STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505017	A. BUILDING _____ B. WING _____	**09/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WASHINGTON CARE CENTER	**2821 SOUTH WALDEN STREET SEATTLE, WA 98144**

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** - 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 interview and record review, the facility failed to implement appropriate and effective interventions to prevent Resident #1 from engaging in resident-to-resident physical and verbal altercations with four other residents (#2, #3, #4 and #5), in a sample of six residents. This failure prevented staff from identifying resident behavior disturbances and implementing appropriate behavioral interventions, which contributed to recurent resident to resident altercations, and placed all residents at risk for physical/mental abuse, and well as diminished quality of life. Findings included . According to the annual Minimum Data Set (MDS) assessment, dated 03/31/2020, Resident #1 was initially admitted to the facility on [DATE] with medically disabling conditions including developmental delay, irritability, and anger. Review of Resident #1's comprehensive Care Plan (CP) and the resident Treatment Administration Record (TAR) dated 06/30/2020, showed Resident #1 exhibited abusive behaviors, and staff were to monitor the resident for the number of episodes of yelling, hitting, throwing things and refusal of care. Further review of the TAR dated September 2020, showed Resident #1's had behavior disturbances twice on 09/01/2020, twelve times on 09/02/20, twice on 09/03/2020, once on 09/04/2020, and three times on 09/08/2020. The TAR did not specify for any of these episodes what behaviors the resident exhibited, or what associated interventions staff implemented to ensure resident safety. Review of the above TAR showed that in addition to documenting specific resident behaviors/related interventions, staff were to document the effectiveness of the interventions. Review of this TAR and related progress notes did not show staff followed up with the resident to determine effectiveness of any interventions that were attempted. Review of facility investigations and progress notes revealed Resident #1 was involved in four resident-to-resident altercations from January 2020 through September 2020. The following altercations represented physical abuse by Resident #1 toward other residents. INCIDENT #1 Review of the nursing progress notes and investigation related to resident-to-resident altercation on 01/30/2020 showed Staff F, a Social Worker (SW) heard Resident #1 yelling, when she approached the elevator area, she observed Resident #1 yelling at Resident #2 and stated, Stupid(NAME) he would not let me out. Resident #1 then proceeded to hit Resident #2 in the right upper arm. The investigation showed staff immediately separated the residents. Record review of Resident #1's medical record including Comprehensive Care Plan did not show the facility implemented new interventions to prevent recurrence. INCIDENT #2 Review of the facility investigation and progress notes related to an incident on 05/09/2020 revealed Resident #1's roommate (Resident #3) reported allegations of physical and verbal abuse by Resident #1 to Staff G a Social Worker (SW). Resident #3 told Staff G that, Resident #1 threw a cup of water on her. The investigation showed, when Resident #1 was asked, she acknowledged and confirmed throwing a cup of water on the roommate (Resident #3). The altercation did not result in physical injury. Resident #3 was moved to a different room as preventative measure for further altercations. Further review of the investigation and Resident #3's care plan did not show how the facility was going to ensure the safety of Resident #1's future roommate and the safety of the other residents from Resident #1's abusive behavior. Review of the Resident #1's CP showed how staff were to intervene if they noted the resident exhibiting abusive behaviors (Yelling at other resident, Hitting other residents and throwing water cups at other residents), but the CP did not address measures staff were to implement to prevent further altercations. INCIDENT #3. Review of the facility investigation and progress notes related to an incident on 06/03/2020 showed at 4:40 PM Staff G, noted Resident #1 outside of her room yelling and shouting in a loud voice at her roommate (Resident #4) stating You are white trash. Staff G entered Resident #1's room to check on the roommate to ensure she was safe. When Staff G left the resident's room, Resident #1 re-entered the room and continued shouting and yelling at her roommate (Resident #4). According to the progress notes and the investigation, when Staff G attempted to redirect Resident #1, the resident threw a cup of water on Staff G. When Staff H attempted to redirect the Resident #1, the resident hit Staff H, a Social Worker (SW) on the arm. According to the incident investigation, Resident #4 was moved to a different room for safety. There were no new implemented interventions in place to ensure safety of the resident's new roommate Resident #6, who had just moved in after Resident #4 was moved to another room. INCIDENT #4 Per the facility investigation and progress notes, related to an incident on 08/21/2020, Resident #1 was temporarily moved out of her room to an isolation room as a precautionary measure. Review of progress notes dated 08/21/2020 showed, Resident #1 was cleared from isolation and moved back to her originally designated room on 08/17/2020. Further review of progress notes showed, Resident #1 found a new roommate (Resident #5), who was newly admitted 07//01/2020 and moved into Resident #1's room on 08/12/2020. On 08/21/2020 at 9:30 AM (three days of Resident #1 and Resident #5 sharing a room), Resident #5 reported to staff that Resident #1 had thrown a cup of water on her. Upon assessment, Resident #5's body and bed covers were noted to be wet, and an empty cup of water was noted next to the Resident #5' bed. There were no physical injuries noted. When Resident #1 was asked, she acknowledged throwing water a cup of water on Resident #5. Resident #5 was moved to a different room for safety and to prevent her from having further altercations with Resident #1 According to the incident investigation documentation, Resident #1 was the youngest resident in the facility ([AGE] years old) and her needs priorities were different. Resident #1 had multiple incident altercations, with Resident #1 being the aggressor. This investigation, noted Resident #1 was Developmentally Delayed (DD) and her reasoning was flawed. On 10/01/2020 in an interview, Staff I, a Social Worker (SW) who was familiar with Resident#1's behaviors, stated, Resident #1 exhibited behaviors such as yelling and throwing stuff and hitting other residents and staff and Resident #1 was easily irritable. Staff I further stated that Resident #1 was not a right candidate for sharing a room with other residents considering her past behaviors and incidents with other residents. On 10/01/2020 at 5:15 PM, when Staff B, the facility's Director of Nursing Services (DNS) was asked what interventions the facility had put in place to ensure Resident #1's roommates (Residents #3, #4, & #5) were safe, having known the resident's abusive behavior towards others residents? Staff B did not answer, and stated that he was going to consult with his team and provide a response the following day 10/02/2020). On 10/02/2020 10:00 AM, when asked, Staff B said, he did not foresee any altercations between the residents. When asked how he made the determination there were not going to be altercations between Resident #1 and Resident #2, Staff B said he made the determination based on Resident #1's quiet nature On 10/02/2020 at 10:30 AM, Staff A, the facility's administrator acknowledged deficiency practice. Despite the facility's awakes of the resident's abusive behavior towards other residents, impaired cognition and inability to comprehend safety instructions not to abuse roommates and other residents, the facility did not implement appropriate interventions to prevent Resident #1 from abusing future roommates and / or other residents. This failure, placed all vulnerable residents at risk for serious harm and diminished quality of life.

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.