STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505195	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTH AUBURN REHAB & HEALTH CENTER	**2830 I STREET NORTHEAST AUBURN, WA 98002**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** 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 ensure one (#1) of one resident reviewed for abuse, was free from actual physical abuse by not recognizing, potential prior abuse, in the form of uninvestigated bruising on the face, chest, and torso of the resident; failed to immediately protect the resident by removing the person responsible for slapping the resident. The failure of the facility to protect Resident #1 from actual physical abuse, even though signs were there, caused physical and psychosocial harm and created an atmosphere of continued ongoing physical abuse. Failure of the facility to ensure residents were free from abuse and staff understood when and how to identity, react or handle abuse situations resulted in an Immediate Jeopardy on 06/04/2020. Findings included . Refer to: CFR 483.12(c)(1)(4), F-609, Timeframe: Abuse Reported to Administration/State Agency CFR 483.12(c)(2)-(4), F-610, Investigate Abuse/Protect resident during investigation Report Investigation Results State The Code of Federal Regulation (CFR) defines abuse as, the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. According to the Washington State Reporting Guidelines for Nursing Homes (Purple Book) dated October 2015, Abuse is the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. The undated facility, Prevention and Reporting: Resident Mistreatment, Neglect, Abuse , policy included, Physical Abuse includes hitting, slapping .A resident has the right to be free from abuse, neglect .The center shall: not use verbal, mental, sexual, or physical abuse, corporal punishment .Require center staff, which included employees, consultants, contractors .Provide for the immediate safety of the resident upon identification of potential abuse Prevent further potential abuse .while the investigation is in progress . RESIDENT #1 According to the 03/12/2020, Quarterly Minimum Data Set, (MDS), an assessment tool. Resident #1 exhibited unclear speech patterns, was cognitively impaired and unable to make decisions, had experienced disorganized or incoherent thinking and other behavioral problems not directed toward others, required one person physical assistance for activities of daily living, and had a mental health disorder diagnosis. The clinical record showed the resident had a [DIAGNOSES REDACTED]. According to the 03/27/2020 revised Care Plan based on the MDS and clinical diagnoses, staff were to provide, 1 on 1 care, redirect the (resident), and provide (psychological) consult as needed. and, Anticipate needs, Be [MEDICATION NAME] . Review of Progress Notes dated 05/30/2020 showed that, at around 12:30 PM, Housekeeper reported that around 11:20 AM she witnessed Resident hitting at the one on one staff member (Staff C, Certified Nursing Assistant (CNA)) for Resident. The one on one Staff member then slapped Resident in the face twice. Left side of face is red . Although, the Housekeeper did take some actions, there was an hour delay in protecting Resident #1, by leaving Staff C alone and unsupervised, before reporting to the nurse that Staff C had slapped the resident. In an interview on 06/01/2020 at 2:45 PM, Staff B, Director of Nursing, was asked if Staff C, slapped Resident #1, Staff B, stated, The abuse was witnessed. Review of a written statement by Staff H, Licensed Practical Nurse dated 05/30/2020, showed Staff E, Housekeeper asked Staff H, what to do if someone had seen a staff member slap a Resident. Staff E stated that he would tell a nurse right away. Staff H asked Staff E if someone was slapped, and Staff E said yes. When asked who saw the Resident get slapped, Staff E stated that he promised he would not say anything. During an observation on 06/02/2020 at 2:05 PM, Resident #1 was seated in a wheelchair, in his room, accompanied by Staff I, a one-on-one caregiver. Resident #1 was observed with discolorations to left cheek and a dark discolored area above the left eye. During an interview at this time, when asked if staff treated him well, Resident #1 replied, No. When asked if staff were nice to him, Resident #1 replied, No. Resident #1's attempts to respond in full sentences were difficult to understand due to rambled and slurred speech. For this resident who was unable to express the full effect of having been slapped, the psychological as well as physical effects of such abuse can be inferred by any reasonable person. In an interview on 06/03/2020 at 9:30 AM Staff D, a Housekeeper/witness, stated (Resident #1) was swinging his hands, it looked like horse play. (Resident #1) didn't hit (Staff C,). (Staff C), got up from the chair in which he was sitting close to (Resident #1), and slapped (Resident #1) pretty hard, twice. (Staff C) told me to close the door. When asked how Resident #1 seemed after the incident, Staff D, stated, (Resident #1) was upset, he wasn't crying, he just didn't look right. Staff D stated this incident was subsequently reported to Staff E, another housekeeping staff. In an interview on 06/03/2020 at 9:50 AM, Staff D stated that after witnessing Staff C strike Resident #1, Staff D left Resident #1 to tell Staff E about the incident. When asked, Staff D stated they had never received training in abuse prevention. During an interview on 06/03/2020 at 10:00 AM, Staff E, stated that they had not received training in abuse prevention, but knew, reporting the incident was, the right thing to do. Further review of Resident #1's clinical record showed the resident had previously sustained substantial injuries that were not reported to the Department and that the facility failed to thoroughly investigate to rule out abuse. Review of the facility investigation documents, showed the facility did not identify how long Resident #1 was left alone in the room with the alleged perpetrator, Staff C. In addition, the facility failed to identify that as soon as Staff E alleged abuse to Staff H, Staff H failed to remove Staff C from resident care and failed to ensure Resident #1 was safe prior to initiating an investigation. Additionally, the facility failed to ensure four staff (D, E, H & F) reported abuse of Resident #1 as mandated, which placed all residents at risk for unidentified, ongoing abuse. Review of documentation by the ARNP (Advanced Registered Nurse Practitioner) on 05/30/2020 showed, Nurse (Staff H) called at approximately 1600 to report a housekeeper witnessed a nursing assistant slapped this patient across the face. Altercation resulted in a red mark to patient's right (sic) cheek .Patient placed on alert charting to monitor for latent injury, pain, and psychological harm . Nurse instructed to contact provider for any complaints of pain, psychological harm, or other . injury as stated. Review of documented monitoring in the Progress Notes on 05/31/2020 showed, Resident was tearful X 1 this shift. I could not understand what he was saying. Decreased Redness to left side of face. Blotchy red areas/bruising noted. The 06/01/2020 2:40 PM Progress Notes showed the resident sustained [REDACTED]. Dark bruising around left eyebrow. A colored picture was provided by the facility on 06/03/2020 at 3:22 PM, taken on 06/02/2020, that showed a large dark purple periorbital (surrounding the eye) bruise that extended up the left forehead, into the scalp, and down the left cheek and towards the left ear. Staff G, Licensed Practical Nurse (LPN), MDS Nurse, stated in an interview on 06/01/2020 at 2:37 PM, that Resident #1 had a mark on the face. During an interview on 06/02/2020 at 1:30 P.M. Staff F, LPN, Resident Care Manager (RCM) stated, I saw his face yesterday, and oh God it was bruised. Past incidents of unexplained bruising Review of progress notes dated 04/14/2020 showed, Resident had a shower, the Aide noted old bruises on upper arm, chest and back, yellowish in color/purplish in color There was no evidence this was investigated by the facility to rule out abuse. Review of physician progress notes [REDACTED]. He has small bruises on

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) his upper back and right upper arm. There was no evidence this was investigated by the facility to rule out abuse. Review of a 05/04/2020 physician progress notes [REDACTED].Hematoma is still there, size of tennis ball. There was no evidence this was investigated by the facility to rule out abuse. Review of Progress Notes showed on 05/16/2020 at 9:45 PM, Certified Nursing Assistant reported to LN (Licensed Nurse), multiple bruises behind knees. Bruise on right lower flank area (area between the lower rib and hip bone/torso/side). There was no evidence this was thoroughly investigated by the facility to rule out abuse. The resident had a one on one care giver to keep the resident safe. Due to the lack of investigations of the bruising, the facility failed to identify if the above bruising was a result of abuse. REFERENCE: WAC 388-97-0640 (1) .
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.** Based on interview and record review, the facility failed to develop written policies and procedures that were consistent with current regulations pertaining to reporting incidents of possible/alleged resident abuse or neglect. This failure placed all residents for abuse or accidents, at risk for unreported abuse or neglect. Findings included . Refer to: CFR 483.12(a)(1), F-600, Free From Abuse and Neglect CFR 483.12(c)(1)(4), F-609, Timeframe: Abuse Reported to Administration / State Agency Review of Washington State law, RCW 74.34.035 showed that, When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department .When there is reason to suspect that physical assault has occurred or there is reasonable cause to believe that an act has caused fear of imminent harm: Mandated reporters shall immediately report to the department. Record review of the facility's undated policy titled, Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property showed staff were to, Notify the Shift Supervisor/Charge Nurse immediately if allegation of abuse, neglect, exploitation, mistreatment, injuries of unknown source or misappropriation of resident property occurs, Report the incident immediately to the Executive Director and Director of Nursing/designee, who will report immediately any allegations of abuse, .to applicable state and other agencies; including state survey agencies and Adult Protective Services where state law provides for jurisdiction in long term care facilities. Note: Person(s) initially identifying potential abuse, neglect, mistreatment, and/or misappropriation of property may, by State law, be accountable to make initial call. The written procedures did not specify that any staff with direct observations of abuse or neglect, or any staff to whom a resident had reported an allegation of abuse, neglect, mistreatment or exploitation was mandated to report this to the State Agency by directly contacting the Complaint Resolution Unit (CRU), in addition to reporting to their supervisor. Record review of the facility's undated policy titled, Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property showed Training was to include, how to report incidents, but did not include Mandated Reporter training requirements. Review of a facility provided written statement by Staff H, Licensed Practical Nurse dated 05/30/2020 showed Staff E, Housekeeper asked Staff H, what to do if someone had seen a staff member slap a Resident. Staff E stated that he would tell a nurse right away. Staff H asked Staff E if someone was slapped, and Staff E said yes. When asked who saw the Resident get slapped, Staff E stated that he promised he would not say anything. During an interview on 06/03/2020 at 10:00 AM, Staff E, stated that they had not received training in abuse prevention, but knew reporting the incident was, the right thing to do. Staff B, the Director of Nursing, in an interview on 06/10/2020 at 9:00 AM, stated that the abuse policy provided was what the facility believed to be the current abuse policy. 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 four staff (D, E, H & F) reported abuse of Resident #1 as mandated. In addition, the facility failed to identify and report possible abuse and neglect for three (#s 1, 2 & 4) of five residents reviewed for abuse and neglect. This failure placed all residents at risk for unidentified, ongoing abuse. In addition, the facility failed to notify the Department or Fire Marshall of the actual discontinuation of boiler/hot water services. This failure prevented residents from receiving timely hot bathing/showers, and had the potential to affect the availability of clean laundry and dietary services' ability to wash and sanitize dishes, utensil and pots and pans. Findings included . Refer to: CFR 483.12(a)(1), F-600, Free From Abuse and Neglect CFR 483.12(c)(2)-(4), F-610, Investigate Abuse/Protect resident during investigation Report Investigation Results State CFR 483.25, F-609, Quality of Care The undated facility, Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source , policy included, When allegations that meet the definition of abuse, neglect .including injuries of unknown source .the center shall: Ensure that all alleged violations are reported immediately .Person(s) initially identifying potential abuse, neglect, mistreatment .may by State Law, be accountable to make initial call. Review of Washington State law, RCW 74.34.035 showed that, When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department .When there is reason to suspect that physical assault has occurred or there is reasonable cause to believe that an act has caused fear of imminent harm: Mandated reporters shall immediately report to the department. MANDATED REPORTERS RESIDENT #1 Review of a 05/30/2020 facility incident investigation showed, Staff D (Housekeeper), was in Resident #1's room cleaning, when she saw Staff C, Certified Nursing Assistant (CNA), slap Resident #1 two times across the face. Staff D left the room and reported the incident to her co-worker Staff E, Housekeeper. Staff E then reported the incident to Staff H, Licensed Practical Nurse (LPN). Staff H subsequently interviewed Staff D and assessed Resident #1 for pain and injury. During an interview on 06/02/2020 at 1:30 PM Staff F, LPN, Resident Care Manager (RCM) stated that Staff H called her around 12:30 PM and notified her that the housekeeper saw Staff C slap Resident #1 in the face. Staff F stated that she instructed Staff H to call the police, notify the family and assess the resident. Staff F stated that she told Staff C to clock out and escorted out of the building. Staff F stated that she spoke to Staff D on the phone as well. Review of the Department's Complaint Resolution Unit system showed that the abuse was not reported by facility staff with first hand knowledge of the incident (Mandated Reporters): Staff D, Staff E, Staff H and Staff F. SUBSTANTIAL INJURIES Review of the Nursing Home Guidelines, AKA The Purple Book, dated February 2012 showed Substantial Injuries, include those injuries occurring in areas not generally vulnerable to trauma, such as the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital or anal area. All Substantial injuries of unknown source, regardless of the extent, must be reported to the Department. RESIDENT #1 BRUISING RIGHT FLANK Review of Progress Notes showed on 05/16/2020 at 9:45 PM , Certified Nursing Assistant reported to LN (Licensed Nurse), multiple bruises behind knees. Bruise on right lower flank area (area between the lower rib and hip bone/torso/side). Resident placed on alert charting to monitor for multiple bruises Review of the May 2020 Reporting Log showed the incident was coded as small bruises occurring in places generally vulnerable to trauma, such as arms, forearms, and shins. The Department hotline was not notified. The facility failed to identify flank bruising as a substantial injury and indicator of potential abuse. HEMATOMA TO HEAD Review of a 04/25/2020 11:00 PM Progress Note showed, Resident .fell down and hit the floor on top of the head and sustained a hematoma (an accumulation of blood under the skin, typically related to injury). Neuro checks initiated and DNS (Director of Nursing Services), MD (Medical Doctor), and family member .notified . Review of a 05/01/2020 physician progress notes [REDACTED]. The patient was sleeping in his wheelchair, and fell forward, hitting the frontal portion of his head on the ground, resulting in a hematoma. Neurochecks (an assessment for [MEDICAL CONDITION]) were performed and the patient continues to maintain his baseline. The hematoma appears to be healing well. Review of a 05/04/2020 physician progress notes [REDACTED]. He was talking but was not making any sense. I was informed today that he fell ,[DATE] days (ago) and hurt his head and developed hematoma on top of the head. Patient has slurred speech. Hematoma is still there, size of tennis ball. Patient could not provide any history. I ordered CT (Computerized Tomography, specialized X-ray equipment to obtain images) head to r/o (rule out) SDH (Subdural Hemorrhage, a condition in which blood collects on the brain's surface beneath the skull) or [MEDICAL CONDITION] (bleeding

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) in the brain). Review of the April and May 2020 Reporting Logs showed the incident and resulting injury was not logged or reported to the Department. BRUISING TO FOREHEAD & UPPER BACK Review of Progress Notes dated 04/15/2020 showed, CNA watching him saw him bumping himself accidentally on the forehead while trying to position self, little bruise noted. Review of physician progress notes [REDACTED]. He has small bruises on his upper back and right upper arm. Review of the April 2020 Reporting Log showed the incident and resulting injury was not logged or reported to the Department. BRUISING TO CHEST AND BACK Review of progress notes dated 04/14/2020 showed, Resident had a shower, the Aide noted old bruises on upper arm, chest and back, yellowish in color/purplish in color Review of the April 2020 Reporting Log showed the injuries of unknown origin to areas not generally vulnerable to trauma were not logged and not reported to the Department. RESIDENT #2 HEAD INJURY Review of Progress Notes dated 05/06/2020 at 01:00 AM showed, Called to room [ROOM NUMBER]-1 by CNA. Reported that resident was on the floor . Resident assessed for injuries and found to have a 5 cm (centimeter) hematoma to his left forehead with some noted bleeding . Review of the May 2020 Reporting Log showed the fall was logged, with no injury. The substantial injury was not reported to the Department as required. Staff B, interviewed on 06/05/2020 at 10:10 AM, confirmed that the State was not notified of the potential abuse/neglect. RESIDENT #4 Review of the Progress Notes dated 05/28/2020 at 2:00 PM showed, Patient reported that another resident came into her room last night and hovered over her in bed and patient stated that the other patient in her room threatened to hit (Resident #4). (Resident #4) reported feeling unsafe. Informed (Resident #4) that SS (Social Services) discussed with the other patient and that the patient was put on 20 minute checks for the night. Patient was agreeable to this intervention. Review of the May 2020 Reporting Log showed the allegation of abuse was not logged. During an interview on 06/05/2020 at 9:55 AM, when asked if the above incidents were entered into the facility incident log, and if the Department was notified of the incidents, Staff B, stated that if the incidents were not logged, the Department was not notified. DISCONTINUATION OF SERVICES The Department received an intake 06/01/2020 at 11:41 AM, that showed the facility's boiler was not functional. Staff A, interviewed on 06/03/2020 at 1:45 PM, stated that the boiler malfunction occurred on 05/23/2020 but was not reported until 06/01/2020, a reporting delay of ten days. When asked if the Fire Marshall was notified of the interruption in hot water services, Staff A stated that maybe the Maintenance Director notified the Fire Marshall. During an interview on 06/02/2020 at at 1:15 PM, Staff Q, Maintenance Director, stated that he notified Staff A, who notified the Department when water temperatures could not be maintained. The facility failed to notify the Department and the State Fire Marshall as required, when the risk of discontinuation of services was identified with the boiler malfunction. REFERENCE: WAC 388-97-0640(2)(b)(5)(7)(a). .
F 0610 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect Resident #1 from further abuse when Staff (D), left the resident in the room after witnessing a physical assault by the alleged perpetrator (Staff C). In addition, the facility failed to thoroughly investigate incidents of potential abuse of four (#s 1, 2, 4 & 9) of five residents reviewed for abuse; substantial injuries to Resident #1 & #2, and allegations of abuse to Residents #4 & #9. Additionally, the facility failed to ensure staff were trained and demonstrated understanding of when and how to identify, react or handle abusive situations. These failures prevented the facility from determining the extent to which incidents were related to abuse and/or neglect and placed all residents at risk for being abused and/or neglected. These failed practices resulted in an Immediate Jeopardy on 06/04/2020. Findings included . Refer to: CFR 483.12(a)(1), F-600, Free From Abuse and Neglect CFR 483.12(c)(1)(4), F-609, Timeframe: Abuse Reported to Administration / State Agency The undated facility, Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source , policy included, When allegations that meet the definition of abuse, neglect .including injuries of unknown source .the center shall: Thoroughly investigate all alleged violations and retain documents showing that all alleged violations are thoroughly investigated .Prevent further potential abuse .while the investigation is in progress . In addition, the undated facility Prevention and Reporting: Resident Mistreatment, Neglect, Abuse . policy showed the center shall, Provide Annual training for all staff who provide care and service with ongoing training programs .Provide training for all new employees .through/during orientation .How to provide protection .Require center staff, which included's employees, consultants, contractors .Provide for the immediate safety of the resident upon identification of potential abuse . RESIDENT #1 According to the 03/12/2020 Quarterly Minimum Data Set, (MDS, an assessment tool), Resident #1 exhibited unclear speech patterns, was cognitively impaired and unable to make decisions, experienced disorganized or incoherent thinking and other behavioral problems not directed toward others, required one person physical assistance for activities of daily living, and had [DIAGNOSES REDACTED].#1's clinical record a [DIAGNOSES REDACTED]. Review of the 03/27/2020 Care Plan showed Resident #1 required one-on-one care. PHYSICAL ABUSE Review of a 05/30/2020 facility incident investigation showed, staff to resident abuse was reported to Staff H, Licensed Practical Nurse (LPN) by Staff E, housekeeper. Staff C, Certified Nursing Assistant (CNA), slapped Resident #1 on the left side of his face two times. The information was given to Staff E, by eyewitness Staff D, Housekeeper. Staff H went directly to Staff D, who was in the break room, to confirm the information. Staff D then reported that she was in the room cleaning when she saw Staff C slap the resident two times across the face. Staff D stated that she walked over to Staff C and said, I saw what you did. Stop. Staff D left the room, reported the incident to her co-worker, Staff E. After interviewing Staff D, Staff H went to Resident #1's room, and removed Resident #1 from Staff C's care. Staff B, in an interview on 06/01/2020 at 2:45 PM, reported that Staff D did not leave Resident #1 alone with Staff C, the accused perpetrator. But in an 06/02/2020 email response to a request for documents, Staff B stated that, .(Staff D) had a different version (of the incident response) than was reported to me by staff. She did initially intervene, but then did leave the room . During an interview on 06/02/2020 at 2:00 PM, Staff B, Director of Nursing, stated that the facility, found deficits with the housekeeper who was contracted staff. Staff B stated that education was provided to Staff D on the morning of 06/02/2020. When asked what the deficit was, Staff B stated, She left the room with the caregiver (alleged perpetrator) in the room with the resident. Review of the facility investigation documents did not include the facility identification of the staff deficit, nor did the facility identify that as soon as Staff E alleged abuse to Staff H, Staff H failed to remove Staff C from resident care and failed to ensure Resident #1 was safe prior to initiating an investigation. Witness statements were provided by the facility on 06/09/2020 at 3:43 PM. Review of a Statement of Staff C, dated 06/01/2020 showed that when Staff C started on 05/30/2020 around 6:00 AM, Resident #1 was asleep and in the company of Staff K, CNA. At about 7:00 AM, Staff C noticed that Resident #1's face was reddish, mostly the cheeks. Staff C documented going on break at around 10:00 AM and leaving Resident #1 in the company of Staff L, CNA. Staff C documented Resident #1 was exhibiting behaviors through the morning, including, scratch his face and hair, and kept waking up and sit on the bed. The facility investigation did not include statements from Staff K or Staff L regarding the presence of reddish cheeks, Resident #1's and/or Staff C's behaviors. Abuse Prevention Education documents for staff were requested on 06/01/2020 at 3:18 PM, and received on 06/03/2020 at 2:38 PM, including information that Staff C, had received computer training on abuse prevention on 03/02/2020. A copy of the curriculum was requested but not received. Review of this list of trainees showed that the list did not include the housekeeping Staff D and E. Computerized records were obtained by the facility from the contracted management company who provided housekeeping services, indicating Staff D received abuse training in general orientation and electronically signed a 09/12/2019 document. Similar documentation was received for Staff E that showed this staff was trained and acknowledge the training on 10/04/2019. In an interview on 06/03/2020 at 9:50 AM, Staff D stated that after witnessing Staff C strike Resident #1, Staff D left Resident #1 to tell Staff E about the incident. When asked, Staff D stated they had never received training in abuse prevention. Staff E, in an interview on 06/03/2020 at 10:00 AM, stated that they had not received training in abuse prevention, but knew reporting the incident was, the right thing to do. Staff B, in a 06/03/2020 2:12 PM interview and email stated that the contracted housekeeping management company, not the facility, provided background checks and abuse prevention education to housekeeping staff. SUBSTANTIAL INJURIES BRUISING RIGHT FLANK Review of Progress Notes dated 05/16/2020 at 9:45 PM showed, Certified Nursing Assistant reported to LN (Licensed Nurse), multiple bruises behind knees. Bruise on right lower flank area (area between the lower rib and hip bone/torso/side). Resident placed on alert charting to monitor for multiple bruises . Review of the facility 05/16/2020 incident investigation showed the investigation was not completed within five days as required. The conclusion dated 05/28/2020 stated that when resident attempts to reposition he has poor control when sitting back down hitting his flank on the armrest of the wheelchair and back of knee on wheelchair frame. The investigation did not identify who the one-on-one staff member on duty was, statements from staff to determine a timeframe of when the bruises may have

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F 0610 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) occurred, if an incident had occurred that was not previously reported, or what data the facility used to draw the conclusion. The facility failed to rule out abuse or neglect. Staff B, interviewed on 06/05/2020 at 9:58 AM, was asked if the facility had procedures for investigating possible abuse/neglect and if the facility investigated Resident #1's right flank bruising. Staff B stated that she was not sure if the facility had a policy or procedure for investigating potential incidents of abuse/neglect. Staff B stated that, sometimes the Residential Care Managers can initiate an investigation. HEMATOMA TO HEAD Review of a 04/25/2020 11:00 PM Progress Note showed, Resident was sleeping in the wheel chair, when he fell down and hit the floor on top of the head and sustained a hematoma. Neuro checks initiated and DNS (Director of Nursing Services), MD (Medical Doctor), and family member .notified. Put on alert charting. Review of a 05/01/2020 physician progress notes [REDACTED]. The patient was sleeping in his wheelchair, and fell forward, hitting the frontal portion of his head on the ground, resulting in a hematoma. Neuro checks were performed and the patient continues to maintain his baseline. The hematoma appears to be healing well. Review of a 05/04/2020 physician progress notes [REDACTED]. He was talking but was not making any sense. I was informed today that he fell ,[DATE] days (ago) and hurt his head and developed hematoma on top of the head. Patient has slurred speech. Hematoma is still there, size of tennis ball. Patient could not provide any history. I ordered CT head to r/o (rule out) SDH (Subdural Hemorrhage, a condition in which blood collects on the brain's surface beneath the skull) or [MEDICAL CONDITION] (bleeding in the brain). Staff B, interviewed on 06/05/2020 at 9:59 AM, stated that the facility incident log was up to date and correct. If an incident was not on the log there was no investigation. Review of the April 2020 Reporting Log showed the incident and resulting injury was not logged. The incident was not investigated to rule out abuse and/or neglect. BRUISING TO FOREHEAD Review of progress notes dated 04/15/2020 showed, CNA watching him saw him bumping himself accidentally on the forehead while trying to position self, little bruise noted. Review of physician progress notes [REDACTED]. The caregiver reports that the patient has been exhibiting episodes of increased agitation and sometimes aggressive behavior in as trying to reach out and strike being or someone. The patient did sustain a small bruise to his forehead, a couple days ago when he bumped himself on the forehead. He has small bruises on his upper back and right upper arm. Staff B, interviewed on 06/05/2020 at 10:05 AM, stated that, Resident #1 does that, bump his head, that is why the facility initiated the seat belt. In response to being questioned about the facility's investigation and notifying the Department, Staff B stated that, The facility's log is complete and if the incident is not logged or there is no designation the Department was notified there is no investigation and the Department was not notified of the potential abuse/neglect. Review of the April 2020 Reporting Log showed the incident and resulting injury was not logged. The incident was not investigated to rule out abuse and/or neglect. BRUISING TO CHEST AND BACK Review of progress notes dated 04/14/2020 showed, Resident had a shower, the Aide noted old bruises on upper arm, chest and back, yellowish in color/purplish in color. Continues on 1:1 monitor with no behavior issues today. Staff B, in an interview on 06/05/2020 at 10:05 AM, stated that if the incident is not on the log and there is no notation the Department was notified, there is no investigation and the Department was not notified of the potential abuse/neglect. Review of the April 2020 Reporting Log showed the injuries of unknown origin to areas not generally vulnerable to trauma were not logged. The bruising of unknown origin were not investigated to rule out abuse or neglect. RESIDENT #2 According to the 04/01/2020 Quarterly Minimum Data Set, (MDS, an assessment), staff assessed Resident #2 as able to communicate, cognitively aware and able to make their own decisions, exhibiting no behaviors, and requiring one person supervision/oversight for activities of daily living. Review of the 10/07/2020 Risk for falls/injury CP showed interventions included, Ensure that resident is wearing appropriate footwear. The 09/26/2019 Self Care Performance Deficit CP showed the resident required one staff participation to dress. Review of progress notes dated 05/06/2020 01:00 AM showed, Called to room [ROOM NUMBER]-1 by CNA. Reported that resident was on the floor. When this LN went to room, resident had placed himself back into his w/c. Resident states he was attempting to stand when he slipped on the slippery floor. Floor was noted to be dry. Resident was wearing nonskid sock on his left foot and a slipper on his right foot. Resident assessed for injuries and found to have a 5 cm hematoma to his left forehead with some noted bleeding. Area cleansed with normal saline and pressure applied which stopped the bleeding. Ice was applied, but resident didn't tolerate it for long. Neuro checks were initiated. Resident denies dizziness or lightheadedness. No orthostatic drop. Denies pain/discomfort. BS 206. Resident refused to go to hospital. MD notified. Will place on alert charting for fall with injury. Review of the facility incident investigation dated 05/06/2020 did not include a caregiver statement regarding the resident's footwear, or identify the location of the left slipper. The incident investigation showed the Resident sleeps in his wheelchair and concluded, Resident possibly was asleep and had leaned forward in wheelchair and fell to the floor resulting in head injury. The CP did not show a resident behavior of sleeping in the wheelchair. The facility failed to interview staff on duty at the time of the incident to determine when the resident had last been seen, and doing what, where. An additional comment on the incident investigation showed that while LN was investigating fall in the resident's room a bottle of coke with rum was sitting on his bedside stand. The investigation failed to identify how long the resident had the alcohol, where the resident obtained the alcohol, if the resident exhibited behaviors indicative of having consumed the alcohol. During an interview on 06/02/2020 at 1:30 PM Staff F, LPN, RCM, stated I have not seen (Resident #2) drink, but I have removed many bottles from his room. In addition, the notes concluded, It is very likely that resident had weakness secondary to needing a blood transfusion. The facility failed to conclude the investigation, determine the circumstances of the event and rule out neglect of staff to provide care and supervision of Resident #2 to ensure the resident's safety. Staff B, interviewed on 06/05/2020 at 10:10 AM, stated that there was no investigation to rule out abuse and neglect. RESIDENT #4 Review of the progress notes dated 05/28/2020 at 2:00 PM showed, Patient reported that another resident came into her room last night and hovered over her in bed and patient stated that the other patient in her room threatened to hit Resident #4. Resident #4 reported feeling unsafe. Informed (Resident #4) that SS (Social Services) discussed with the other patient and that the patient was put on 20 minute checks for the night. Patient was agreeable to this intervention. Review of the May 2020 Reporting Log showed the allegation of abuse was not logged. Interviewed on 06/05/2020 at 10:10 AM, Staff B, stated that the incident, if not logged was not investigated and the Department was not notified, if this action was not indicated on the log. Staff B, continued stating that, the perpetrator, Resident #8, was placed on twenty minute observations by staff. When asked how this would protect Resident #4, considering Resident #8 was self-ambulatory and had easy access to all areas of the facility, Staff B had no reply. RESIDENT #9 Review of progress notes dated 03/31/2020 showed Resident #9 complained about Resident #10 waking him up and night and wanting to fornicate with him. Review of Resident #10's record showed a 03/10/2020 at 1:32 PM physician documentation that Staff reports that he has been having an increase in inappropriate sexual behavior . Review of the 03/31/2020 5:11 PM facility report to the Department, showed at 5:30 AM Resident #9 told Staff B that his roommate (Resident #10) approached his bed and began making inappropriate comments .Resident #9 told Staff B, If he touches me, I'm going to punch him in the face. Staff B told Resident #9 that it would be considered assault and the police would be called if he touched another resident. Resident #9 asked that Resident #10 be moved to another room. Staff B assured Resident #9 that she would discuss this with the IDT (Interdisciplinary Team) and find a solution and get back to him. In addition, in the report to the Department, Staff B stated that later in the afternoon, Resident #9 told another staff member in more graphic detail what Resident #10 said, including the statement, I'm going to f**k you in the ass and that he was, very upset about this. Review of a 03/31/2020 12:36 PM Progress note showed Resident #10 was, provided room change following verbal conflict with roommate. The facility failed to identify alleged sexual abuse, and failed to protect Resident #9 from his roommate, Resident #10 pending investigation. The facility investigation was requested. On 06/08/2020 the facility provided a report which indicated an investigation was initiated, but failed to include investigative documents, statements from staff working at the time of the alleged incident, behavior monitoring, or similar information the facility would use to conclude if abuse or neglect occurred. The facility failed to conduct a thorough investigation. REFERENCE: WAC 388-97-0640(6)(a)(b). .
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure 16 (#s 7, 3, 20, 26, 12, 28, 25, 13, 19, 21, 23, 24, 27, 29, 2 & 30) of 19 Residents reviewed for provision of bathing/showers, were offered and/or received

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) showers/bathing. This failure placed these residents in a position to be dissatisfied with care provision, suffer skin break down, and placed all residents at risk for receiving less than necessary and customary care and services. Findings included . RESIDENT #7 Resident #7, in an interview on 06/12/2020 at 10:40 AM, stated that regular showers were not provided for 11 weeks, resulting in a skin infection. Resident #7 stated that the last shower received was 06/04/2020. Resident #7 stated that the lack of bathing was so upsetting and made the resident cry. Resident #7 stated that there was no longer a bath aide and the assigned aide was not providing bathing/showers. A collateral interview on 06/12/2020 at 9:20 AM stated that Resident #7 told family about the lack of bathing/showers. Review of the 06/10/2020 Quarterly Minimum Data Set (MDS - an assessment tool) showed that bathing did not occur during the (seven day) observation period and the resident had not refused care. Review of the 05/12/2020 Care Plan showed Resident #7 required one person assist with bathing/showering, but the frequency of bathing was not noted. May 1, 2020 through June 12, 2020 bathing records were reviewed and showed that staff documented Resident #7 refused bathing/shower on 05/28/2020. The record showed on 06/04/2020 staff documented bathing was not applicable. There was no other documentation to support bathing/showers were offered, refused, or provided during this time period. Staff B, Director of Nursing, in an interview on 06/12/2020 at 4:29 PM, stated that Staff M, the Certified Nursing Assistant assigned to Resident's #7's care, stated that Resident #7 received a shower 6/11/2020, despite Resident #7's claim that showers were not received. Review of May to June 2020 Physician order [REDACTED].#7 did have skin breakdown that required medical intervention. RESIDENT #3 Review of the 06/02/2020 Quarterly MDS showed bathing did not occur during the observation period and the resident had not refused care. Review of the 02/25/2020 Care Plan showed Resident #3 required one person assist with bathing/showering 2 X/week and as necessary. During an interview on 06/02/2020 at 2:55 PM Resident #3 stated that his last shower had been about two weeks prior. Resident #3 stated, they don't have no shower aides, the nursing assistants assigned to do showers had not offered a shower, or a bed bath, they skip over ya. Review of shower records on 06/03/2020 showed Resident #3 had been offered and received only two showers in the prior 30 days, on 05/05/2020 and 05/12/2020. RESIDENT #20 Review of the 03/17/2020 Quarterly MDS showed the resident required one person physical assist with bathing and the resident had not refused care. During an interview on 06/15/2020 at 10:35 AM, Resident #20 stated that he had received a shower Friday (06/12/2020). Resident #20 stated, I used to get them twice a week, but when they had the big change over, and people moved positions, I never did get a shower for a couple months. Review of shower records from 04/26-06/12/2020 showed Resident #20 was provided bathing on 04/27/2020, 05/04/2020, 05/08/2020, 05/11/2020, then not offered again until 06/01/2020, and 06/12/2020. RESIDENT #26 Review of the 05/27/2020 Admission MDS showed bathing did not occur during the observation period and the resident had not refused care. Review of the 05/30/2020 Care Plan and aide directives showed that there was no instruction to staff on the residents bathing preference or number of times the resident wanted to be bathed/showered during the week. Resident #26's May-June 2020 bathing/shower records showed that this resident was not offered or received bathing or showers. RESIDENT #12 Review of the 06/03/2020 Admission MDS showed bathing did not occur during the observation period and the resident had not refused care. Review of Resident #12's clinical record showed that the resident was admitted to the facility 05/27/2020. Review of the 05/27/2020 Care Plan and aide directives, revised 06/09/2020 showed there was no instructions to staff about the resident's bathing choice or number of times they wanted to be bathed/showered during the week. Review of the bathing records showed Resident #12 was not offered, received, or refused bathing or showers. RESIDENT #28 Review of the 05/06/2020 Admission MDS, and the 06/11/2020 Discharge MDS showed bathing did not occur during the observation periods and the resident had not refused care. The 05/30/2020 Care Plan and aide directives did not include instruction to staff on the resident's bathing choice or the number of bathing opportunities the resident wanted during the week. Resident #28's May-June 2020 bathing/shower record showed that this resident was not offered or received a bath/shower. RESIDENT #25 Review of the 06/04/2020 Admission MDS showed the resident required one person physical assist for bathing, and the resident had not refused care. Review of the 05/29/2020 Care Plan and aide directives showed that the level of bathing assistance and frequency was not specified. Resident #25's clinical record showed that the resident was admitted to the facility 05/29/2020 but had not been offered or refused bathing opportunities as of 06/12/2020. Similar data was identified for; RESIDENT #13 Review of the 03/16/2020 Admission MDS showed the resident required two person physical assistance with bathing and the resident had not refused care. Resident #13's May-June 2020 bathing/shower records showed that Resident #13 was last showered on 5/17/2020. RESIDENT #19 Review of the 06/07/2020 Discharge MDS showed bathing did not occur during the observation period and the resident had not refused care. Resident #19's May-June 2020 bathing/shower records showed that this resident received one bath/shower on 05/25/2020 RESIDENT #21 Review of the 06/10/2020 Discharge MDS showed bathing did not occur during the observation period and the resident had not refused care. Resident #21's May-June 2020 bathing/shower records showed that Resident #21 received a shower on 05/16/2020, a bed bath on 05/20/2020 and 05/21/2020, and refused 05/26/2020. The resident was discharged [DATE] with no additional offers or refusals of bathing. RESIDENT #23 Review of the 04/03/2020 Quarterly MDS showed bathing did not occur during the observation period and the resident had not refused care. Resident #23's May-June 2020 bathing/shower records showed Resident #23 had not received a shower since 05/23/2020. RESIDENT #24 Review of MDS data showed an Entry Tracking MDS dated [DATE], which does not include bathing or behaviors. Resident #24's May-June 2020 bathing/shower records showed that this resident received no bathing/showers since 5/27/2020. RESIDENT #27 Review of the 05/03/2020 Annual MDS showed bathing did not occur during the observation period and the resident had not refused care. Review of the 10/29/2019 Care Plan showed the resident required total assistance with bathing/showering 2 X/Week and as necessary. Resident #27's May 1, 2020-June 12, 2020 bathing/shower records showed that this resident received only two bed baths, on 05/18/2020 and 05/20/2020. RESIDENT #29 Review of the 05/27/2020 Admission MDS showed bathing did not occur during the observation period and the resident had not refused care. Resident #29's clinical record showed that the resident was admitted to the facility on [DATE]. The May-June 2020 bathing/shower records showed that this resident had only one shower on 06/09/2020. RESIDENT #2 Review of MDS data showed an Entry Tracking MDS dated [DATE], which does not include bathing or behaviors. During an interview on 06/02/2020 at 1:30 PM Staff B stated that Resident #2 had a strong preference for one aid, and would only accept showers from that aide. Staff B stated that Resident #2 had been offered showers from different aides and refused. During an interview on 06/15/2020 at 9:05 AM Resident #2 stated that he had gone five weeks without a shower, and prior to that three weeks without a shower. Resident #2 stated that the last shower was provided five days prior. Resident #2 stated that the facility wanted him to receive a shower by staff other than the shower aide, and commented that some people are not trained for it, some do not have the personality to do it, and as a result everybody runs around trying to figure it out and nothing gets done. RESIDENT #30 Review of the 06/06/2020 Quarterly MDS showed bathing did not occur during the observation period and the resident had not refused care. During an interview on 06/15/2020 at 10:40 AM, when asked about showers, Resident #30 stated, No, for some reason I'm not getting them. When asked when a shower had been provided last, Resident #30 stated, I don't remember. I'm always asking for one. During an interview on 06/15/2020 at 10:49 AM Staff A, Administrator stated that the bath aide position had been eliminated within the last month. Staff B stated that the dedicated bath aide was returned to the floor to lower staff to resident ratios, but with the call outs it actually increased the work load, and it didn't work out. REFERENCE WAC 388-97-1060(2)(c) .
F 0689 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**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 observation, interview and record review, the facility failed to provide adequate monitoring and supervision of five (#s 2, 3, 4, 6 & 7) of six sampled residents who smoked. The facility failed to accurately assess each resident's smoking safety, failed to ensure precautions were implemented for residents' safety, including ensuring residents smoked only in designated areas, supervising residents whose assessments and care plans indicated a need for assisted and supervised smoking, limiting the accessibility of lighters by residents who needed supervision when smoking for safety reasons. The facility's failure to ensure that their smoking policy was implemented regarding smoking safety and supervision of residents who smoked, resulted in an Immediate Jeopardy on 06/04/2020. Findings included . Review of the facility undated Smoking Policy and Procedure showed, All residents who smoke will be screened using the Smoking Safety Data Collection UDA, to assess their ability to smoke independently upon admission, quarterly, and with a significant change of condition to determine any special needs and to assess their ability to smoke independently.; All residents who meet the criteria to smoke independently may smoke in the Center's designated smoking areas without staff supervision.

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 5) Residents who are assessed as independent smokers may retain possession of their smoking materials .such residents must adhere to the following requirements No smoking materials will be given to another resident. Residents who fail to adhere to these requirements after counseling will be required to have all their smoking materials stored in a secure area at the nurse's station. Review of the facility Smoking Evaluation template section F2 showed instructions to evaluating staff, Has resident demonstrated non-compliance with smoking policy requirements? If yes, resident is unsafe to smoke. On 06/02/2020 around 2:30 PM in the company of Staff B, Director of Nursing Services (DNS), Resident #2 was observed smoking outside on the cement pathway leading to the smoking area, with Resident #3 and Resident #4. No ashtrays were observed in the area. Staff B stated that Resident #2 was not supposed to be out smoking at all and was super non-compliant. At this time, Staff B informed the residents they were to smoke in the designated smoking area. Resident #3 stated I tried to get to the smoking section, but I can't get through. Resident #4 was observed blocking the pathway to the smoking area. Resident #2 was observed to discard a cigarette butt in a trash can located on the back patio. Staff B instructed the resident to use the ashtray in the smoking area. When asked if all three residents were assessed as independent smokers, Staff B stated, Yes. RESIDENT #2 Review of the Smoking Evaluation dated 12/09/2019 showed Resident #2 was assessed as an Independent Smoker. Review of the 02/21/2020 Care Plan, showed Resident is a daily smoker. The only intervention listed was, Provide smoking policy and ongoing safety surveillance. Review of Progress Notes dated 01/12/2020 at 10:20 PM showed Resident was found to be smoking in his room. Went in the room and resident stated that he had fallen asleep in his chair and woke up and automatically lit a cigarette, and then put it out. Explained to the resident that this is a fire hazard and will not be tolerated. Cigarettes and lighter removed from his room. The facility failed to reassess the resident's smoking safety after the resident demonstrated non-compliance with the smoking policy. Review of a Progress Note dated 03/17/2020 at 9:24 PM showed, Staff member reported to this writer that he caught this resident smoking in the room. Upon asking the resident, resident denied. Resident stated he keeps cigarettes buts in his jacket and that's what's smelling. Resident educated the dangers of smoking in his room and advised not to put cigarettes buts in his jackets due to risk of fire and resident voiced understanding. Review of a Progress Note dated 03/19/2020 at 9:55 AM showed, Spoke with resident regarding smoking in his room. Resident denies smoking in his room. He tells LN (Licensed Nurse) that he collects his cigarette butts in his pack because he can not reach the ashtray. He tells LN he was not smoking in his room and he knows how to use his locking draw. Resident is noted to be a/o x 4 (alert and oriented times four) and has never been known to be non compliant with smoking policy. The facility failed to reassess the resident's ability to demonstrate use of an ashtray after the resident reported an inability to reach the ashtray. Review of the 04/06/2020 Discharge Minimum Data Set (MDS - an assessment tool) showed that on 04/06/2020 Resident #2 had an unplanned discharge, return anticipated. Review of the 04/16/2020 Entry Tracking MDS showed that Resident #2 readmitted to the facility on [DATE]. Review of a Progress Note dated 04/16/2020 at 10:18 PM showed, reported by DON (Director of Nursing) that resident was back to facility this morning . resident went outside couple of times this shift for smoke, resident is in isolation, encourage resident not to socialize with other resident's all the way to other side of smoking zone, resident is ok with that, admission paper work has been done . The resident was not assessed for smoking safety until 04/22/2020. According to the 04/22/2020 Smoking Evaluation, the resident was assessed as safe to smoke independently. According to this evaluation the resident had not previously demonstrated non-compliance with the smoking policy requirements. Review of Progress Notes dated 05/16/2020 at 2:48 AM showed, Resident in and out smoking most part of the night. He denied having any pain, swelling on the eye due to a fall slightly gone down with no bleeding noted. Will continue monitor. Review of Progress Notes dated 05/28/2020 at 10:25 AM showed, This AM (Resident #2) was outside on the patio (not the smoking section) lighting up a cigarette. Writer of this note approached resident about the smoking policy. Writer of this note stated that it was a safety issue and that this was for everyone that smoked here at Auburn. (Resident #2) stated, I was just about ready to give you a compliment but now I find out you are like the rest of the people here. Resident then immediately went towards the smoking section to smoke the rest of his cigarette. Review of progress notes dated 06/01/2020 at 06:42 AM showed, At this time resident again is out of his room on the back patio smoking under the no smoking sign. Resident informed again that he is under self quarantine and should not be in the hall or smoking in non smoking areas. The facility failed to reassess the resident's smoking safety after the resident demonstrated non-compliance with the smoking policy. Additionally, record review showed Resident #2 signed an acknowledgment of having read the smoking policy, and agreement to abide by the Center's Smoking Policy on 11/13/2019. The facility did not have the resident review the smoking policy when readmitted to the facility, or after demonstrated non-compliance. RESIDENT #3 Review of the Smoking Evaluations dated 09/16/2019, 12/09/2019, and 04/02/2020 showed Resident #3 was deemed an Independent Smoker. According to the 09/25/2018 Care Plan, Resident #3 was At risk for injury when smoking. The Interventions listed were, Complete Smoking Data Collection and Assessment, and Due to homeless people in our community resident to ask staff to escort to the smoking area. and Store smoking materials at nurses station. During an interview on 06/02/2020 at 2:55 PM, when asked about smoking materials, Resident #3 stated, I keep them in my pocket. If I go to sleep, I lock them up. RESIDENT #4 Review of the Smoking Evaluations dated 10/17/19 and 12/09/19 showed Resident #4 was deemed an Independent Smoker. Review of the resident's Care Plan showed the resident was identified as At risk for injury when smoking on 10/17/2019, and non-compliant with smoking rules on 12/13/2019. Interventions included, Monitor compliance to smoking policies and Review smoking rules when non-compliant. Review of a Progress Note dated 03/22/2020 at 8:15 PM showed, Resident has been noted to be going out the back door to smoke, has been explained that there is a designated smoking area, and this is where residents need to smoke. Resident has been noted outside on the sidewalk after asking her to go to designated area. Review of the 11/06/2019 Resident signed facility Smoking Policy and Procedure, showed the resident had not reviewed the smoking policies when non-complaint, as directed in the resident's plan of care. In addition, the facility failed to reassess the resident's smoking safety after the resident demonstrated non-compliance with the smoking policy. Similar findings were noted for Resident #6 & #7 for whom the facility failed to reassess residents for smoking safety, or provide an increased level of supervision after the facility became aware of increased safety risks. RESIDENT #6 Review of the 04/28/2020 Care Plan showed Resident #6 was Non Compliant with smoking rules. Interventions listed include, Educate risk of non-compliance (e.g. potential discharge, risk of center fire), Encourage resident to follow smoking rules .Encourage resident to provide own smoking materials to prevent the need to bum/borrow from other residents Review of the Smoking Evaluation dated 04/30/2020 showed Resident #6 was deemed an Independent Smoker. Review of a progress note dated 04/20/2020 at 10:22 PM showed, Resident was found sitting on the floor on the outside patio, walker in front of her. Resident in no apparent distress laughing and joking around with nursing staff. Resident wearing slippers. Resident had gone out for a smoke. Walker unlocked. 'I tried to sit on my walker but I forgot to lock it. I slipped down and hit the floor on my butt. Just help me get up already, I am not hurt. Review of a progress noted dated 05/29/2020 at 8:35 AM showed, SSA (Social Service Assistant) and admissions director talked to rsd (Resident) about not giving cigarettes to other residents. Rsd seemed to understand that she might lose her smoking privilege if she continues to give cigarettes to other residents. RESIDENT #7 Review of the 01/31/2017 Care Plan showed Resident #7 was At risk for injury when smoking r/t (related to) deconditioning. Interventions included, Due to homeless people in our community resident to ask staff to escort to the smoking area, Review smoking policy with resident/responsible party, Rsd to keep cigarettes and lighter secured on person or in room locked up, Store smoking materials at nurses cart. The resident will turn in smoking supplies on return from smoking . Review of progress notes dated 04/13/2020 at 04:08 AM showed, Resident also likes to go out to smoke at night she knows she is suppose to call LN (Licensed Nurse) using the walkie talk to call for door to be opened. However sometimes the resident refuses to use it. Resident needs a reminder of clear policy on smoking and timings of smoking going forward while in isolation room. Resident also not comfortable smoking in that area at night but we can't have the door open. Review of the facility Smoking Policy and Procedure, showed the resident had not reviewed and signed the smoking policy and procedure since 09/19/2019. Review of the Smoking Evaluation dated 04/17/2020 showed Resident #7 was deemed an Independent Smoker and demonstrated no non-compliance with smoking policy requirements. REFERENCE: WAC 388-97-1060(1)(3)(g) .
F 0838 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.** Based on interview and record review, the facility failed to thoroughly and completely evaluate its resident population in

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F 0838 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 6) order to develop, evaluate, and implement a Facility Assessment which addressed and incorporated all required components to meet each resident's care and service needs. This failure had the potential to affect the 82 residents who resided at the facility. Findings included . Review of the undated Facility Assessment showed the Facility campus is strictly smoke-free for residents (yes) and staff (no). The Resident Profile data did not include Resident Smokers. The Physical Environment Module of the assessment did not include the designated smoking area. The facility assessment of equipment and supplies did not include those items required to ensure safe smoking, including but not limited to smoking aprons, and safety ashtrays. The facility provided a list of resident smokers on 06/03/2020 that included seven (#s 2, 3, 4, 5, 6, 7 & 9) Residents. Record review of the facility's undated policy titled, ID/OR/WA Smoking Policy, showed that the facility permits residents to smoke in the designated smoking areas. During an interview on 06/09/2020 at 12:30 PM, Staff A, Administrator acknowledged the resident profile did not address smokers. Staff A stated that the environmental and supply information may be in the Emergency Preparedness Planning and Resource Book. The facility provided a 06/09/2020 revised facility map which noted the area of the smoking area on 06/10/2020. In addition, review of the Facility Assessment showed that although the resident capacity was noted (125), the number of residents (census), at the time the resident data was obtained, the current census when the assessment was reviewed and/or the facility average census was not noted. During an interview on 06/09/2020 at 12:30 PM, Staff A was notified and stated that the average facility census was 87 residents. Review of the undated Facility Assessment did not address staffing levels or how the facility determined the level of staffing needed to meet the resident's needs and to ensure safety. Those healthcare workers who provide direct care (Certified Nursing Assistants, Nurses), without management duties was blank. In addition, contracted Healthcare Professionals, including, but not limited to Dentist, Therapists, Podiatrist, was not addressed. In addition, the Facility Assessment did not include the Payroll Based Journal (PBJ) data that was submitted to Centers for Medicare & Medicaid Services (CMS). Review of staffing levels is a vital component in the facility's ability to provide quality care. During an interview on 06/09/2020 at 12:30 PM Staff B, Director of Nursing stated that the information could be retrieved from the software. Review of the undated Facility Assessment showed a 10/15/2018 Facility Characteristic Report derived with data from a facility other than this facility. During an interview on 06/09/2020 at 12:30 PM, Staff A stated the Facility Assessment had been reviewed by the former Administrator in September 2019. No associated WAC .
F 0865 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a plan that describes the process for conducting QAPI and QAA activities.** Based on interview and record review the facility failed to identify deficient systems of care and services. Failure to ensure effectiveness of a comprehensive Quality Assurance and Performance Improvement (QAPI) program for these care and services placed residents at risk for reduced quality of care and quality of life. Findings included . Review of the facility, Quality Assurance and Performance Improvement (QAPI) Process, dated January 2017, the facility reviewed metrics include, Review of survey issues, Accident and incident data, and Safety Issues in the QAPI Process. The facility QAPI program failed to monitor or evaluate the effectiveness of previous corrective action/performance improvement activities, and revise as needed, the following identified areas of past non-compliance: Reporting of Alleged Violations (Refer to F 609). This is a repeat citation from 01/16/2020, 11/28/2018, and 08/09/2017. Review of an electronic transmission dated 06/09/2020 at 3:36 PM, sent by Staff A, Administrator, showed that the facility held QAPI meetings in February 2020 and May 2020, and that no abuse trends were noted for the most recent QAPI meeting of 05/27/2020. On 06/15/2020 at 11:04 AM Staff A and Staff B, Director of Nursing were notified that failure to identify the facility's failure to implement Abuse Prevention measures, including, but not limited to Prevention, Identification, Reporting, and Investigation indicated the facility QAPI program was not effective. In addition, On 06/15/2020 at 11:04 AM Staff A and Staff B were notified that failure of the facility to identify deficiencies in the area of safety and accidents, as it related to implementation of the facility smoking policy and procedure, indicated the facility QAPI program was not effective. Reference WAC 388-97-1760(1)(2) .
F 0926 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have policies on smoking.** Based on observation and record review, the facility failed to ensure policies regarding smoking, smoking areas, and smoking safety were established in accordance with state and local laws and regulatory requirements. Failure of the facility placed residents, staff, and visitors at risk for second-hand smoke inhalation, at risk for residents to have smoking materials who were unsafe to handle them, and placed residents at risk of non-compliance with the facility smoking policy. Findings included . Record review of the facility's undated policy titled, ID/OR/WA Smoking Policy, showed that Residents admitted prior to the effective date of this policy and who are assessed as independent smokers may retain possession of their smoking materials if desired. Record review of the undated Facility Assessment showed that the date of the most recent policy and procedure review and update was 12/01/2017 and that the facility did not have any residents who smoke that were grandfathered in. Record review of the facility's undated policy titled, ID/OR/WA Smoking Policy, showed that all residents who smoke will be screened using the Smoking Safety Data Collection and Assessment UDA . Record review showed the facility screened residents who smoked using the Smoking Evaluation. Record review of the facility's undated policy titled, ID/OR/WA Smoking Policy, did not address storage of smoking materials for those residents deemed independent, who were not admitted prior to the effective date of the policy, or for those residents assessed as requiring smoking supervision. On 06/02/2020 around 2:30 PM Residents # 2 and #3 were observed to have cigarettes and lighters in their possessions. Record review of the facility's undated policy titled, ID/OR/WA Smoking Policy, showed the policy did not include the prohibition of smoking when oxygen is in use, disposal of smoking materials and prohibition of sharing of smoking materials. Record review of the facility's undated policy titled, ID/OR/WA Smoking Policy, did not address applicable state, and local laws and regulations (RCW 70.160.075, November 2005) prohibiting smoking within twenty-five feet from entrances, exits, windows that open, and ventilation intakes. On 06/02/2020 around 2:30 PM in the company of Staff B, Director of Nursing Services (DNS), Resident #2 was observed smoking outside on the cement pathway leading to the smoking area, with Resident #3 and Resident #4. The residents were observed smoking near windows that opened to resident rooms. REFERENCE: WAC 388-97-1780. .
F 0947 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.** Based on interview and record review, the facility failed to maintain and track in-service hours for four (Staff N, K, O, & P) of four Nursing Assistants (NA) sampled to ensure each NA received at least 12 hours of training per year. This failure placed residents at risk of not receiving adequate care and services. Findings included . Review of facility provided User Learning computer print outs per staff member showed a columns with a computer code, Title of the training, Type, Grade, Due Date and Completed date. Additional training records were also reviewed. Review of training records provided did not include documentation of the duration of each class. Review of employee records provided by the facility showed Staff N, Certified Nursing Assistant (CNA), date of hire (DOH) was 10/24/2018. Review of training records provided by the facility showed that from 10/24/2018 to 10/23/2019, Staff N had only completed General Orientation on 10/16/2019. No additional training hours occurred during the employee's training year. In addition, Staff N had not received dementia management training since being hired. On 06/11/2020 at 2:50 PM the facility provided an email clarification that Staff N's hire date was October 2019 not 2018. Review of employee records showed Staff K's, CNA, DOH was 12/31/2014. Review of training records showed from 12/31/2018 to 12/30/2019 the employee completed 21 trainings, of unknown duration. Staff K's record did not include resident abuse prevention training. It was not until the Department requested staff training records, did the facility recognize Staff K had not completed CNA Skills Competency. In an electronic transmission, dated 06/11/2020 at 2:55 PM, Staff B, Director of Nursing, stated that the Competency was completed on 06/11/2020. Review of training records for Staff O, CNA and Staff P, CNA showed no duration of trainings completed, and no cumulative hours for their training year. In an electronic interview on 06/10/2020 at 4:43 PM, Staff B, Registered Nurse and Director of Nursing Services, stated that We inquired about calculating hours on education, but that information is not available. In an electronic interview on 06/11/2020 at 8:35 AM, Staff B stated that the facility had a list of hours earned for each course, but it is not automatically calculated. We are figuring out hours for your sample. On 06/11/2020 the facility provided results of their audits, which showed, the following staff had less than 12 hours of inservice education; Staff K in 2016, and Staff P from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505195	A. BUILDING _____ B. WING _____	**06/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTH AUBURN REHAB & HEALTH CENTER	**2830 I STREET NORTHEAST AUBURN, WA 98002**

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F 0947 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 7) 2/2017-01/2018. REFERENCE WAC 388-97-1680 (2)(a-c) .