month shelf life once opened. Staff S acknowledged it should be dated in order to establish the discard date. REFERENCE: WAC: 388-97-1300(2). .
F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on observation, interview and review of facility menus, the facility failed to ensure written menus were followed for Residents #36, #52, #71, #31, #45, #78, #13, and #72, eight of approximately 60 residents for whom meal service was observed on 02/27/2020. Failure by the facility to follow written menus and accurately serve planned menu items placed residents at risk for fewer calories than planned, or receiving foods inconsistent with their current diet. Findings included During observations of the noon meal service on 02/27/2020 from 11:00 AM until 12:15 PM, staff failed to follow written menus for eight residents when serving this meal. INACCURATE PORTION SIZE According to their written menu cards, Resident #36 was to be served a large portion of protein (meatloaf) and Resident #71 a double portion. When observed during the meal service, both residents were served a smaller, regular portion of the meatloaf until the serving error was identified by the surveyor, and acknowledged by staff. For Resident #52, who was to be served small portions (which meant she was not to receive a roll with her meal), staff initially served this item. FAILURE TO FOLLOW SPECIFIC DIET According to her written menu, Resident #31 was to receive a lower sodium diet. For lunch on 02/27/2020 she was served a hot dog, instead of meatloaf, which was on her written menu. Additionally she was served scalloped potatoes instead of regular mashed potatoes. Resident #45, who was to be served fortified mashed potatoes, was initially served regular mashed potatoes, until the error was identified. Resident #78, whose written menu specified she was on a cardiac diet, was initially served meatloaf, even though she was to receive a hamburger patty instead. OMISSIONS According to his written menu, Resident #13 was to be served four ounces of cottage cheese as part of his meal. This was not served until staff were informed of this omission. Resident #72 was to be served ice cream with her meal. This was omitted until staff were informed. The above serving errors were discussed with staff prior to the tray being served, so the errors could be addressed. At 12:20 PM on 02/27/2020, the pattern of errors observe was discussed with, and acknowledged by, Staff G (Dietary Services Manager). REFERENCE: WAC 388-97-1160(1)(a)(b). .
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, the facility failed to include bed side rails in the facility's QAPI (Quality Assurance and Performance Improvement) plan. Failure to include this equipment placed residents at risk for the unnecessary use of side rails and their associated risks. In addition, the facility failed to adequately address issues with identification, reporting, and investigation of resident-to-resident abuse in the QAPI plan. This failure placed residents at risk for abuse. Findings included . Within this statement of deficiencies, reference F700 regarding deficent practice in side rail use and F600 regarding deficient practice in abuse prevention. Review of the facility's QAPI policy, dated 02/2020, showed the facility would estblish and implement practices to encourage feedback, collect data, and monitor high risk, high volume or problem-prone areas, including adverse event monitoring. On 03/04/2020 09:18 AM, Staff A, Administrator, was asked how the facility determined what issues would be addressed in QAPI. Staff A said staff looked at those issues which were most likely to cause harm or present a safety concern. Staff A was asked why side rail use was not identified in the facility's QAPI plan. Staff A replied he believed the facility had already fixed side rails, and there were no complaints about them from residents or staff. Staff A said Resident #74's side rails were talked about in QAPI. Staff A was asked if the facility QAPI committee addressed side rail use by other residents and he said, There's lack of follow through, that's our issue right there, and added, Not having enough data (we) can't do much. Staff A was also asked if resident-to-resident abuse was addressed in QAPI committee. Staff A said they had for the past three months, and said a review resulted in no findings. Staff A commented, We didn't dig deep. 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 three of three blood glucose meters in use were disinfected in accordance with the manufacturer's instructions and the CDC (Centers for Disease Control). This failure placed residents who required the use of a blood glucose meter to check their blood sugars at risk for blood borne infections. Findings included . A facility policy dated November 2017 and titled Infection Prevention and Control Program showed the staff would clean the blood glucose meter (BGM) between residents according to manufacturer's recommendations. According to the CDC, blood glucose meters soul not be shared and, if shared, the device should be cleaned and disinfected after every use per manufacturer's instructions, to prevent carry-over of blood and infectious agents. An observation during medication administration in the South Hall on 0[DATE]20 at 9:12 AM, showed Staff I, Charge Nurse, wiped a BGM glucose meter with a prepackaged pad labeled 70% [MEDICATION NAME] Alcohol (rubbing alcohol), prior to checking a resident's blood sugar. The BGM was labeled as an Evencare G2 model. When asked if the BGM was shared between the residents in the facility, Staff I stated it was shared. When asked if rubbing alcohol was the correct disinfectant for the BGM, Staff I stated, We can't use that? I'm not going to lie. Honestly, that's what I have always been using. In an interview on 0[DATE]20 at 9:32 AM, when asked if the Middle Hall had residents who required blood glucose testing, Staff K, Charge Nurse, answered, Five. When asked if the BGM was shared between residents, Staff K answered, Used for all of them. When asked if he had been trained on infection control for BGMs, Staff K answered, Yes, not that long ago, within a year. When asked what he learned about the disinfection of BGM, Staff K answered, I don't remember. When asked what he used to disinfect the BGM, Staff K answered, We clean it with alcohol, and showed a prepackaged pad of 70% [MEDICATION NAME] Alcohol. On 0[DATE]20 at 9:32 AM, in an interview with the North Hall Medication Nurse, when asked how many residents required blood glucose checks, Staff R, Registered Nurse, stated, Five. When asked if the BGM was shared by multiple residents, Staff R answered, Yes. When asked what kind of training she had received about infection control for BGMs, Staff R answered, We do (online) training, includes glucometers. When asked how she disinfected BGM between uses, Staff R answered, We have alcohol wipes so we just use these ones. When asked to show what alcohol wipes were used, Staff R showed an prepackaged pad labeled 70% [MEDICATION NAME] Alcohol. The above findings were shared with Staff B, Director of Nursing on 0[DATE]20 at 12:29 PM. Staff B provided the manufacturer's instructions for disinfecting the Evencare G2 BGM. The instructions showed, To disinfect your meter, clean the meter with one of the validated disinfecting wipes . These instructions did not show 70% [MEDICATION NAME] alcohol as one of the validated disinfecting solutions. In this interview, when asked if 70% [MEDICATION NAME] alcohol met the disinfectant criteria for the BGM, Staff B stated, It (the manufacturer's instructions) does not list it. WAC: 388-97-1320(1)(a). .
F 0912 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.**

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F 0912 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	(continued... from page 11) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a minimum of 80 square feet of space per resident in resident rooms for 32 of 36 two-bed rooms, and two of four four-bed rooms. Failure to provide the required minimum square footage placed residents at risk for a reduced quality of life. Findings included . According to facility documentation and observation, the following rooms measured less than 80 square feet (sq. ft.) per resident room: Twenty-six two-bed rooms (Rooms 1-10, 12-15, 17-23, 25-29) measured 149 sq. ft., or 74.5 sq. ft. per resident. room [ROOM NUMBER] (a two-bed room) measured 148 sq. ft., or 74 sq. ft. per resident. rooms [ROOM NUMBERS] (two-bed rooms) measured 150 sq. ft., or 75 sq. ft. per resident. rooms [ROOM NUMBER] (two-bed rooms) measured 157 sq. ft., or 78.5 sq. ft. per resident. rooms [ROOM NUMBERS], each a four-bed room, measured 317 sq. ft., or 79.25 sq. ft. per resident. During an interview on 02/23/2020 at 9:27 AM, Staff A (Administrator) and Staff B, Director of Nursing (DNS) were asked if the square footage of resident rooms had changed since the previous annual survey. Staff B replied they had not. The lack of sufficient square footage was discussed with Staff A and B on 03/04/2020 at approximately 12:15 PM. There was no indication the undersized rooms negatively affected the residents' care or quality of life during the survey. REFERENCE: WAC 388-97-2440(1). .