STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505251	A. BUILDING _____ B. WING _____	**03/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WHITMAN HEALTH & REHAB CENTER	**1150 WEST FAIRVIEW ROAD COLFAX, WA 99111**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to develop effective interventions to assure the safety of two sample residents (#1, 2), and to prevent further resident-to-resident physical abuse involving the residents, who had a history of [REDACTED]. Findings included . Review of Resident #1's record showed she was admitted to the facility in December 2019, with [DIAGNOSES REDACTED]. Review of the comprehensive assessment, dated 03/05/2020, showed the resident was unable to complete cognitive testing, and was independent with turning in bed, transfers, and ambulation. The assessment also showed she required extensive staff assistance with dressing and personal hygiene, and supervision with toileting and eating. In addition, the resident had a history of [REDACTED]. Review of Resident #2's record showed he was admitted to the facility in November 2019, with [DIAGNOSES REDACTED]. Review of the comprehensive assessment, dated 03/09/2020, showed he was unable to complete cognitive testing, was independent with turning in bed, and required one staff to supervise with transfers, ambulation, and toilet use. The assessment also showed he required extensive assistance with one staff for personal hygiene and dressing, and was independent with setup help only, with eating. Review of facility investigation reports showed the following: 12/26/2019 - Resident #1 had wandered over to Resident #2 in the main dining/activity room and in the process of taking a pillow away from the resident, she scratched him on the left forearm. Preventative measures included one to one staffing for Resident #1 for 72 hours, to prevent further altercations. 02/13/2020 - Resident #1 wandered into Resident #2's room, despite a banner being placed over the doorway of the room, and scratched him on the right wrist. Review of Resident #1's plan of care showed preventative measures included one to one staffing for Resident #1 for 72 hours, (an intervention which was discontinued on 02/16/2020), and then facility staff were to reevaluate her activity. 03/10/2020 - Resident #2 was seated on a couch in the main dining/activity room, with his walker in front of him. Resident #1 walked by Resident #2, and touched his walker. Resident #2 then stuck his hand out, and shoved Resident #1 on the arm. The two assigned Nursing Assistants, Staff A and B, immediately got between the two residents, however, Resident #1 managed to reach over and slap Resident #2 on the right cheek with her hand. Resident #2 stated he was going to hit Resident #1, at which time they were both redirected by staff. An inservice provided to staff on 03/10/2020 showed Resident #1 was to have one to one staffing at all times (being at an arms length), and was not to get close or interact with Resident #2. Despite the one to one staffing being discontinued after 72 hours, following the altercations on 12/26/2019 and 02/13/2020, there was no assessment to evaluate the effectiveness of the one to one staffing, to determine the intervention was no longer required. Staff C, Administrator, stated on 03/23/2020 at 10:00 AM, that the previous one to one staffing, following altercations on 12/26/2019 and 02/13/2020, was discontinued following 72 hours, as there were no trends of Resident #1 being aggressive. Staff B, Nursing Assistant, stated during a telephone interview on 03/25/2020 at 12:02 PM, that at the time of the third altercation between Resident #'s 1 and 2, there was no plan to provide one to one staffing for Resident #1. She stated Resident #2 was very protective of his walker, and there had been times when Resident #1 had tried to take it. At the time of the incident on 03/10/2020, both she and Staff A were in the main dining/activity room, at a distance away from either resident. Staff B stated she was not directly in front of Resident #1, which allowed Resident #1 the ability to slap Resident #2 on the face. Staff B stated she, couldn't stop her, she is real quick. Resident #1 was observed on 03/23/2020 at 2:30 PM, seated on the couch in the main dining/activity room with a staff member, watching television. Resident #2 was seated at a table across the room from Resident #1. Reference (WAC) 388-97-0640(1)

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.