STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505418	A. BUILDING _____ B. WING _____	**09/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PROVIDENCE MARIANWOOD	**3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029**

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 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 Abuse Prohibition policies and procedures including, but not limited to, prevention, identification, investigation and protection of one (#1) of one resident reviewed for abuse. This failure placed the resident at risk for mental anguish and a diminished quality of life. Findings included . A facility policy dated 01/2020 and titled Abuse and Neglect Guidelines showed, No injury will be determined accidental without a thorough investigation to determine cause. RESIDENT #1 Review of a 07/13/2020 Significant Change Minimum Data Set (MDS-an assessment tool) showed Resident #1 was re-admitted to the facility on [DATE], had impaired vision, moderately impaired cognition, and a [DIAGNOSES REDACTED]. Male caregiver reported to this author that it is not the first time she reported some fears while in bed. This situation made the caregiver uncomfortable. In an interview on 09/01/2020 at 2:17 PM, Staff D, Certified Nursing Assistant (CNA), confirmed he was a designated CNA for Resident #1. When asked about her mood and behavior, Staff D stated, There's a point there where she was depressed quite a while, but for the past week she was very confused. She would say things like, 'I'm having a baby.' When I was working with her she accused me and said, 'You're raping me, you're raping me.' That really stood out to me. When asked who he reported this incident to, Staff D stated, (Staff F). When asked when this incident happened, Staff D stated, I wanna' say it happened sometime last week. Review of the medical record showed no documentation the facility investigated the resident's fears while in bed or allegation of Staff D raping her. Review of a facility Investigation Summary (IS) showed that on 08/20/2020, a maintenance staff reported to RCM (Resident Care Manager) that (Resident #1) reported to him that she was raped in the facility. This IS showed Resident #1 stated, she was afraid to be raped again, that it happened nine months ago by the father of her son. Review of the IS showed that, while the facility interviewed cognitively intact residents, the facility did not interview staff who worked directly with Resident #1. In an interview on 09/01/2020 at 1:01 PM, Staff E confirmed she was a designated CNA for Resident #1. Staff E stated, She just moved to our unit more than three to five months ago. She used to be able to make decisions. She has had a change in cognition. When asked if she was aware of a sexual assault allegation, Staff E stated, No. Never said anything like that. In an interview on 09/01/2020 at 4:52 PM, when asked about Resident #1's general mood, Staff F responded, What is this about? When informed about the sexual assault allegation, Staff F stated, What? I'm not aware of it. No, she didn't report that to me. Nobody told me something like that. She was acting a little confused. Never like that, never heard a statement like that. When asked if Staff D reported to her concerns with Resident #1, Staff F stated, He mentioned he did not feel comfortable because the resident was saying, 'Oh no, I don't wanna' be left alone,' and he had to take care of other residents. When asked if Staff D told her about the resident having fears while in bed Staff F stated, No, he didn't say that. I don't think she even said that to him. Basically, she didn't want to be left alone. The above findings were shared in a joint interview with Staff A, Administrator, Staff B (Director of Nursing in Training) and Staff C (Interim Director of Nursing), on 09/02/2020 at 11:30 AM. When asked what the components of an investigation included, Staff A stated, Ensure we interview staff and patients and inform the family members, doctors, clinical managers and Director of Nursing. When asked if the investigation showed the facility interviewed designated staff who had potentially relevant information about the resident's fear while in bed or sexual assault allegations, Staff B stated, I didn't see it. When asked if the facility investigated Resident #1's fears while in bed and what made him uncomfortable about it, or the allegation of Staff D raping her, Staff B stated, No. When asked if the care plan showed the resident experienced fears while in bed and developed interventions to address those fears, Staff A acknowledged it did not and that it would be relevant to include and stated, Certainly, it is. In this continued interview Staff A added, We actually discussed that this morning, about the lack of communication to staff. When asked how she became aware of the lack of communication, Staff A stated the staff called her, after (the Surveyor) called the caregivers, and the caregivers were actually a bit disturbed they were not aware of that (sexual assault allegation) as well. My take on it is there are communication issues. It's each of our responsibility to communicate that over and over again until it's been resolved. When Staff A was asked if the lack of communication with the staff detracted from conducting a thorough investigation as stated in their policy, Staff A stated, We have to do our due diligence, that did not happen, and acknowledged an insufficient investigation. REFERENCE: WAC 388-97-0640(2). .

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.