STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505296	A. Building B. Wing	07/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis of Bellingham	3121 Squalicum Parkway Bellingham, WA 98225

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 - 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** 36787 Based on observation, interview and record review, the facility failed to ensure two of four residents (1 and 21), were free from abuse. The facility failed to protect and adequately assess Resident 1 after an allegation of abuse. The facility failed to obtain an agency nurse's aides background check and ensure adequate preparation and abuse training to meet the resident's needs. This failure resulted in harm for Resident 1 who voiced complaints of physical injury and emotional distress from endured abuse/mistreatment from a Nursing Assistant Certified (NAC). The facility staff failed to protect residents from the agency staff member with an identified allegation, which allowed potential abuse to continue. The facility failed to protect Resident 1 from an agency staff member and Resident 21 from (Resident 4) who the facility identified with a pattern of aggression who recently emotionally abused Resident 21. These failures showed a willful disregard of safety, left all residents vulnerable to continued abuse and resulted in harm for Resident 1 and 21 and placed all residents at risk for abuse, physical injury, fear, mental anguish, agitation, isolation intimidation, and feelings of victimization. Findings included . Review of facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, showed each resident has the right to be free from abuse including verbal, mental and physical abuse. The facility was to protect residents from abuse, neglect by anyone including facility staff and other residents. The facility was to conduct employee background checks, identify and investigate all possible incidents of abuse and protect residents from any further harm during investigations. Review of the facility's policy, Alert charting guidelines for abuse & neglect, undated, directed staff they must intervene and protect the resident(s), notify the on-call nurse manager, contact the DNS (Director of Nursing Services)/ADM (Administrator), call hotline (or ensure DNS or Admin will be calling), notify family/Power of Attorney (POA), place the resident on alert status. RESIDENT 1 Resident 1 admitted on [DATE] with diagnoses to include chronic respiratory conditions. According to the 07/14/2022 Quarterly Minimum Data Set (MDS) assessment, the resident was cognitively intact and able to make their needs known. (continued on next page)

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
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(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 - Actual harm Residents Affected - Few	Review of a progress note on 07/10/2022 at 11:22 PM, showed Resident 1 reported that yesterday (07-09-2022) a Nurse's Aide Certified, (NAC) grabbed them by their arm from the toilet to their wheelchair (w/c) and left a bruise. They stated that it was a man who helped them. An (unidentified) NAC reported this to the nurse that the resident had a bruise on their left deltoid (upper arm) area. The bruise was 2.5 centimeters (cm) long and 0.05 cm wide. The bruise was pink/blue in color. The resident was to be assessed for latent injuries. The nurse on call, the DNS and the resident's daughter was notified. Review of a progress note on 07/11/2022 at 6:37 PM, showed a skin assessment done today, the resident had purple discoloration on their left deltoid (which measured 9 centimeters by 5 centimeters), a 9 centimeter (cm) by 1 cm to their left upper chest and a 2 cm by 2 cm bruise to their right knee. Review of the facility report to the state hotline on 07/10/2022 at 11:15 PM, showed Resident 1 reported to their nurse, that yesterday on 07/09/2022, Staff O, Agency NAC, grabbed them by their arms from the toilet to their wheelchair (w/c) and left a bruise. The report showed Staff O was off the floor during the investigation. In an interview on 07/28/2022 at 2:17 PM, Staff N, Registered Nurse (RN), stated that Resident 1 had no skin issues or bruises right now. Staff N stated when there was an abuse allegation, staff were to start a risk management, get statements from staff, report the allegation to the state, the DNS, and Administrator. Staff were to protect the resident. The person who was involved needed to be suspended until the investigation was complete. The resident was placed on alert charting to monitor them. In an interview on 07/28/2022 at 2:57 PM, the DNS stated they started the investigation on 07/09/2022. The DNS stated Staff O had not been suspended as they did not have clear insight from the resident. The DNS stated Resident 1 was unsure of the staff's gender, skin tone and type of hat the staff wore. The DNS stated Staff O continued to work at the facility since then. The DNS acknowledged there was no background check obtained for Staff O upon hire and until 07/27/2022. They acknowledged that there was no review of the employee file or background information as part of the investigation. The DNS was asked about bruising to Resident 1's left chest and right knee discovered on 07/11/2022. The DNS stated they were unaware of those bruises and confirmed they were not included in the investigation. The DNS stated Resident 1's skin was very fragile due to chronic prednisone use and they considered the blood pressure cuff could have been the cause of the bruising. The DNS agreed the resident thought this incident to occur and remained consistent in reporting that staff grabbed them and caused the bruising. The DNS acknowledged other resident's skin was not assessed to ascertain if other residents were affected at the time of the investigation. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an observation and interview on 07/29/2022 at 9:38 AM, Resident 1 was in bed watching TV. They stated their left arm bruise was about gone. There was a 2 cm by 2 cm dark purple bruise on their left upper arm. Resident 1 stated the bruise was from some man that jerked them off the toilet. The resident stated they did not know their name. They stated the man wore a stocking cap and at first, they could not tell if it was a man or a woman so when they were on the toilet, they asked if they were a man or a woman. Resident 1 stated, At that time, he responded man then jerked me by the arm. I thought I was going to die. He hurt me. My nurse came into give me pills after and I had my pajama top on, and they saw the bruise. I told them about the man. I do not want them back here. Everyone knows my skin was fragile. I have been on Prednisone for years. I can barely get a bump and I will get a bruise. When asked about the right knee bruise. Resident 1 stated, Do you know what that is from .they bang my knee on the bathroom door when coming out. They need to be careful; my skin is fragile. A review of Staff O's employee file revealed date of first shift was 07/05/2022. Staff O had no background check obtained until 07/27/2022, twenty-two days after beginning work unsupervised around vulnerable residents. Review of the schedule showed Staff O worked the following shifts on evening and nights when there was less supervision and oversight; night shifts on 07/05/2022, 07/06/2022, 07/07/2022, 07/08/2022, and 07/09/2022, and double shifts (PM and night shift) on 07/12/2022 PM, 07/13/2022 PM, 07/14/2022, 07/15/2022, 07/16/2022, 07/19/2022, 07/20/2022, 07/22/2022 and night shift only on 07/23/2022. RESIDENT 21 Resident 21 admitted to the facility on [DATE] with diagnoses to include Alzheimer's disease. According to the Quarterly MDS assessment dated [DATE], they had severe cognitive impairment. Review of a progress note on 07/26/2022 at 12:42 AM, showed on or around 10 PM to 11 PM, Resident 4 had an outburst against another resident coming out of their room. Resident 4 became hostile and started yelling, Your bad, your bad. Resident 4 was redirected/distracted while Resident 21 was being comforted. There were no interventions documented to protect Resident 21 or other residents from Resident 4. Review of a social services note on 07/26/2022 at 4:54 PM, showed Resident 21 was placed on alert charting for potential signs of psychosocial harm related to resident-to-resident interaction. Social services had informed the guardian of the allegation the following day after the incident. RESIDENT 4 Resident 4 admitted on [DATE] with diagnoses to include traumatic brain injury, stroke, and anxiety. According to the Quarterly MDS on 04/22/2022, they had severe cognitive impairment, and were able to go on and off the unit with supervision. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the state hotline report on 07/27/2022 at 7:44 AM by the DNS, stated Resident 4 had an outburst directed towards Resident 21. The progress note read that Resident 4 yelled at Resident 21 coming out of their room in the hall Your bad, your bad. Resident 4 was redirected away from the resident. The DNS reported the incident was a pattern of behavior that had occurred three times in last few months. The action reported to prevent reoccurrence was the residents were immediately separated. There was no other plan or interventions in place to protect Resident 21 or other residents from Resident 4. Review of Resident 21's care plan directed staff to assure Resident 21 was safe but did not inform staff to supervise Resident 4 or attempt to keep Resident 4 away from Resident 21. In an observation on 07/26/2022 at 9:40 AM, Resident 4's room was located across the hall and down one door from Resident 21's room. In an interview on 07/29/2022 at 9:18 AM, Staff R, NAC stated they tried to keep Resident 4's door closed to keep them away from Resident 7. Staff R stated there was no warning when Resident 4 was going to get upset. They commented Resident 4 gets irritated easily, it was sudden, and the resident can be joking around with you then yell. Staff R stated they were unaware of any recent altercations with Resident 4 but commented Resident 4 had just been placed on every 15-minute checks again. Staff R stated, the resident had been on 15-minute checks for a super long time prior. Staff R said they attempt to redirect them when they were around them. In an interview on 07/29/2022 at 11:29 AM, Staff S, NAC, stated Resident 4 was in and out of their room and sometimes gets set off. Staff S said they placed Resident 4 back on 15-minute checks to monitor the resident and to prevent a resident-to-resident altercation. Staff S stated there was no warning with the resident, they just (made snapping motion with their fingers). They stated it can be hard to watch the resident as they have a lot of residents who require two-person assist or require all care to be completed in pairs. In an interview on 07/29/2022 at 12:40 PM, Staff I, Social Services stated Resident 4 was impulsive and has had verbal aggression against other residents. Staff I stated the resident was placed on 15-minute checks again. Staff I stated they put interventions in place on the care plan. In an observation on 07/29/2022 at 11:11 AM, Resident 21 was in the solarium when Resident 4 self-propelled into the room in their wheelchair. No staff were present. Staff were observed to be outside of the solarium and were not aware the residents who had been involved in a resident-to-resident altercation were alone, unsupervised in the solarium from 11:11 AM until 11:33 AM. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 07/29/2022 at 11:42 AM, Staff Q, Regional Director of Clinical Services, stated the expectation for resident-to-resident altercations was staff are to protect the resident, maintain safety of all residents, report to the hotline, investigate and develop a plan to keep them safe and then evaluate the plan. The residents would go on alert charting and the provider was to be notified. Staff Q stated they identified a pattern with Resident 4, and they had been on every 15 minutes checks. Staff Q was unsure when and why Resident 4 was no longer on 15-minute checks. Staff Q stated Resident 4 would be irritated with one-on-one supervision, but the staff could do distant supervision or place medication carts by their rooms . something. Staff Q acknowledged that the recent resident altercations occurred during busy dinner time and change of shift when staff are preoccupied. Staff Q stated they expected Resident 4 to have more supervision. Staff Q acknowledged they had heard Residents 4 and 21 were just found unsupervised in the solarium. Review of the incident report investigation for 07/26/2022, included a progress note for Resident 4 on 07/29/2022 at 11:23 PM. The progress note showed, Resident 21 had been verbally assaulted by another resident. The resident wheeled themself from their room and was headed for the solarium when another resident in the hall (Resident 4) became agitated and swung their fist at resident. The other resident was separated from the resident, however at around 10:50 PM, while they were in the solarium, the same resident came around the corner and began shouting, Shoot her, shoot her quick before she gets away! The resident who shouted at Resident 4 was quickly removed so both residents could be safe without further escalation. The incident investigation on 07/26/2022 included a plan to prevent Resident 4 from other residents they are triggered by but did not include how. The investigation did not include consideration of room moves to protect Resident 21 for further altercations with Resident 4 who leaves their room and often self-propels past their room. Although, Resident 21 had cognitive impairment and may not be able to express their feelings, a reasonable person in similar circumstances would not want to be yelled You're bad, you're bad when at their doorway, have a fist swung at them or hear Shoot her! Shoot her quick before she gets away. The reasonable person would feel uneasy, upset, and unsafe. Reference: (WAC) 388-97-0640 (1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on observation, interview and record review, the facility staff failed to conduct a thorough investigation for three of four residents (1, 21, and 32) reviewed for accidents. The facility failed to thoroughly investigate a fall with major injury, and a resident-to-resident altercation. The facility failed to investigate the fall and the resident-to-resident altercation to rule out abuse/neglect and determine further actions necessary including screening of new employees and evaluating staff competency to reduce the risk of recurrence and protect the residents. These failed practices placed residents at risk for pain, injury, and neglect. Finding include . Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised April 2021 stated the facility will identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident's property. The facility will protect residents from any further harm during investigations. Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation - Reporting and Investigating revised April 2021 stated the facility will suspend any accused staff member when abuse or neglect is suspected .interview other residents to whom the accused employee provides care or services . reviews all events leading up to the alleged incident . and report to all relevant professional and licensing boards are notified and documented in the employee personnel record. Review of the [NAME] State Nursing Home Guidelines, The Purple Book, Sixth Edition, (October 2015), included the resident's record must include enough information about the incident to enable staff to identify, plan for and meet the resident's needs which would allow staff to appropriately plan for and meet the resident's needs. Included the guidelines for Prevention and Protection, Incident Identification, Investigation and Reporting for nursing homes, the facility investigation should end with the identification of who was involved in the incident, and what, when, where, why, and how the incident happened including the probable or reasonable cause. RESIDENT 32 Resident 32 admitted to the facility on [DATE] with diagnoses to include Diabetes, cirrhosis (disease of the liver), and pressure ulcers to sacrum (portion of your spine between your lower back and tailbone). Review of the Admission Minimum Date Set (MDS) assessment dated [DATE], showed the resident required two persons assist for transfers. The resident had moderate impaired cognition with no rejection of care. Review of the resident's Activities of Daily Living (ADL) care plan dated 07/08/2022, showed the resident was deconditioned. The care plan directed staff to perform transfers by stand pivot into a wheelchair or chair. The resident required maximum assist with toileting to include cleaning their private area and clothing management. The care plan showed ambulation was only to occur with the therapy department. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the investigation fall summary dated 07/09/2022 showed that Staff T, Nursing Assistant Registered (NAR), reported that the resident had fallen in the restroom after they had walked the resident to the restroom from their bed with a front wheeled walker (FWW) on 07/09/2022 at 1:40 AM. Staff T stated that as the resident was pulling their pants down, they lost their balance and fell forward onto the floor. The investigation failed to recognize that the fall was an allegation of neglect. The facility failed to place Staff T on leave until the investigation was completed, leaving other residents at risk for injury. The facility failed to interview other residents that Staff T had provided care for. The facility failed to report Staff T to the state licensing board after determination was made that Staff T did not follow the care plan that led to Resident 32's fall with significant injury. In an interview on 07/28/2022 at 9:31 AM, Staff E, Licensed Practical Nurse (LPN) stated they were hired on 05/23/2022. Staff E stated they were not prepared for the accident that occurred when Resident 32 fell and was not clear on the procedure. Staff E was unaware they were supposed to suspend Staff T, Nursing Assistance Register (NAR) for an allegation of neglect. In an interview on 07/28/2022 at 3:13 PM, Staff T, NAR stated that they reviewed all the Kardex's (Care guide for floor staff) for their residents at the beginning of their shift. Staff T stated when the resident requested to use the restroom, and they saw the FWW in the room, they assumed the resident was able to ambulate and walked the resident to the restroom. Staff T stated that the resident then lost their balance and fell forward. In an interview on 07/28/2022 at 12:28 PM, Staff F, Director of Nursing Services (DNS) confirmed that Staff T, NAR did not follow the care plan. Staff F confirmed that they did not suspend Staff T for the allegation of neglect. Staff F confirmed they did not interview other residents that Staff T had also provided care with, and the facility did not report Staff T's license to the Department of Health. RESIDENT 21 Resident 21 admitted on [DATE] with diagnoses to include Alzheimer's disease. According to the 06/22/2022 Quarterly MDS, the resident had severe cognitive impairment. RESIDENT 4 Resident 4 was a long-term resident who admitted on with traumatic brain injury, impulse disorder, pseudobulbar effect, major depressive disorder, and anxiety. According to the Quarterly MDS assessment dated [DATE], the resident had significant cognitive impairment with verbal behavioral symptoms directed toward others (threatening others, screaming at others, cursing at others) occurred one to three days, same as last assessment. Review of a progress note for Resident 4 on 07/26/2022 at 12:42 AM, Staff E, LPN, documented, On or around 10 to 11 PM (07/25/2022) Resident 4 had an outburst against another resident (Resident 21) coming out of their room. Resident 4 became hostile and started yelling, Your bad, your bad. Resident 4 was redirected/distracted while the Resident 21 was being comforted. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 21's medical record showed no progress note about the incident or resident assessment for injury. The first progress note about the incident was on 07/26/2022 at 4:54 PM. Failure to monitor resident following an incident of alleged abuse placed residents at risk for delayed identification of psychosocial outcomes such as fear of staff, and delayed identification of latent injuries related to the incident. Review of a witness statement by Staff E, LPN on 07/25/2022 stated the nurse could recall that around 9 to 10 PM Monday they were at their medication cart documenting the care of another resident when they heard Resident 4's voice. The resident was in their wheelchair attempting to go back to their room. As Resident 4 turned the corner to go back out of the solarium, the nurse stated they assumed (Resident 4) was startled by Resident 21. Staff E documented they did not see the beginning of the altercation. Staff E noted Resident 21 began yelling aggressively, You get away, you're bad, get away. Staff E documented possibly two or three Nursing Assistant Certified (NAC) discreetly separated the residents and added those NACs were privy to the whole situation. The incident investigation was started on 07/26/2022 by Staff F, DNS. The investigation date was listed as 07/26/2022 rather than 07/25/2022. The immediate intervention showed staff were to separate the residents and ensure immediate safety. There were no statements included from the nurses' aides present on the shift or around that time as it was close to change of shift. There was no interview of other residents to ascertain if there were other concerns of this nature. There was no room move consideration when Residents 4 and 21 had rooms on the same hall, across from one another and one room down. The plan on 07/30/2022 was Resident 4 was put back on 15-minute checks due to the outburst and needed to be separated from residents that they were triggered by. Review of Resident 4's care plan directed staff to provided one on one as needed for Resident 4. There was no documentation one on one was provided to protect Resident 21. In an interview on 07/29/2022 at 11:42 AM, Staff Q, stated they heard there was a verbal altercation involving Resident 4 and 21. Staff Q stated the expectation when resident to resident altercations occur was staff are to protect the residents, maintain safety of all residents, report to the hotline, investigate and develop a plan to keep them safe and evaluate the plan. The resident was to go on alert charting and the provider was notified. Review of a progress note dated 07/29/2022 at 11:23 PM, included with the investigation of the altercation between Resident 4 and 21 on 07/25/2022, showed Resident (21) was verbally assaulted by another resident. Resident 21 wheeled themself from their room and was heading for the solarium when another resident in the hall (4) became agitated and swung their fist at the resident. Resident 4 was separated from Resident 21, however at 10:50 PM, while Resident 4 was in the solarium, the same resident (Resident 4) came around the corner and began shouting, Shoot her! Shoot her quick before she gets away!' Resident 4 was quickly removed so both residents could be safe without escalation. Resident 4 was placed on 15-minute checks on 07/30/2022, five days after the first incident with Resident 21. The facility failed to protect the residents, and thoroughly investigate the fall on 07/09/2022, or resident altercations on 07/25/2022 and two separate incidents on 07/29/2022 in a timely manner. Reference WAC 388-97-0640(6)(a) (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	44110

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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** 15406 Based on observation, interview and record review, the facility failed to provide adequate supervision for three of three residents (4, 7 and 21), reviewed for altercations. The facility failed to ensure appropriate interventions were implemented to prevent falls with injury for one of three residents (32), reviewed for falls. This failed practice resulted in harm for Resident 32 who obtained a right hip fracture that required surgical intervention, and a right shoulder fracture that resulted from a fall. The facility failed to recognize the high risk for the repeat behavior of verbal aggression of Resident 4 and analyze all individual risk factors or provide the necessary supervision/monitoring for one of two residents (Resident 4) reviewed for supervision. The failure to adequately supervise Resident 4 and address a known history of verbal aggression towards other residents, resulted in harm to Resident 7 and 21 who endured unwanted verbal assault. This failure placed the residents at risk for fear, isolation, physical and psychological injury, lack of feelings of safety and decreased quality of life. Findings include . <Falls> Review of the facility's policy titled, Fall and Fall Risk, managing, revised March 2018, stated staff will identify interventions related to the resident's specific risks and causes to prevent the resident from falling. RESIDENT 32 Resident 32 admitted to the facility on [DATE] with diagnosis to include Diabetes, cirrhosis (disease of the liver), and pressure ulcers to sacrum (portion of your spine between your lower back and tailbone). Review of the Admission Minimum Date Set (MDS) assessment dated [DATE] that was started on 07/09/2022, showed the resident required two persons assist for transfers. The resident had moderate impaired cognition with no rejection of care. Review of the hospital discharge summary dated 07/13/2022 showed that the resident had been admitted to the hospital after a fall that occurred at the facility. The summary showed the resident was admitted for a closed fracture to the right hip that required surgical repair and a fracture of the right upper arm. Review of the resident care plan with a focus dated 07/08/2022 showed the resident had Activities of Daily Living (ADL) related to deconditioning with interventions to include transfers to be a stand pivot into a wheelchair or chair, toileting maximum assist with cleaning their private area and clothing management, and ambulation to only occur with therapy department. Review of the residents fall risk assessment dated [DATE] showed that the resident was high fall risk. (continued on next page)

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	505296	A. Building B. Wing	07/29/2022

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Occupational Evaluation and Plan of Treatment dated 07/08/2022 showed that toileting should be contact guard assist with a transfer from wheelchair to toilet. Review of the investigation fall summary dated 07/09/2022 showed that Staff T, Nursing Assistance Register (NAR), reported that the resident had fallen in the restroom after they had walked the resident to the restroom from their bed with a front wheeled walker (FWW) on 07/09/2022 at 1:40 AM. Staff T stated that as the resident was pulling their pants down, they lost their balance and fell forward onto the floor. In an interview on 07/28/2022 at 8:55 AM, Staff U, Nursing Assistant Certified (NAC) stated that they were present on the day the resident admitted to the facility on [DATE]. Staff U stated they recalled the therapist was in the room on 07/08/2022 conducting an assessment on the resident. Staff U stated that the therapist explained to them that the resident should only ambulate with therapy at this time as the resident would lose their balance. The therapist stated to Staff U, if the resident needed to use the restroom to transfer the resident using a stand and pivot to the wheelchair and take into the restroom, then to stand and pivot on to the toilet. Staff U stated they recalled reporting this conversation with the therapist to the next shift when they gave report at the end of their shift that day. In a phone interview on 07/28/2022 at 9:31 AM, Staff E, Licensed Practical Nurse (LPN) stated they were the nurse on duty when the resident had their fall on 07/09/2022. Staff E stated that Staff T, NAR flagged them down and told me Resident 32 had fallen in the bathroom. Staff E stated that Staff T had taken the resident to the restroom, when they looked away the resident fell forward and landed on their right side. In a phone interview on 07/28/2022 at 3:13 PM, Staff T, NAR stated that they review all the Kardex's (Care guide for floor staff) for their residents at the beginning of their shift. Staff T stated when the resident requested to use the restroom, and they saw the FWW in the room, they assumed the resident was able to ambulate and walked the resident to the restroom. Staff T stated that the resident then lost their balance and fell forward. In an interview on 07/28/2022 at 2:00 PM, Staff V, Director of Rehabilitation (DOR) stated they agreed with the assessment made by the Occupational Therapist evaluation that was completed on 07/08/2022 that determined the resident should only ambulate with the therapy department. In an interview on 07/28/2022 at 12:28 PM, Staff F, Director of Nursing (DNS) stated that Staff T, NAR had ambulated the resident from the bed to the restroom with only an FWW. Staff F confirmed that the residents care plan was specific that they were to only ambulate with the therapy department due to the resident had balance issues. Staff F confirmed that Staff T, did not follow the care plan, which resulted in the resident had lost their balance, fell on to the bathroom floor, and obtained a right hip fracture that required surgical intervention, and a right upper arm fracture. RESIDENT 4 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the undated Admission Record in the electronic medical record (EMR) under the Profile tab revealed Resident 4 was admitted to the facility on [DATE]. Resident 4's diagnoses included hemiplegia and hemiparesis following cerebral infarction (stroke) affecting right dominant side, muscle weakness, impulse disorder, blindness left eye, repeated falls, shortness of breath, anxiety disorder, and history of traumatic brain injury. Review of the quarterly Minimum Data Set with an assessment reference date (ARD) of 04/22/2022 revealed Resident 4 was severely impaired in cognition with a Brief Interview for Mental Status (BIMS) score of 5 out of 15 (score of 0-7 indicates severe cognitive impairment). Resident 4 required supervision for transfers, locomotion on the unit, and walking in the room. Resident 4 required limited assistance walking in the corridor. Resident 4 required extensive assistance for toilet use and dressing. Resident 4 was not steady moving on and off the toilet and only able to stabilize with assistance; and they were not steady with surface-to-surface transfer (transfer between bed and chair or wheelchair) but able to stabilize without assistance. Resident 4 had experienced one fall without injury during the prior MDS assessment. Review of a Nursing Care Note dated 07/22/2022 at 6:38 PM in the EMR under the Progress Notes tab revealed, this LN [licensed nurse] was called to resident room and found resident on the laying on the floor on their left side by their bed and their w/c [wheelchair] was by their closet. The resident was wearing regular socks and no shoes, pajama bottom and a shirt. The resident was unable to relate to what happened and could not remember how they got to the floor. The resident was assessed for any injuries, and none were found at that time, no bruising, swelling, or bleeding. The resident was assisted up and back to their bed, the resident able to bear weight to their LE [lower extremities] and able to move both UE [upper extremities]. The staff changed their socks to non-skid socks and lowered the bed. The resident did not remember hitting their head on the floor and denied any pain at this time. The resident's brother was notified via phone call and left a message, placed a fax communication to the nurse practitioner, the resident was placed on alert charting to monitor latent injuries, and started neurological checks and vital sign checks, and reported to next shift. Review of a Fall Risk Evaluation dated 07/25/2022 in the EMR under the Assessment tab revealed Resident 4 was at moderate risk for falls, had experienced one to two falls in the past six months, was frequently incontinent, was unsteady, and experienced a loss of balance while standing. Review of a Nursing Care Note dated 07/26/2022 in the EMR under the Progress Notes tab revealed, IDT [interdisciplinary team] meets to discuss fall for Resident 4 this weekend. Identified that they were not wearing non-skid footwear when attempting to get up from bed and prefers to wear regular socks when in bed contributing to them slipping at bedside. TELs [maintenance request/tracking system] order placed for non-skid strips next to bed to provide a non-skid surface and prevent slipping . Care plan updated. Review of the Care Plan dated 10/28/2020 in the EMR under the Care Plan tab revealed a problem of Resident 4 is at moderate risk for falls related to history of falls, vision impairment: (L) [left] side, syncope. The goal was they will not sustain injury from falls. Interventions included in pertinent part, Resident 4 has a history of refusing to wear non-skid footwear and throwing their call light when it is placed next to them. Encourage Resident 4 to wear non-skid footwear and use their call light. Place their call light within reach was initiated on 07/27/2022 . Non-skid strips applied to floor next to bed was initiated on 07/25/2022. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Observations during the survey revealed non-skid strips were not applied to the floor in Resident 4's room: -On 07/26/2022 at 10:51 AM, Resident 4 was lying on the bed in their room. There were no non-skid strips applied to the floor. -On 07/27/2022 at 12:00 PM, Resident 4 was lying on the bed in their room. There were no non-skid strips applied to the floor. -On 07/28/2022 at 10:00 AM, 10:47 AM and 11:10 AM, Resident 4 was lying on the bed on their side. There were no non-skid strips applied to the floor. During an interview on 07/28/2022 at 12:44 PM, Staff B, the Maintenance Director, stated they ordered and just received the non-skid strips today. Staff B stated they were planning to install the non-skid strips this afternoon in Resident 4's room. During an interview on 07/29/2022 at 8:33 AM, Staff A, Registered Nurse (RN) Resource Nurse, stated Resident 4 should have minimum assistance from staff when transferring but had a history of self-transferring. Staff A stated Resident 4's room was in the main hall for increased supervision. Staff A stated Resident 4 did not use the call light very often and was blind on one side. Staff A stated re-educating Resident 4 was hard to do based on their cognition. Staff A stated non-skid strips had been applied to the floor in Resident 4's room on 07/28/2022 as a new measure to prevent falls. Review of the Work Orders Report for 07/22/2022 - 07/29/2022, provided by the facility, revealed a work order was placed for non-skid strips applied next to the bed in Resident 4's room. Review of the Completed Work Orders report dated 07/27/2022 - 07/29/2022 and provided by the facility, revealed the non-skid strips had been applied to the floor in Resident 4's room. Continued observations and interviews revealed non-ski strips were not applied to the floor in Resident 4's room: -On 07/29/2022 at 9:14 AM, Staff C, housekeeper, was cleaning Resident 4's room. The surveyor did not see non-skid strips on the floor in Resident 4's room. Staff C confirmed there were no non-skid strips on the floor. -On 07/29/2022 at 10:06 AM, Staff D, the Administrator, and Staff B went into Resident 4's room. Both Staff D and Staff B confirmed non-skid strips were not applied. Staff B stated they had applied the non-skid strips in the wrong room, the room next door. An observation was made in the room next door and the strips had been installed in the room next door and not in Resident 4's room. <SUPERVISION> RESIDENT 4 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident 4 was a long-term resident who admitted on with traumatic brain injury, impulse disorder, pseudobulbar effect (uncontrollable laughing and or crying), major depressive disorder, and anxiety. According to the Quarterly Minimum Data Set assessment dated [DATE], the resident had significant cognitive impairment with verbal behavioral symptoms directed toward others (threatening others, screaming at others, cursing at others) occurred one to three days, same as last assessment. Review of Resident 4's care plan developed on 12/16/2020, showed problematic behavior characterized by ineffective coping with history of resident to resident (altercations) derived from Cognitive impairment due to cerebral infarction (stroke) and history of traumatic brain injury (TBI) and Pseudobulbar Affect (PBA). The goal updated on 04/28/2022 was for reduced incidents of agitated behavior verbal & physical aggression and abuse, history of agitation resulted in refusals of care and medications. One of the interventions implemented on 05/02/2022 was for staff to provide one on one care as needed. Review of an incident report on 06/16/2022 at 5:25 PM, showed Resident 4 was sitting in the solarium door when Resident 7 asked Resident 4 to move so they could get through. Resident 4 became verbally aggressive towards the other resident, observed by the licensed nurse who was at the nurse's station. The nurse and other staff on the floor immediately separated both residents. The DNS was notified, and the resident was placed on alert. The incident report showed Resident 4 had been experiencing mood and emotional changes secondary to diagnosis and repeatedly declining psychotropic medications. Recommendations were staff to check on resident's routinely when they were out of their room or propelling their wheelchair to ensure Resident 4's pathway was clear from obstacles. Maintenance and safety committee were to address the solarium area to ensure this area is set up for management of high resident flow in doorway. Activities was to consider taking group activities to the large dining room with transportation escort assistance for increased participation and safety. The investigation noted Resident 4 had physically aggressive behavior on 07/30/2021 and 08/19/2021. Review of a progress note dated 06/27/2022 at 3:00 AM, showed Resident 4 continued to have overwhelming emotions overnight, crying and laughing at the same time then having swift mood changes to yelling and aggressive behaviors. One on one time spent, refused evening meal out of anger. Note place in physician box to assess and advise as resident behaviors are steadily escalating and they have refused most of their medications. Review of the progress note dated 07/04/2022 at 11:48 PM, showed Resident 4 was ambulating with their walker around the unit living room area when several patients were watching television quietly when Resident 4 began calling Resident 7, a c**ks****r and saying You are a monster! You should not even be here! Staff CC, LPN, Staff BB, NAC and Staff Z, RN, all ran when they heard the angered words exchanged. Resident 4 then stood up quickly and started to walk toward Resident 7 in anger. Staff Z put themselves in between the two. Staff BB grabbed Resident 4's wheelchair and stood behind them and redirected them back to their room. Staff E, LPN was assigned to be one on one with Resident 4. Resident 7 came to the nurse's station several times overnight to make snide comments about the situation that occurred. The nurse documented they could not tell which resident had started the aggression first and both residents have had verbal exchanges before. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of an incident report dated 07/04/2022 at 5:45 PM, showed the nurse found Resident 4 in the solarium with another resident (7) shouting at each other. There was a table in between them and Resident 4 was visibly irritated. The nurse noted they got between the two residents and escorted the other resident out into the backyard. Resident 7 was taken out of the solarium by a CNA. They were given ice cream and 1 on 1, resident calmed down. The plan was for Resident 4 to be placed on every 15-minute checks pending further interventions. The resident was to be redirected away from solarium if Resident 7 was in there. Resident's 4 and 7 were to be supervised continuously if they attempted to enter the solarium concurrently and could not be redirected away. Social Services requested a significant change Pre-admission Screening and Resident Review (PASRR) for Resident 4. The care plan was updated on 07/05/2022 to include 15-minute checks to monitor interactions between Resident 4 and Resident 7. The report showed Resident 4 and 7 had a history of altercations in solarium when self-propelling, Resident 4 was allowed to enter the solarium per their request. Staff were directed to ensure Resident 7 was not in the solarium with Resident 4 and, if the residents were in the solarium staff were to attempt to divert them. Residents were to be supervised continuously if they attempted to enter the solarium. Review of a progress note on 07/05/2022 at 4:56 AM, Staff E, LPN documented on 07/04/2022 at or around 1800, Resident 4 was the recipient of an unprovoked verbal assault with another resident. Resident was supervised 1:1 to provide safety and emotional support after the altercation. Physical altercation was after initial supervision resident was assessed Q15 on the hour until resident went to sleep. No further instances of unprovoked assault reported for the rest of the night. Review of a progress note dated 07/05/2022 at 11:02 PM, showed Staff Y, RN was at the nurse's station receiving report when Resident 7 walked by the nurses' station. Resident 4 was sitting in the solarium and had a verbal altercation with this resident earlier, Resident 4 became verbally aggressive toward Resident 7. Resident 4 stood up from their wheelchair and started cussing loudly and chasing Resident 7 into the hallway. Immediately the staff members intervened, stood between them, and redirected them to their rooms. Review of an interdisciplinary (IDT) meeting nursing care note for Resident 4 on 07/05/2022 at 2:48 PM, stated the resident was going to be on-going 15-minute checks related to recent verbal altercation with another resident. 15-minute checks were to be performed whenever the resident was outside of their room until their planned room move was complete to reduce interaction with other resident involved in verbal altercation. Care plan was Resident 4 was to be monitored continuously while in the Solarium if resident (7) was present. Review of the incident report investigation on 07/05/2022 showed there were repeated verbal resident to resident altercations between Resident 4 and Resident 7. The care plan was to try and prevent future negative verbal interactions and completed 15-minute checks when they are out of their room. The investigations showed both residents appear to be triggered by the presence of the other one. Long term intervention was that Resident 4 required distant supervision for meals in the solarium with staff present. The corrective action was to be completed on 07/13/2022. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a progress note for Resident 4 by Staff AA, Physician's Assistant on 07/08/2022 at 12:26 PM, showed a psychological assessment for impulse disorder and pseudobulbar affect. The provider noted the resident had increased behaviors recently, and had altercations with another resident, possibility of turning violent and need to be better controlled. Residents' behaviors had been getting progressively worse since discontinuation of Depakote on 04/13/2022. Resident 4 was on 15-minute checks August 2021 to April 2022 and was no longer receiving this level of supervision Review of a progress note for Resident 4 on 07/25/2022 at 11:33 PM, Staff E, LPN, documented, On or around 10 to 11 PM (07/25/2022) Resident 4 had an outburst against another resident (Resident 21) coming out of their room. Resident 4 became hostile and started yelling, Your bad, your bad. Resident 4 was redirected/distracted while the Resident 21 was being comforted. RESIDENT 7 Resident 7 was a long-term resident with delusional disorder and generalized anxiety. According to the 05/06/22 Quarterly MDS showed the resident is independent with Activities of Daily Living. The resident demonstrated verbal behavioral symptoms directed toward others the past 1 to 3 days. Review of the care plan developed on 12/06/2021 for Resident 7 showed the resident had a potential psychosocial well-being problem related to poor interaction with other residents. In an interview and observation on 07/26/2022 at 9:55 AM, Resident 7 was sitting on the edge of their bed stating they were going to shoot the [NAME]. In observations on 07/26/2022 at 11:08 AM, 07/27/2022 at 9:58 AM, 07/29/2022 at 9:02 AM, Resident 7 was up ambulating independently with their 4wheeled walker in the halls with no staff supervision. In an interview on 07/28/2022 at 2:15 PM, Staff N, RN stated there were no residents on 15-minute checks at this time. In an interview on 07/28/2022 at 2:31 PM, Staff A, RN stated Residents 4 and 7 are not on one-to-one supervision or every 15-minutes checks. Staff A said Resident 7 had a history of resident-to-resident altercations and spent most of the time in their room but came out in the evenings. Staff A said Resident 4 had a history of resident-to-resident altercations and liked to go to the solarium in the evening time. In an interview on 07/28/2022 at 2:36 PM, Staff M, RN agency, stated Residents 4 and 7 are not supposed to be in proximity of each other. Staff M stated they had seen both residents babble at each other but no physical aggression. Staff M stated Resident 7 was more mobile and comes and goes from their room and Resident 4 was more active in the night but does come out sometimes in the day. They stated supervision of the residents was easier on day shift as there is extra help with administration there. They said staffing was low at night but on day shift they can manage appropriately. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 07/28/2022 at 3:12 PM, Staff F, DNS stated Residents 4 and 7 had resident to resident altercations on 06/21/2022, 07/04/2022 and 07/05/2022. They stated Resident 7 was evaluated and has calmed substantially and was not agitated now. Staff F stated Resident 4 was to be on Q 15 minutes checks for supervision after the 07/05/2022 incident. Staff F commented that Residents 4 and 7 got irritated just with line of sight of each other and they both had robust care plans for their behaviors. Staff F was asked how the staff were to provide adequate supervision with Resident's 4 and 7 who are ambulatory and had altercations in the solarium, which was a high traffic area, across from the nurse's station. Staff F said the first altercation in June was thought to be isolated, but they have definitely established a pattern now. Staff F stated the staff were to supervise both residents when they are near each other. Staff F acknowledged the three incidents occurred between 5:25 PM and 6:00 PM which was a busy time for staff related to dinner and shift change. Staff F could not state how the staff was to ensure another resident to resident did not occur between these same two residents. In an interview on 07/29/2022 at 9:22 AM, Staff R, NAC stated Resident 7 has behaviors and runs around the hallways yelling at staff. Staff R stated Resident 7 and Resident 4 interacting does not work well. In an interview on 07/29/2022 at 11:42 AM, Staff Q Regional Director of Clinical Services, (RDCS) stated they were unsure why Resident 4 came off 15-minute checks and the facility should have a plan in place to keep residents safe and maintain their safety. Staff Q confirmed there was a pattern of altercations with Resident 4 and 7 and they occurred during a busy time. Staff Q acknowledged more could be done to prevent altercations and suggested staff could do distant supervision or place carts by their rooms. Staff Q stated their expectation was more supervision for these residents. In an interview on 07/29/2022 at 12:45 PM, Staff I, Social Services stated Resident 7 was more the victim with Resident 4. Staff I said the altercations occurred in the solarium and Resident 4 is there more that Resident 7. Review of a care plan problem for Resident 7 initiated on 03/08/2022 showed problematic behavior in which the resident acts characterized by ineffective coping: verbally aggressive, and pounds their walker. The goal will be reduced incidents of agitated behavior. Staff were directed to always approach resident calmly and unhurriedly, be careful to not invade residents' personal space, redirect, remain calm, assure safety of residents and staff, and refer to social services and monitor for verbal aggression toward staff, pounding walker against doors and perseverating on discharging. Resident 7 did recall the 07/04/2022 altercation with Resident 4 and came out of their room several times during the night to discuss it. The reasonable person would not want to be yelled at in their home. RESIDENT 21 Resident 21 admitted on [DATE] with diagnoses to include Alzheimer's disease. According to the 06/22/2022 Quarterly MDS, the resident had severe cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a witness statement by Staff E, LPN on 07/25/2022 stated the nurse could recall that around 9 to 10 PM Monday they were at their medication cart documenting the care of another resident when they heard Resident 4's voice. The resident was in their wheelchair attempting to go back to their room. As Resident 4 turned the corner to go back out of the solarium, the nurse stated they assumed (Resident 4) was startled by Resident 21. Staff E documented they did not see the beginning of the altercation. Staff E noted Resident 21 began yelling aggressively, You get away, you're bad, get away. Staff E documented possibly two or three Nursing Assistant Certified (NAC) discreetly separated the residents and added those NACs were privy to the whole situation. In an interview on 07/29/2022 at 11:42 AM, Staff Q, stated they heard there was a verbal altercation involving Resident 4 and 21. Staff Q stated the expectation when resident to resident altercations occur was staff are to protect the residents, maintain safety of all residents, report to the hotline, investigate and develop a plan to keep them safe and evaluate the plan. The resident was to go on alert charting and the provider was notified. Review of a progress note dated 07/29/2022 at 11:23 PM, included with the investigation of the altercation between Resident 4 and 21 on 07/25/2022, showed Resident (21) was verbally assaulted by another resident. Resident 21 wheeled themself from their room and was heading for the solarium when another resident in the hall (4) became agitated and swung their fist at the resident. Resident 4 was separated from Resident 21, however at 10:50 PM, while Resident 4 was in the solarium, the same resident (Resident 4) came around the corner and began shouting, Shoot her! Shoot her quick before she gets away!' Resident 4 was quickly removed so both residents could be safe without escalation. The facility failed to implement appropriate fall interventions for Resident 32, that resulted in major injury. The facility failed to provide adequate supervision for Resident 4, who had a known pattern of aggressive behavior and who showed verbal aggression to Resident's 7 and 21. Reference WAC 388-97-1060(3)(g) 36787 44110