STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505236	A. Building B. Wing	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edmonds Care	21400 72nd Avenue West Edmonds, WA 98026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35787 Based on interview and record review, the facility failed to timely notify the resident representative of a fall for 1 of 4 residents (Resident 1) reviewed for falls. The failure to notify the resident representative of an unwitnessed fall with head injury did not allow the resident representative an opportunity to make decisions on medical care. Findings included . Review of the admission evaluation form dated 03/14/2023 showed Resident 1 admitted to the facility on [DATE], the admission diagnosis included generalized weakness and recurrent falls. Review of a fall investigation dated 03/20/2023 showed Resident 1 was found supine (lying on back) on the floor of the resident's room at 4:15 PM. A 4.0 x 5.0 centimeter bruise was observed on the left side of the resident's forehead and face at that time. Further review of the fall investigation dated 03/20/2023 and review of the medical record did not show the resident representative was notified of the unwitnessed fall on 03/20/2023 with bruising to the left side of the forehead and face. On 03/30/2023 at 3:32 PM, Staff D, Licensed Practical Nurse/Unit Manager, said that the Resident Representative (RR) should be notified as soon as possible after a resident had a fall. Staff D also said that the RR was not notified until the following day on 03/21/2023 during a care conference that afternoon and that when asked if the RR was aware Resident 1 had a fall the previous day on 03/20/2023, the RR told Staff D they had not been notified of Resident 1's fall incident that occurred on 03/20/2023. On 03/30/2023 at 4:01 PM, Staff B, Director of Nursing Services, said that the RR should have been notified on 03/20/2023, the day of the fall. Reference: (WAC) 388-97-0320

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505236	A. Building B. Wing	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edmonds Care	21400 72nd Avenue West Edmonds, WA 98026

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** 35787 Based on interview and record review, the facility failed to ensure 3 of 5 residents (Residents 4, 6 & 3) were free from abuse. The facility failed to evaluate the effectiveness of current interventions/redirections to monitor Resident 2's intrusive behaviors, after allegations of resident to resident altercations. This failure placed the residents at increased risk for emotional and physical abuse. Findings included . RESIDENT 2 Review of the quarterly Minimum Data Set (MDS-a required assessment tool) dated 03/01/2023, showed the resident was admitted to the facility on [DATE]. The MDS also showed the resident had impaired thinking, memory, and used a wheelchair for mobility. Further review of the quarterly MDS assessment dated [DATE], showed the resident had verbal and physical behaviors that placed other residents at risk for injury, and it showed the resident intruded on the privacy/activity of others and disrupted the living environment. Review of an incident investigation report dated 02/24/2023, showed Resident 4 reported to facility staff that Resident 2 came into their room and grabbed items from the roommates' (Resident 6) over bed table, which included a small cider bottle that was swung at the roommate. Further review of the incident investigation showed Resident 4 grabbed the back of Resident 2's wheelchair and moved Resident 2 away from Resident 6. The incident investigation also documented that Resident 2 swung hands at Resident 4, but it was blocked. A staff member then removed Resident 2 from their room. On 04/13/2023 at 1:55 PM, Resident 4 stated that there was yelling in Resident 4 and 6's room and stated, I went around to my room mates' side of the room, and I saw the resident [Resident 2] next to my roommate's bed. Resident 4 stated that Resident 2 was taking items off Resident 6's table and swung a bottle at them, but Resident 4 was able to block it. Then a staff member took Resident 2 out of their room. On 04/13/2023 at 2:17 PM, Resident 6 stated that Resident 2 was told they were in the wrong room, but Resident 2 came in anyway and reached for items off my table, grabbed the covers on my bed and swung a bottle from my table at me. Resident 6 further stated, I cannot get out of bed by myself, my roommate came over and moved the resident [Resident 2] away from me. Resident 6 stated that after the incident, a staff member removed Resident 2 from their room. Review of the incident investigation report dated 02/24/2023 documented actions to prevent recurrence: Resident will be evaluated for possible infection and medication evaluation by the mental health provider. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505236	A. Building B. Wing	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edmonds Care	21400 72nd Avenue West Edmonds, WA 98026

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	Review of an incident investigation report dated 03/03/2023 showed Resident 3 reported to staff, while Resident 3 waited to use the vending machine in the hallway, Resident 2 came behind Resident 3 and struck them in the back with an open hand. On 04/13/2023 at 12:59 PM, Resident 3 stated that they did not get hurt, and thought Resident 2 tried to push me out of the way. Further review of the incident investigation report dated 03/03/2023 documented actions to prevent recurrence: The resident [Resident 2] was placed on 1:1 monitor. On 03/30/3023 at 3:19 PM, Staff H, Certified Nursing Assistant, stated that Resident 2 always went into other resident rooms and could be difficult to get Resident 2 out. Staff H also said that sometimes Resident 2 would strike out at staff when they tried to remove them from other resident rooms. On 04/13/2023 at 1:21 PM, Staff J, Social Services Assistant, stated that they put Resident 2 on 1:1 for staff monitor when Resident 2 gets agitated but there were no indicators or way of knowing when Resident 2 would get agitated. Staff J stated that it was usually when Resident 2 was told no, and that staff tried to keep Resident 2 in their line of sight and redirect them. On 04/13/2023 at 2:00 PM, Staff B, Director of Nursing Services, stated they have tried redirection, evaluation of Resident 2's medication and now pain management to see if that would help. Reference: (WAC) 388-97-0640 (1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505236	A. Building B. Wing	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edmonds Care	21400 72nd Avenue West Edmonds, WA 98026

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35787 Based on interview and record review, the facility failed to provide residents and/or their representatives written notification in a manner which they understood for 2 of 3 residents (Residents 11 & 1) reviewed hospitalization . The failure to inform the residents' representative of transfer location and the failure to provide written documentation of the transfer placed the residents and/or their representatives at risk of not being informed and potential misinformation. Findings included . RESIDENT 11 Resident 11 was a long time resident of the facility. Review of the nursing progress note dated 02/02/2023, showed Resident 11 was transferred to the hospital for an evaluation of a change in medical condition at the request of the Resident Representative (RR). The nursing progress note dated 02/02/2023, showed Resident 11 was transferred by emergency transport to a nearby hospital. Review of the nursing home transfer or discharge notice dated 02/02/2023, showed location to which resident is transferred or discharged was blank and there was not a named hospital on the transfer/discharge notice. On 03/24/2023 at 9:11 AM, RR3 stated, that they were told Resident 11 went to a nearby hospital, and when RR3 went to the hospital to see Resident 11, RR3 was told Resident 11 was not there and that they had to call around to so many hospitals to find Resident 11. RR3 stated that it was an awful feeling. RR3 stated that when they found the hospital, they had no idea why Resident 11 was there, the facility did not send any paperwork with Resident 11. Resident 11 readmitted back to the facility from the hospital on 02/10/2023. Review of the hospital discharge summary dated 02/10/2023, showed Resident 11 was not admitted to the hospital that was nearby as documented in the nursing progress notes but to a different hospital at a different location. RESIDENT 1 Resident 1 admitted to the facility on [DATE] and was transferred by emergency transport to the hospital on 03/21/2023. Review of the medical record did not show that the facility completed a nursing home transfer or discharge notice for Resident 1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505236	A. Building B. Wing	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edmonds Care	21400 72nd Avenue West Edmonds, WA 98026

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/13/2023 at 2:00 PM, Staff B, Director of Nursing Services, stated that the transfer or discharge notice dated 02/02/2023 was not complete for Resident 11. The hospital location was not filled out. Staff B also stated there was not a nursing home transfer or discharge notice completed on 03/21/2023 when Resident 1 went to the hospital. Reference: (WAC) 388-97-0120 (2) (a-d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505236	A. Building B. Wing	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edmonds Care	21400 72nd Avenue West Edmonds, WA 98026

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35787 Based on interview and record review, the facility failed to ensure 1 of 4 residents (Resident 1) reviewed for falls received complete and timely assessments after a fall with a head injury. The facility had specific guidelines for monitoring residents' neurological status after a fall with head trauma yet did not follow these for Resident 1 who experienced harm with an unrecognized change in level of consciousness, potential pain, and delayed medical response. Findings included . Review of the Admission Evaluation form, dated [DATE], showed Resident 1 admitted to the facility on [DATE] with diagnoses that included recurrent falls and weakness. The Admission Evaluation form also showed the resident was a high risk for falls, required extensive assistance for mobility, and needed supervision for eating meals. Review of the Medication Administration Record dated [DATE] through [DATE] showed Resident 1 was receiving Aspirin (blood thinner) 81 milligrams every morning. Review of a fall investigation, dated [DATE], showed Resident 1 was found in the supine position (lying on back) on the floor of their room at 4:15 PM with a 4.0 centimeter (cm) x 5.0 cm bruise observed on the left side of the resident's forehead and face. Review of the neurological assessment (used to assess, check, and record signs/status following an injury in suspected or actual head trauma) flowsheet form dated [DATE] showed: This assessment should be completed at the following intervals for follow up on falls. A fall that is unwitnessed, or in which the head is struck requires neurological checks. Any change in resident condition requires a phone call to the primary care physician. The neurological assessment intervals listed on the form were to be performed every 15 minutes eight times, every 30 minutes four times, every 60 minutes four times, every four hours four times and every eight hours six times. The neurological assessment flowsheet consisted of two pages. The second page of the neurological assessment flowsheet assessed the level of consciousness (alert, drowsy, stuporous[unresponsive], comatose [unresponsive] and response [appropriate, inappropriate or no response] to pain. Review of the neurological assessment, dated [DATE], showed Resident 1 had an unwitnessed fall with a head injury. The second page of the neurological assessment form was not attached/completed and had no documentation that assessments for Resident 1's level of consciousness or response to pain were performed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505236	A. Building B. Wing	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edmonds Care	21400 72nd Avenue West Edmonds, WA 98026

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 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 2:00 PM, Resident Representative 1 (RR1), stated they visited Resident 1 on [DATE], when entering the room, Resident 1 was unresponsive, had food spilled on the floor, and the resident's legs were covered with milk. RR1 stated that they had to call for staff to come, and three unknown staff members came to Resident 1's room, at 5:58 PM, and one of the three unknown staff members asked the other unknown staff member, What is this [referring to the spilled food and milk]. RR1 said that the other staff member said that it was the resident's lunch tray and that bruises and a huge hematoma (a collection of blood or pooling of blood outside of a blood vessel caused by trauma were observed on the left side of the head and face of Resident 1. RR1 stated, the resident had bruises and had a huge hematoma on her head and supposedly that happened 24 hours prior to that. They should have called 911 right away and the firemen said the same thing. On [DATE] at 8:31 AM, Resident Representative 2 (RR2), stated if someone would have told me she fell on [DATE], the day she fell and hit her head, I would have said I want her sent to the hospital immediately. She might still be alive today if she would have been sent to the hospital the same day she fell . On [DATE] at 3:12 PM, a phone interview with Staff C, Registered Nurse, said they knew Resident 1 was a high risk for fall and they started the neurological checks 15 minutes after Resident 1 fell and saw the bruises and the hematoma on the left side of Resident 1's head and face. Staff C stated that a complete neurological check may show changes in the resident condition after a head injury or other injuries and that it was important to check if they were more confused, not responding at all to pain or anything else, especially with an unwitnessed fall and head injury. Staff C stated that the form they started was only one page long and Staff C stated that they did not see the second page of the neurological assessment form. On [DATE] at 3:19 PM, Staff H, Certified Nursing Assistant, said that residents that required supervision during mealtimes should be checked to see if they were okay or needed help with anything. Staff H also said Resident 1 ate meals independently in their room and required staff supervision. Staff H stated it would be unusual for Resident 1 to spill food and milk and that it would be a change for Resident 1 to do something like that. On [DATE] at 3:03 PM, Staff I, Licensed Practical Nurse, said that RR1 came to the facility on [DATE] around dinner time and found Resident 1 in their wheelchair with their lunch tray on the floor. Staff I also said there was food noted on the floor and that bruises and a hematoma on the left side of the head and face was from a fall that the Resident 1 had the previous day on [DATE]. Staff I said that they could not remember if the second page of the neurological assessment form were completed or not. Staff I then said that RR1 was the one who called 911 and the medics took Resident 1 to the hospital. On [DATE] at 4:01 PM, Staff B, Director of Nursing Services, said that the neurological assessment forms the facility used was two pages long and the second page was not completed for the fall incident that Resident 1 had on [DATE]. Staff B then said if the form had been completed it may have shown changes of condition or assisted staff to recognize a change of condition or injuries. Staff B also said that their expectation was for the nursing staff to complete the neurological assessment form completely if a resident had an unwitnessed fall and/or fell and hit their head. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505236	A. Building B. Wing	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edmonds Care	21400 72nd Avenue West Edmonds, WA 98026

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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of hospital records, dated [DATE], showed Resident 1 admitted to the hospital with an altered mental status and a traumatic brain bleed, was placed on comfort care, and died in the hospital on [DATE]. Reference: (WAC) [DATE] (1)