STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505042	A. Building B. Wing	02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballard Center	820 Northwest 95th Street Seattle, WA 98117

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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 39651 Based on interview and record review, the facility failed to ensure staff treat each resident with respect and dignity in a manner that promoted the maintenance or enhancement of quality of life and recognizing each resident's individuality, failed to ensure that each resident could exercise their rights without fear of intimidation and reprisal, and failed to protect each resident for exercising their rights for 2 of 4 residents (Residents 17 and 15) reviewed for dignity. This failure resulted in the residents expressing ongoing anger from violation(s) of their rights. Findings included . RESIDENT 17 Resident 17 was a long-term resident of the facility. The resident's diagnoses list included heart failure and muscle weakness. A review of Resident 17's quarterly Minimum Data Set (MDS) assessment, dated 12/17/2021, showed the resident had intact cognition and was independent with locomotion on and off the unit. On 02/09/2022 at 2:00 PM, Resident 17 reported an incident that happened between her and Staff B Director of Nursing (DNS) in May 2021 (could not recall specific date and time). Resident 17 stated she was forcibly dragged and that Staff B forced her to get inside the facility and falsely imprisoned her by not allowing her to leave the facility, not even to get some fresh air at the front desk area. Resident 17 stated she had gone on an outing with her daughter when this incident happened, and she had forgotten to sign out. Resident 17 said that it had not been explained to her that signing out was a requirement to leave the building. According to Resident 17, when she arrived at the bus stop, she saw Staff B, DNS smoking outside with her dog. Resident 17 stated she didn't know who Staff B was at that time and had not met her. Resident 17 also stated Staff B had no form of any identification that would identify her as an employee of the facility. (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

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F 0550 Level of Harm - Actual harm Residents Affected - Few	Resident 17 stated when she got off the bus, Staff B immediately asked her If I wanted to talk to my daughter and that (Staff B) had her daughter on the phone. Resident 17 stated that Staff B told her that they had called the police and that they had been looking for her. According to Resident 17, she had asked Staff B who she was, but Staff B refused to give her name and responded it was not important. Resident 17 stated that Staff B told her she would be waiting for her until she got back into the facility, and that Staff B stood up with her dog and grabbed her wheelchair. Resident 17 stated she told Staff B to not grab her wheelchair and to not force her to move as she needed time to rest. Resident 17 stated that Staff B also directed her to a different way back to the facility (parking lot instead of the sidewalk area). This was when Staff B grabbed her wheelchair again and pushed her. This was when Resident 17 stood up to hold and push her wheelchair, so that Staff B would stop forcefully pushing her. Resident 17 stated Staff B continued to grab her even after being told to not push or touch me. According to Resident 17, she felt relieved that a staff person, who introduced himself as a therapist, came and assisted her. Resident 17 stated she felt fear and harassed by Staff B because she didn't know who she was, and that Staff B continued to be aggressive with touching her and pushing her wheelchair. Resident 17 stated as she got closer to the front door area, and it was just her and Staff B, she told Staff B that she wanted to catch her breath and sit on her wheelchair for a while. Resident 17 stated that Staff B started to push her wheelchair again and grabbed her arms to stop her from propelling/moving her wheelchair. Resident 17 stated she resisted and told her to please stop touching me, but Staff B dragged her to the front door. This was when a staff member (Staff N, Licensed Practical Nurse/Staff Development Coordinator [LPN/SDC]) intervened and told Staff B to let me go. Resident 17 stated that Staff B initially refused to listen to Staff N, but eventually followed him to his office. Resident 17 stated that Staff ZZ, a former employee of the facility, also witnessed when Staff B grabbed her wheelchair and blocked the front door so she could not leave the facility. Resident 17 stated she had reported abuse and false imprisonment to Staff A, Administrator, but she had not heard anything from the facility. Resident 17 stated there was no follow-up and no communication as to why I am being detained here at the facility. According to the resident, she felt like she was a prisoner, treated like a child, discriminated against and was physically hurt and abused by the Staff B, DNS. Resident 17 further stated she felt that her rights were violated, and the facility had tolerated Staff B's actions by not even talking to her [Resident 17] and letting her know that her concern were heard or investigated. Resident 17 was visibly upset, tearful and stated she was very angry about the situation. Resident 17 stated that Staff B, DNS and the facility had done so many bad things to her, including making false documentations into her record and for making her look insane with mental health issues. According to Resident 17, all she really wanted was for the facility to hear her concerns and give her an explanation as to why they did not acknowledge and listen to her and protect her from these on-going violations of her rights as a person. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	On 02/09/2022 at 4:30 PM, Staff ZZ, former employee, stated she remembered the incident that occurred last May 2021 (could not recall the specific date and time) between Resident 17 and Staff B, DNS. Staff ZZ stated she remembered seeing Staff B holding Resident 17's wheelchair to bring her back in the facility. Staff ZZ also stated that when Staff B managed to bring Resident 17 back inside the facility, she saw Staff B blocked the doors to prevent Resident 17 from leaving the facility. Staff ZZ stated Resident 17 was refusing to get inside the facility and wanted to stay outside. Staff ZZ further stated she was shocked and did not know what to do and whether she needed to do anything, but the facility Administration was aware of the incident, including Staff A, Administrator. On 02/09/2022 at 6:20 PM, Staff N LPN/SDC stated he remembered the incident between Resident 17 and Staff B, DNS last May 2021 (could not recall the specific date and time). Staff N stated he heard a loud commotion between Staff B and Resident 17, so he got out of his office to intervene. Staff N stated he asked Staff B to step away from the situation and took her in to his office. According to Staff N, he told Staff B that what she was doing was not right and that she could not block Resident 17 from going outside the facility. On 02/15/2022 at 1:30 PM, Staff R, Social Services (SS) stated she did a follow-up visit and interview with Resident 17 several times and stated Resident 17 was very consistent on what happened and the specific details of the incident and how Staff B had violated her rights as a resident of the facility and as a human being. Staff R also stated Resident 17 suffered psychosocial harm related to this incident in that it made Resident 17 very angry, felt like she was treated like a child, discriminated and physically hurt by Staff B and the facility. A review of Resident 17's clinical records and the facility's incident investigation report, dated 02/10/2022, showed Resident 17 was consistent with reporting the details of the incident to multiple staff members and had verbalized/documented evidence of psychosocial harm. RESIDENT 15 Resident 15 was a long-term resident of the facility. The resident's diagnoses list included stroke with left sided weakness and obesity. A review of Resident 15's annual MDS assessment, dated 12/01/2021, showed the resident had intact cognition and needed two person staff assistance with bed mobility and transfers. On 02/09/2022 at 2:55 PM, Resident 15 stated she felt abused and violated by Staff B, DNS in the past. Resident 15 stated that there were at least two instances where she was very angry and upset with Staff B. One was when Staff B forcefully searched and touched me to find a lighter when I was not allowed to smoke (could not recall specific date or time). According to Resident 15, this specific incident happened at the front desk area close to the front office. Resident 15 stated this incident was witnessed by staff members including a receptionist. Resident 15 further stated, I also reported the incident to my aide and [Staff A, Administrator]. Resident 15 stated that the second incident was when Staff B entered her room and illegally searched her personal belongings and closets (could not recall specific date and time) apparently looking for a lighter and cigarettes. Resident also stated, that during both incidents, she refused and told Staff B to not touch her and search her personal belongings but she did it anyway. According to Resident 15, she felt that Staff B harassed me and treated me like a child. Resident 15 further stated she was angry about the situation and she had lost sleep for days after the incident happened. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	On 02/10/2022 at 11:30 AM, Staff ZZ,former employee, stated she remembered the incident that she witnessed (could not recall the specific date and time) between Resident 15 and Staff B, DNS at the front office (Infection Preventionist office). Staff ZZ stated Staff B searched and reached for Resident 15's pockets and clothing searching for smoking materials. Staff ZZ also stated that Resident 15 was screaming and shouting at Staff B to not touch her, but Staff B proceeded and searched Resident 15 against her will. According to Staff ZZ, Resident 15 was very upset and angry after the incident. A review of the facility's incident investigation report, dated 02/10/2022, showed that Resident 15 had reported a similar incident to Staff YY, NAC (unknown date and time). The witness statement signed by Staff YY on 02/14/2022 showed Resident 15 had reported that Staff B searched her room and drawers without permission and confiscated a cigarette lighter, Resident 15 was mad about it. It indicated that Staff A, Administrator was aware of the incident and had Resident 15's lighter. On 02/15/2022 at 1:30 PM, Staff XX, Chief Operating Officer (COO) stated the facility had investigated both the allegations made by Resident 15 and by Resident 17 against Staff B. Staff XX stated that the facility was not able to substantiate abuse and/or neglect regarding Resident 15's allegations, but they were able to verify that Staff B took a cigarette lighter from Resident 15. However, Staff XX stated that the circumstances and the details of the incident were not clear because it had been quite a while since the incident happened, and there were some discrepancies with the possible location and the timing of the incident. Staff XX stated that Staff B had confirmed and told the facility investigator that she took a lighter from Resident 15. Staff XX stated that regarding Resident 17's allegation against Staff B, the facility was not able to substantiate abuse and/or neglect. According to Staff XX, the incident showed that there could have been a situation where Staff B attempted to help Resident 17 when she was outside the facility and prevent her from leaving the facility due to safety concerns, but he believes that the intention was to help the resident and not to cause any harm. Staff XX also stated that regardless of what Staff B's intent was, Resident 17's perception was that Staff B had violated her rights and that she should have allowed her [Resident 17] to do what she wanted without blocking the exit doors and while providing a safe environment (as possible), but also promoting the resident's independence. Reference: (WAC) 388-97-0180 (1-4)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 39651 Based on interview and record review, the facility failed to implement written policies and procedures related to Grievance process and ensure an effective system was in place to document, initiate, and promptly respond to/resolve grievances for the facility's' resident organized group (resident council). These failures placed residents at risk for harm and unmet care needs. Findings included . A review of the facility's Grievance Policy dated 08/25/2021 showed the purpose of the grievance policy was to ensure that any resident or resident representative has the right to express grievance/concern without fear of restraint, interference, coercion, discrimination, or reprisal in any form. The policy directed facility staff to: A. Upon receipt of the grievance/concern, the grievance/concern form will be initiated by the staff member receiving the concern and document in the Grievance/Concern Log. B. The Administrator or appropriate department supervisor will be notified. C. Immediate action will be taken to prevent further potential violation of any resident rights while the alleged violation is being investigated. A review of the facility policy titled, Resident Council, dated and revised on 04/01/2018, showed the facility would provide residents and guests an opportunity to meet regularly and without interference to participate in education opportunities, and to have input into the recreation, policies, and issues affecting their care and lives in the facility. The policy indicated: A designated staff person approved by the council will act as a liaison between the council and the facility's leadership in providing information on concerns to the Administrator and other appropriate department managers. Responses and rationale will be documented, reviewed by the Administrator, and maintained with the council minutes. B. Grievances and concerns will be documented on the Grievance/Concern form of the Departmental Response Form with a copy of the resolution maintained with the Council Minutes. Actions taken and/or considerations given to the issues will be reported back to the council at the next meeting. On 02/09/2022 at 11:45 PM, Resident 4 stated she had serious concerns about her safety in the facility. Resident 4 stated the facility had been very short staffed for a long time now, maybe longer than three months and she felt like the facility was just ignoring both her concerns and the concerns of other residents, including the Resident Council. According to Resident 4, they [Resident Council] shared a lot of grievances and complaints about lack of staff, especially during the evenings, nights, and weekends. Resident 4 stated she received no follow-up from the facility except the facility tried to make me feel like I don't know what's going on. Resident 4 further stated that residents reported waiting for hours to get assistance from staff. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/09/2022 at 12:05 PM, Resident 5 (Resident Council President) stated she and the resident-organized group (Resident Council) had reported on-going concerns and complaints from residents about lack of staff. Resident 5 stated she could recall discussing the issues regarding the lack of staff for at least the past 2 council meetings (December 2021 and January 2022). Resident 5 stated the issue with staffing was discussed a lot and there were a lot of residents complaining about staffing. According to Resident 5, the council reported specific concerns including some residents waiting for at least 30 minutes to an hour or longer when needing assistance from staff. Resident 5 gave permission to access and request the resident council minutes from the facility for the November 2021 to January 2022 council minutes. Resident 4 stated that she could not recall receiving any resolution from the facility. A review of the Resident Council minutes from November 2021 to January 2022 showed no evidence that the facility had documented and/or addressed the staffing complaints and grievances from the Resident Council Group. Additionally, a review of the facility's grievance log from November 2021 to February 1, 2022 showed no documented grievance and/or concerns related to staffing shared and reported by the Resident Council. On 02/09/2022 at 12:15 PM, Resident 6 stated she attended the Resident Council meetings on a regular basis and had heard concerns about lack of staff all the time, including during the last month's meeting (January 2022). Resident 6 also stated she even experienced it herself and had to wait a long time to get assistance from staff. Resident 6 stated she could not recall any resolution from the facility related to the staffing concerns they reported. On 02/09/2022 at 1:00 PM, Staff D, Activities Director (AD) stated she could not recall the specific topics or concerns shared by the Resident Council Group and that she needed to see the Resident Council Minutes before making a response. Staff D stated she did not fill out any Grievance report from the Resident Council group. On 02/09/2022 at 1:05 PM, both Staff A, Administrator and Staff B, Director of Nursing (DNS) reviewed the Resident Council Minutes from November 2021 to January 2022 and stated there was no documentation and/or follow-up related to the staffing concerns/grievance reported by the Resident Council. Staff A stated she was the grievance coordinator and was responsible for providing oversight to Staff D, including the Resident Council process. However, Staff A stated she was not sure as to why the staffing concerns reported by the Resident Council group was not documented in the minutes and why there were no follow-up or resolution from the facility. Both Staff A and Staff B stated that any concerns or grievances by the Resident Council group should have been documented to the minutes and should have been addressed and followed-up on by the facility. On 02/15/2022 at 11:00 AM, Staff D stated she did remember the staffing concerns shared by the Resident Council during the Resident Council meetings, and she should have documented the specific concerns/grievances in the meeting minutes and included any follow-up or resolution (if any) as required. Staff D stated there was no documented evidence that the facility had addressed and/or acted on the Resident Council concerns/grievances. Reference: WAC 388-97-0460

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F 0600 Level of Harm - 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** 39651 Based on interview and record review, the facility failed to ensure residents were free from abuse or neglect for 8 of 10 residents (Residents 1, 4, 16, 3, 10, 11, 13 and 14) reviewed for abuse and neglect. This failure caused harm to Residents 1, 4, 16, 3, 10, 11, 13 and 14 and placed other residents at risk for harm and unmet care needs. Findings included . The Code of Federal Regulation (CFR) defined neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. RESIDENT 1 Resident 1 was a long-term resident of the facility. Resident 1's diagnoses list included left-sided paralysis, osteoarthritis (bone degeneration with pain and stiffness) of the hip, and muscle contractures. A review of Resident 1's quarterly Minimum Data Set (MDS) assessment, dated 01/06/2022, showed Resident 1 had intact cognition and needed two-person physical assistance with bed mobility and transfer. A review of the facility's incident reporting log showed that on 01/25/2022, Resident 1 reported an allegation of physical abuse against Staff T, Nursing Assistant Certified (NAC). On 02/08/2022 at 11:00 AM, Resident 1 stated that she was physically abused by a staff member, [Staff T NAC]. Resident 1 stated Staff T came into her room to provide personal hygiene care. Resident 1 stated she told Staff T that she needed two-person care due to her physical limitations and had informed Staff T about her left sided weakness, pain, and to not turn her onto her left side. According to Resident 1, Staff T ignored her and provided the care as she wishes and treated me like dead meat. Resident 1 stated that Staff T scared the hell out of her as Staff T flipped her in bed, shoved and pushed her on the left side while she was pleading and begging for mercy. Resident 1 further stated, she felt unsafe and had serious pain during the care, and had felt fear, intimidation and abused by Staff T. During the interview, Resident 1 was tearful and asked please help me and do not let [Staff T NAC] come back here. Resident 1 stated she did not feel safe around Staff T and she was concerned that [Staff T] would hurt her again if she came back to the facility. According to Resident 1, Staff T did not stop even after she asked and begged for mercy to please stop, but Staff T did not stop until she was done. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 02/08/2022 at 11:30 AM, Staff R, Social Services (SS) stated that Resident 1 had reported the same experience to the facility and her daughter. Staff R stated she had interviewed and followed-up with Resident 1 on 01/28/2022 after receiving a call from the resident's daughter. According to Staff R, Resident 1 showed and verbalized psychosocial harm in the form of fear, emotional and mental anguish. Staff R further stated the facility administration was aware of the situation and the results of her visits. On 02/08/2022 at 12:30 PM, Staff B, Director of Nursing (DNS) stated the incident investigation was completed for Resident 1 and that she was able to substantiate that Staff T, NAC had provided the personal care to Resident 1 alone and was not aware of or did not know what was on Resident 1's care plan. Staff B also stated that Staff T told her that there were not enough staff at the time of the incident, and she had provided care to Resident 1 alone at least 2 times. Staff B stated Staff T was placed on suspension and that she was able to substantiate that Resident 1 had suffered psychosocial harm related to the incident. Staff B further stated that the incident could have been avoided if Staff T had read and followed Resident 1's care plan. RESIDENT 4 Resident 4 was a long-term resident of the facility. The resident's diagnoses list included lung disease and muscle weakness. A review of Resident 4's quarterly MDS assessment, dated 2/15/2022, showed the resident had intact cognition and needed two person staff assistance with bed mobility and transfers. On 02/01/2022 at 11:30 AM, Resident 4 stated she was neglected and felt abandoned by staff so many times. Resident 4 stated that on 01/23/2022 at around 2:00 PM, she called and asked for staff to bring her use a bedside commode. However, Resident 4 stated she had waited for at least 2-3 hours until any staff helped her, and she had peed and pooped herself while waiting. According to Resident 4, it was very humiliating and embarrassing, and this was not the first time that this had happened. Resident 4 stated she had reported these concerns of not getting staff assistance for at least 2-3 hours, and sometimes not at all almost every day and every month to the facility administration, but nothing had happened, They just ignore us and don't care about us. During the interview, the resident appeared visibly upset and stated that she was frustrated and angry about the situation and felt helpless because it wasn't just her who experienced these problems. Resident 4 further stated that she had developed skin breakdown and rash on her private areas and buttocks area because of this on-going neglect of care. A review of Resident 4's clinical records showed the resident had Moisture Associated Skin Damage on her buttock area and there was no documented evidence of any toileting or personal care provided on 01/23/2022 from 2:00 PM to 5:00 PM. A review of the facility's incident investigation report, dated 01/24/2022, showed the facility had investigated Resident 4's allegation and confirmed that the resident did not receive the care she needed on 01/23/2022 between 2:00 PM to 5:00 PM. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 02/01/2022 at 12:45 PM, Staff B, DNS stated that Resident 4 did not receive any care from any staff on 01/23/2022 from 2:00 PM to 5:00 PM. Staff B stated there were no NACs that were assigned to Resident 4 because NACs were late and did not arrive at the facility as scheduled. Staff B also stated that the nurse on duty failed to reassign and rearrange the unit assignments to cover resident care which resulted in Resident 4 not getting any help from the staff that were at the facility. RESIDENT 16 Resident 16 was a long-term resident of the facility. The resident's diagnoses list included muscle weakness and neuropathy (nerve problem). A review of Resident 16's quarterly MDS assessment, dated 11/16/2021, showed the resident had intact cognition and needed two person staff assistance with bed mobility and transfers. On 02/01/2022 at 11:55 AM, Resident 16 stated that on 01/19/2022 and 01/20/2022 morning and afternoon shift (could not recall specific times) she had to wait for at least 1-2 hours to get staff to change her brief. Resident 16 stated she had urinated and had a bowel movement, so she had to call staff to change her. However, Resident 16 stated no staff person came for 1-2 hours and she was sitting in her own waste that made her itch and angry to a point where she had to file a complaint. According to Resident 16, the situation made her felt humiliated and neglected and was concerned because it happens all the time here. On 02/01/2022 at 12:55 PM, Staff B, DNS stated that Resident 16 did not receive timely assistance from staff on 01/19/2022 and 01/20/2022 because the assigned NAC was looking for a second staff person to help and assist with care. Staff B stated that she was not able to confirm how long the resident had to wait for care, but there was less staffing during those days (01/19/2022 and 01/20/2022) which could have lead to not finding another staff person to provide the needed care for the resident. Staff B further stated that when she interviewed Resident 16, the resident stated she had waited for at least 1 hour to get help and was consistent with her report. On 02/01/2022 at 1:30 PM, both Staff A, Administrator and Staff B DNS stated they were aware of the resident's concerns related to not getting timely assistance and care from staff which was the reason the facility developed a contingency plan related to staffing. However, both Staff A and Staff B stated that toileting, personal hygiene, and other basic needs should be provided within a reasonable time frame and not within hours as reported by the residents. RESIDENT 3 Resident 3 was a long-term resident of the facility. The resident's diagnoses list included stroke with left sided weakness. A review of Resident 3's quarterly MDS assessment, dated 12/19/2021, showed the resident had mild cognitive impairment and needed two person staff assistance with bed mobility and transfers. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 02/01/2022 at 10:30 AM, Resident 3 stated, Residents here are being neglected including myself. According to Resident 3, she would ask and call for staff assistance with toileting and brief change, and simple requests for water, medicine and going to bed. The resident said that she had to wait hours to get help and sometimes staff would not return to the point where I've been sitting in my own waste for at least 2-3 hours and sometimes longer. Resident 3 also stated the Administrator and almost all the staff here knew about this and they have done nothing to address the problem. Resident 3 further stated this made her upset and angry because all her friends shared the same experience, and it has been happening for a long time. On 02/15/2022 at 10:30 AM, Resident 3 stated a similar incident of not getting assistance from staff happened again on 02/11/2022 in the morning shift (no specific time reported). Resident 3 stated she needed to have a brief change and get out of bed as usual, but no one came for almost 2-3 hours. According to Resident 3, she had her call light on and waited patiently, but when it was almost 2 hours, Resident 3 stated she had to scream and call staff attention by throwing things in her room hoping they could hear me. Resident 3 stated she was upset and angry about the situation and had reported her concerns to the facility administration. A review of the facility's incident investigation log, dated 02/11/2022, showed the facility was investigating Resident 3's allegation of neglect. On 02/15/2022 at 1:15 PM, Staff U, Regional Nurse Consultant (RNC) stated she was aware of the allegation made by Resident 3 and the facility had not yet finished the investigation. Similar findings were applicable to Residents 10, 11, 13 and 14: RESIDENT 10 and RESIDENT 11 Resident 10 was a long-term resident of the facility. The resident's diagnoses list included heart failure and muscle weakness. A review of Resident 10's quarterly MDS assessment, dated 12/24/2021 showed the resident had intact cognition and needed one person assistance with bed mobility and transfers. Resident 11 was a long-term resident of the facility. The resident's diagnoses list included depression and muscle weakness. A review of Resident 11's quarterly MDS assessment dated [DATE] showed the Resident had intact cognition and needed two person staff assistance with bed mobility and transfers. On 02/15/2022 at 11:00 AM, Resident 10 and Resident 11 (roommates) both stated that the facility had serious problems including neglect of care to the residents. Both residents stated they had to wait at least 2 hours to get staff help and sometimes longer than 4 hours. They also indicated there had been some instances in the past even overnight. Both residents stated they felt the facility staff just don't care and they both experienced neglect because most of the time, they just needed basic care such as to be cleaned and changed. Resident 11 stated, It was inhumane to experience such care, in that they just didn't have a choice and depended on the facility to care for them. Resident 11 became tearful during the interview and stated, they felt helpless at times because this has been the situation here for a very long time. RESIDENT 13 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Actual harm Residents Affected - Some	Resident 13 was a long-term resident of the facility. The resident's diagnoses list included kidney problems, obesity, and muscle weakness. A review of Resident 13's quarterly MDS assessment, dated 01/28/2022, showed the resident had intact cognition and needed one person staff assistance with bed mobility and transfers. On 02/15/2022 at 11:30 AM, Resident 13 stated she felt neglected by the facility a lot of times because she had to wait for at least 1-2 hours before she could get help or assistance from staff. Resident 13 stated this has been the situation at the facility for a very long time and she felt that the facility just wanted the residents to get used to this and not take any actions. According to Resident 13, the facility administration did not care and did not take any actions to help with the ongoing problem. Resident 13 further stated she was worried that if she had an emergency and needed immediate assistance from staff, she would be left alone in bed to die and the staff would just find her dead because of the amount of time needed for staff to respond to a call for assistance. Resident 13 was visibly upset and stated she was angry about the situation they were in because the administration seems to not care at all. RESIDENT 14 Resident 14 was a long-term resident of the facility. The resident's diagnoses list included heart problems and muscle weakness. A review of the residents quarterly MDS assessment, dated 01/03/2022, showed the resident had intact cognition and needed one-to-two-person assistance with bed mobility and transfers. On 02/15/2022 at 11:45 AM, Resident 14 stated she was very upset and angry because she was not getting adequate care from the facility. Resident 14 stated she had to wait for at least 2-4 hours to get help and assistance from staff with basic care needs such as brief change. According to Resident 14, just recently (about 1-2 days ago with no specific date/time) she had to wait for at least 4 hours to get incontinent care. Resident 14 stated she was told by the NAC that there was only one NAC on duty and he can't help it. Resident 14 stated, this has been the situation here for a long time and I'm getting tired of it. The facility failed to provide oversight and monitor the provision of care and services that resulted in multiple residents reporting neglect of care. Additionally, the facility failed to provide the required and effective structures/processes to meet the needs of one or more residents. See also CFR 483.25 - F689 - Free of Accident Hazards/Supervision/Devices and CFR 483.35 F725 - Sufficient Nursing Staff for more information. Reference: (WAC) 388 - 97-0640 (1)(3)(a)(c)

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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. 39651 Based on interview and record review, the facility failed to implement written policies and procedures related to the required screening of health care personnel by obtaining a criminal background check for 1 of 2 medical providers (M1) reviewed. This failure placed residents at risk for harm related to potential abuse/neglect. Findings included . A review of the facility's Abuse and Neglect policy, dated 02/23/2021, showed the facility will screen all potential hires and employees for history of abuse, neglect, mistreating residents, including information from previous employers, and checking appropriate licensing board and registries. A review of the facility's incident reporting log for February 2022 and an incident investigation report, dated 02/09/2022, showed Resident 19 made an allegation of abuse against a facility medical provider (M1). The incident investigation report showed Resident 19 reported during a care conference meeting that M1 inappropriately touched her. A review of the employee personnel files on 02/18/2022 at 1:00 PM showed M1 did not have a criminal background check completed as needed and required by the state agency/department. M1 had been employed and working with unsupervised access to vulnerable adults without a valid criminal background check for an unknown time frame/duration. On 02/18/2018 at 1:30 PM, Staff WW, Director of Clinical Operations confirmed and stated that the facility did not have the required criminal background check conducted for M1 prior to hire. Staff WW also stated the facility did not substantiate the abuse allegation reported by Resident 19. Reference: (WAC) 388-97-0640 (2)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 39651 Based on observation, interview and record review, the facility failed to provide adequate supervision for both residents and staff when staff did not implement the care plans for 3 of 4 residents (Residents 1, 2 and 3) reviewed for avoidable accidents and falls. Failure to provide adequate supervision of staff as determined by assessing the appropriate level and number of staff required, the competency and training of the staff, and the frequency of supervision as determined by the individual resident's assessed needs and identified hazards resulted in harm to Resident 1 and 2 and placed the other residents at risk for harm and injury. The facility's failure to provide the required supervision and care based on the residents' specific care plans and care directives, constituted a situation of an Immediate Jeopardy (IJ) and increased the likelihood of serious injury, impairment and/or death for Residents 1, 2 and 3. The facility was notifed of the IJ on [DATE] at 6:35 PM. An acceptable written removal plan related to the IJ was received from the facility on [DATE]. An onsite survey was conducted on [DATE] to verify the removal of the immediacy related to the Immediate Jeopardy (IJ) on to CFR 483.25 - F689 - Free of Accident Hazards/Supervision/Devices. However, the facility failed to remove the immediacy by not following and implementing the written removal plan. A second and updated removal plan was received form the facility on [DATE]. An onsite survey was conducted on [DATE] to verify the removal of the immediacy. The facility removed the immediacy on [DATE] by assessing the residents for safety, transfer status and falls and by re-educating and re-training staff about following the resident care plans. Findings included . RESIDENT 2 Resident 2 was a long-term resident of the facility. The resident's diagnoses list included stroke with right sided weakness and dementia (memory problem). A review of Resident 2's quarterly Minimum Data Set (MDS) assessment, dated [DATE], showed the resident had impaired cognition and needed two person staff assistance with bed mobility and transfers. A review of Resident 2's care plan, dated [DATE] and revised on [DATE], showed the resident required assistance with activities of daily living (ADLs) due to impaired mobility and stroke. The care plan directed facility staff to provide two-person extensive assistance with bed mobility and incontinent care. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the facility's incident investigation report, dated [DATE], showed Resident 2 had a fall on [DATE] at approximately 12:15 PM. The incident investigation report showed the incident happened during resident care when Staff I, Nursing Assistant Certified, NAC was providing incontinent care and brief change alone, without a second staff person as directed by the resident's care plan. On [DATE] at 4:30 PM, Staff B, Director of Nursing, DNS stated she had interviewed Staff I regarding the incident. Staff B said Staff I told her that she [Staff I] did not read or review Resident 2's care plan before providing the care and [Staff I] was not aware that Resident 2 required 2-person care for bed mobility or when providing incontinent care. Staff B requested that Staff I write a statement regarding the incident. A review of the written statement, dated [DATE], showed Staff I was changing Resident 2 and asked the resident to roll on his right side (which was the resident's weak side). Staff I documented, He [Resident 2] did, but kept rolling. He went off the edge of the bed landing on his knees facing his nightstand. He then rolled to his back [while on the floor]. On [DATE] at 10:30 AM, Staff I stated that she should have reviewed Resident 2's care plan before providing care to ensure the resident's safety. Staff I also stated that she usually worked with Resident 2 and had become familiar with his care, so she did not bother reading and looking at the care plan. According to Staff I, every time she worked and provided care to Resident 2, she always did it alone and independently for a while now. Staff I further stated, I should have not asked Resident 2 to roll on his right side because he kept rolling and fell out of bed. Staff I stated, We were lucky because he could have died and got seriously injured because of this incident. On [DATE] at 4:30 PM, Resident 2 stated his left knee was hurting and he was in pain. Resident 2 showed his left knee area that had two abrasions which both measured approximately 1 centimeter (cm) in length and 1 cm wide. Resident 2 reported soreness and pain to the area rated at 7 out of 10 pain scale (0 being no pain and 10 being the worst pain). Resident 2 was also trying to demonstrate using hand gestures how he rolled out of bed and how he hit the ground hard. Resident 2 was rubbing and massaging his left knee area during the interview. On [DATE] at 4:45 PM, Staff V, Registered Nurse stated he was the shift nurse on duty for Resident 2 and was not aware of the resident's injuries to the left knee area and pain concerns. A joint record review of Resident 2's clinical record showed no documented evidence that the facility had comprehensively assessed, monitored and treated Resident 2's knee abrasions and pain related to the fall incident on [DATE]. There was no documented evidence that the facility had notified the physician of these injuries and what actions were taken to address the resident's injuries and pain. On [DATE] at 5:00 PM, Staff V assessed Resident 2's left knee and identified 2 abrasions measured each at approximately 1 centimeter (cm) in length and 1 centimeter wide. Resident 2 also reported pain to the left knee upon palpation by Staff V. Staff V stated he was not aware of those injuries and that there was no report given to him when he started the shift this afternoon. On [DATE] at 5:15 PM, Staff B, DNS stated the incident involving Resident 2 was avoidable and could have been prevented if Staff I, NAC had read and followed the resident's care plan. Staff B also stated she was not aware of the injuries that Resident 2 had sustained as a result of the incident, but she was glad that the resident was not seriously injured because the incident was very serious and could have resulted in serious injury, impairment or even death. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	RESIDENT 3 Resident 3 was a long-term resident of the facility. The resident's diagnoses list included stroke with left sided weakness. A review of Resident 3's quarterly MDS assessment, dated [DATE], showed the resident had mild cognitive impairment and needed two person staff assistance with bed mobility and transfers. A review of Resident 3's care plan, dated [DATE] and revised on [DATE], showed the resident required assistance with ADLs due to impaired mobility, stroke and obesity. The care plan directed facility staff to provide two-person extensive assistance with transfers. A review of the facility's incident investigation report, dated [DATE], showed the resident had a fall on [DATE] at 10:35 PM. The incident report showed Staff K, NAC transferred Resident 3 from the wheelchair to the bed without the assistance of a second staff person as directed by the resident's care plan. The incident report documented, The resident [Resident 3] lost grip of her left leg and I slowly guided her to the floor. On [DATE] at 11:00 AM, Resident 3 stated she could recall the incident on [DATE] because she was frightened and scared during the transfer. Resident 3 stated she was transferred by a new NAC (Staff K) and she doesn't know what she was doing. According to Resident 3, she told Staff K that she needed a second person to transfer her for safety, but she did not listen and proceeded with the task. Resident 3 further stated she was scared, but at the same time she was glad that she did not hit her head hard or break any bone. On [DATE] at 2:30 PM, Staff K, NAC stated she was a new employee and did not know that Resident 3 required two staff people during care and transfers. Staff K stated she was not aware of the care plan or the kardex (care directives) and she does not know where to locate them. According to Staff K, she did not receive any training or education related to the care plan and was just observing what other NACs had done. On [DATE] at 5:15 PM, Staff B, DNS stated the incident involving Resident 3 was avoidable and could have been prevented if Staff K, NAC had read and followed the resident's care plan. However, Staff B also stated she was not aware that Staff K did not receive any training related to the care plan and the kardex. According to Staff B, Staff K should have been trained first on what the care plan and kardex were, where to locate and how to access them before she was allowed to work independently on the floor. Staff B stated she was glad that the resident was not seriously injured because the incident was serious and could have resulted in serious injury, impairment or even death. On [DATE] at 5:30 PM, Both Staff B, DNS and Staff N, Licensed Practical Nurse/Staff Development Coordinator (LPN/SDC) stated the facility had no current process or system to train new employees (including Staff K, NAC) about the importance of reading and understanding each resident's care plan, including how to locate and access them to ensure an effective and safe delivery of care. Both Staff B and Staff N stated that the facility's lack of an effective system to educate and train staff about care plans and kardex, including the lack of supervision that resulted to accidents does require immediate actions, had placed the residents at risk for the likelihood of serious injuries, serious impairments and/or potentially death from avoidable accidents like falls. RESIDENT 1 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident 1 was a long-term resident of the facility. Resident 1's diagnoses list included left sided paralysis, osteoarthritis (bone degeneration with pain and stiffness) of the hip, and muscle contractures. A review of Resident 1's quarterly Minimum Data Set (MDS) assessment, dated [DATE], showed Resident 1 had intact cognition and needed two-person physical assistance with bed mobility and transfer. A review of Resident 1's care plan, dated [DATE] and revised on [DATE], showed the resident required assistance with ADLs due to generalized weakness and impaired mobility. The care plan directed facility staff to provide two-person extensive assistance with bed mobility and transfers. The care plan also showed that Resident 1 preferred male caregivers when available. A review of the facility's incident investigation report, dated [DATE], showed Resident 1 had made an allegation of physical abuse against Staff T, NAC. The incident investigation showed Staff T did not follow Resident 1's care plan to have a second staff person when providing care. The incident report and supporting documentation, including staff witness statements and social services follow-up visits/notes, showed Resident 1 suffered psychosocial harm as the result of the incident. On [DATE] at 11:00 AM, Resident 1 stated that Staff T, NAC came into her room to provide personal hygiene care on [DATE]. Resident 1 stated she told Staff T that she needed two-person care due to her physical limitations and had informed Staff T about her left sided weakness, pain and to not turn her on the left side. According to Resident 1, Staff T ignored her and provided the care as she wishes and treated me like dead meat. According to Resident 1, Staff T scared the hell out of her as Staff T flipped her in bed,and shoved and pushed her on the left side while she was pleading and begging for mercy. Resident 1 further stated that she had serious pain during the care, and felt unsafe and felt fear, intimidation and abused by Staff T. During the interview, Resident 1 was tearful and asked please help me and do not let Staff T, NAC come back here. Resident 1 stated she did not feel safe to be around Staff T and she was concerned that Staff T will hurt her again if she came back to the facility. According to Resident 1, Staff T did not stop even after she asked and begged for mercy to please stop but Staff T did not stop until she was done. The resident stated she had feared for her safety because she almost fell out bed because of Staff T's action. On [DATE] at 12:30 PM, Staff B, DNS stated the incident investigation was completed for Resident 1 and that she was able to substantiate that Staff T, NAC had provided the personal care to Resident 1 alone and that Staff T was not aware of and did not know what was on Resident 1's care plan. Staff B also stated that Staff T told her that there were not enough staff at the time of the incident, and that she also had provided care to Resident 1 by herself at least 2 times in the past. Staff B stated Staff T was placed on suspension and that she was able to substantiate that Resident 1 had suffered psychosocial harm related to the incident. According to Staff B, Resident 1 could have fallen out of bed or got hurt physically, but also this entire incident could have been avoided if Staff T had read and followed Resident 1's care plan. Staff B offered no explanation as to why the resident's preference to have male caregiver be present was not followed even though there was a male caregiver/nurse present at the time of the incident. Reference: (WAC) [DATE] (1) and WAC [DATE](1)(3)(g)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 39651 Based on interview and record review, the facility failed to ensure sufficient nursing staff were consistently available to meet the needs of all residents of the facility. Failure to have a sufficient number of nursing staff with appropriate competencies and skills sets caused harm to Resident 4, 16, 3, 10, 11, 13 and 14 and placed all other residents at risk for harm and unmet care needs. Findings included . On 02/09/2022 at 5:30 PM, both Staff B, Director of Nursing and Staff N, Licensed Practical Nurse/Staff Development Coordinator (LPN/SDC) stated the facility had no current process or system to train new employees (including Staff K, NAC) about the importance of reading and understanding each resident's care plan, including how to locate and access them to ensure an effective and safe delivery of care. Both Staff B and Staff N stated that the facility's lack of an effective system to educate and train staff about care plans and kardex, including the lack of supervision that resulted to accidents does require immediate actions, had placed the residents at risk for the likelihood of serious injuries, serious impairments and/or potentially death from avoidable accidents like falls. FACILITY ASSESSMENT A review of the facility assessment, dated 01/21/2021 and revised/updated on 08/10/2021, showed the facility needed the following staff (s)/resources to provide competent support and care for its resident population at any given time: A. A full time Infection Preventionist (IP). B. At least 20 licensed nurses (11 nurses in the morning, 6 in the evening and 3 at night) per day. C. Direct care staff (Nursing Assistant Certified [NAC]) were determined based on care acuity and determined by the Minimum Data Set (MDS) Assessment acuity score/report. The Facility assessment showed the acuity report should be reviewed daily including the weekends. A review of the Staffing Pattern from 01/02/2022 to 02/01/2022 completed by Staff B, Director of Nursing (DNS) showed the facility did not meet the required number of staff needed to meet the needs of the residents for all the dates within that timeperiod, as determined by the facility assessment. On 02/09/2022 at 5:30 PM, Staff B stated the facility did not currently have a full time IP and that they were working on hiring more staff to meet the needs of the residents. Staff B also stated that she only had one unit manager currently, and sometimes that unit manager had to work on the medication cart due to staffing needs. According to Staff B, she was not sure when was the last time the facility had reviewed the MDS assessment acuity score, but there was none completed for a long time. Staff B further stated the facility was short of NACs and they had struggled on days where staff were sick and/or failed to show for work. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	On 02/18/2022 at 12:40 PM, Staff W, Registered Nurse/MDS coordinator stated she had not run and/or reviewed the MDS acuity score or report for a long time and that she had not met with the Administrator and/or the DNS to review the facility staffing based on this report. CONTINEGENCY STAFFING PLAN A review of the facility's undated Staffing Contingency Plan showed it was missing specific and detailed plan(s) on how the facility would operate and effectively utilize available resources and implement staffing management according to the facility's emergency plan. The contingency plan also lacked specific plans or interventions regarding which resident care and services would be affected and/or modified, including the duration, and how the facility would document and monitor the residents' response and potential negative implications to the residents' overall well-being. The facility's Staffing Contingency Plan did not address and specify which plan of action would be modified or implemented for basic care needs, including the prevention of abuse and neglect. On 02/09/2022 at 5:35 PM, Staff A, Administrator and Staff B, DNS stated they were not aware that the Contingency Staffing Plan should include such specific and detailed information, or that it should have been incorporated to their facility assessment and emergency plan. Both Staff A and Staff B stated that they were aware of the staffing concerns in the facility and were doing what they can to meet the needs of their residents. However, Staff A and Staff B stated the facility recently opened a COVID-19 unit with at least 10 residents with active COVID-19 infection. Both Staff A and Staff B did not provide an answer as to why the facility, who had urgent staffing needs and struggling to meet the needs of their current resident population, opened a COVID-19 unit that added more workload and pulled away more resources and available staff to be assigned and care for newly admitted residents. The facility failed to implement its own staffing plan to meet the needs of each resident, as detailed in the facility assessment. Additionally, the facility failed to update and incorporate the facility's Contingency Staffing Plan to its own Facility Assessment and Emergency Staffing Plan to ensure that the facility would adequately staffed based on self-assessment, identified risks, hazards and needs. RESIDENT INTERVIEWS RESIDENT 3 On 02/01/2022 at 10:30 AM, Resident 3 stated, Residents here are being neglected, including myself. According to Resident 3, she would ask and call for staff assistance with toileting and brief change and including simple requests for water, medicine and going to bed. Resident 3 said she had to wait hours to get help and sometimes staff would not return to the point where I've been sitting on my own waste for at least 2-3 hours and sometimes longer. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	On 02/15/2022 at 10:30 AM, Resident 3 stated that not getting assistance from staff happened again on 02/11/2022 in the morning shift (no specific time reported). Resident 3 stated she needed to have a brief change and get out of bed as usual, but no one came for almost 2-3 hours. According to Resident 3, she had her call light on and waited patiently but when It's almost 2 hours, Resident 3 stated she had to scream and call staff attention by throwing things in her room hoping they could hear me. Resident 3 stated that she was upset and angry about the situation and had reported her concerns to the facility administration. RESIDENT 4 On 02/01/2022 at 11:30 AM, Resident 4 stated she was neglected and felt abandoned by staff so many times. Resident 4 stated that on 01/23/2022 at around 2:00 PM, she called and asked for staff to bring her a bedside commode. However, Resident 4 stated she had waited for way too long, at least 2-3 hours until she got any staff to help her, and she had peed and pooped herself while waiting. According to Resident 4, what happened was very humiliating and embarrassing, and this was not the first time that this had happened. Resident 4 stated she had reported her concerns of not getting staff assistance for at least 2-3 hours and sometimes not at all, almost every day and every month to the facility administration, but nothing had happened, They just ignore us and don't care about us. RESIDENT 16 On 02/01/2022 at 11:55 AM, Resident 16 stated that on 01/19/2022 and 01/20/2022 morning and afternoon shift (could not recall specific time), she had to wait for at least 1-2 hours to get staff to change her brief. Resident 16 stated she had urinated and had a bowel movement, so she had to call staff to change her. However, Resident 16 stated no staff person came for at least 1-2 hours and she was sitting at her own waste that made her itch and angry to a point where she had to file a complaint. According to Resident 16, the situation made her felt humiliated and neglected and was concerning enough because it happens all the time here. RESIDENT 10 and RESIDENT 11 On 02/15/2022 at 11:00 AM, both Resident 10 and Resident 11 (roommates) stated the facility had serious problems, including neglect of care to the residents. Both residents stated they had to wait at least 2 hours to get staff help and sometimes longer than 4 hours with some instances in the past waited even overnight. Both residents stated they felt the facility staff just don't care and they both felt neglect because most of the time, they needed basic care, such as the need to be cleaned and changed. Resident 11 stated It was inhumane to experience such care but they just didn't have a choice and couldn't help, but to depend on the facility to care for them. Resident 11 became tearful during the interview and stated, they felt helpless at times because this has been the situation here for a very long time. RESIDENT 13 (continued on next page)

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	505042	A. Building B. Wing	02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0725 Level of Harm - Actual harm Residents Affected - Some	On 02/15/2022 at 11:30 AM, Resident 13 stated she felt neglected by the facility a lot of times because she had to wait for at least 1-2 hours before she could get help or assistance from staff. Resident 13 stated this has been the situation here for a very long time and she felt that the facility just wants the residents to get use to this and not take any actions. According to Resident 13, the facility administration did not care and did not take any actions to help with the on-going situation. Resident 13 further stated that she was worried that if she had an emergency and needed immediate assistance from staff, that she would be left alone in bed to die and the staff would just find her dead because of the amount of time needed for staff to respond when she called for assistance. Resident 13 was visibly upset and stated she was angry about the situation they were in because the administration seems to not care at all. RESIDENT 14 On 02/15/2022 at 11:45 AM, Resident 14 stated she was very upset and angry because she was not getting adequate care from the facility. Resident 14 stated she had to wait for at least 2-4 hours to get help and assistance from staff with basic care needs, such as brief change. According to Resident 14, just recently, about 1-2 days ago with no specific date/time, she had to wait for at least 4 hours to get incontinent care. Resident 14 stated she was told by the NAC that there was only one NAC on duty and he can't help it. Resident 14 stated that this has been the situation at the facility for a long time and, I'm getting tired of it. RESIDENT 7 and RESIDENT 8 On 02/15/2022 at 10:00 AM, both Resident 7 and Resident 8 stated that they had to wait a long time to get help and assistance from staff. Both residents stated they had to wait for at least 1-2 hours and sometimes longer to get help, especially during the night and the weekends. Resident 7 stated she had to sometimes call out for help, just to get somebody to her room. Resident 8 stated she had to file a complaint about the lack of assistance because she felt abandoned and neglected most of the time, and also because she had a heart condition that would require immediate action from staff if she developed symptoms of heart irregularities such as chest pain and changes in her vitals. RESIDENT 9 On 02/15/2022 at 10:15 AM, Resident 9 stated the facility had problems with staffing because she had to wait for at least 1-2 hours to get help and assistance from staff. Resident 9 was worried that if she had an emergency or needed immediate assistance, the facility staff would not be there fast enough for her to receive the care she needs. RESIDENT 6 On 02/15/2022 at 10:20 AM, Resident 6 stated she had to wait at least 2 hours most of the time to get help and assistance from staff. Resident 6 stated she would sometimes sit in her urine and own waste for a long time, usually hours before she could get a brief change. RESIDENT 12 (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	On 02/15/2022 at 11:55 AM, Resident 12 stated he would have to wait at least 1-2 hours or longer and sometimes 4 hours even to get help and assistance from staff. Resident 12 stated he had gotten used to it and that waiting for long hours was just the normal at this place. STAFF INTERVIEWS On 02/01/2022 at 2:00 PM (joint interview), Staff F, NAC, Staff L, NAC, Staff P, NAC, Staff X, NAC, and Staff J, RN all stated they did not have enough time to provide the necessary care and services for each resident every shift due the short staffing. Each staff member stated they worked short-staffed most of the time and the residents would complain that they had to wait long hours to get assistance from staff. Each staff member stated if they work short, which happened all the time, tasks like bathing and showers were not done. On 02/09/2022 at 1:30 PM, Staff O, Licensed Practical Nurse stated she did not have enough time to care and complete her tasks and provide the necessary care and services for each resident during her shift. This would often result in the resident not getting timely assistance from her and delay in administering medications. On 02/09/2022 at 6:15 PM, Staff Y, Registered Nurse, stated he did not have enough time to provide the necessary care and services for each resident during his shift. Staff Y stated the residents would sometimes complain of not getting their medications on time or extended wait times for call lights. On 02/15/2022 at 10:00 AM, Staff H, NAC stated they mostly worked short-staffed which affected how they provide timely assistance with residents. Staff H stated it had been an on-going issue for a while and residents would mostly verbalize that they had waited a long time to get assistance from staff. On 12/15/2022 at 10:05 AM, Staff P stated the facility did not have enough staff to meet the needs and concerns of residents, such as answering call lights timely and providing quality care because they must rush and get to the next resident as quick as possible. Staff P stated that sometimes they were not able to provide showers because they worked short of NACs. On 02/15/2022 at 10:15 AM, Staff N, Staff Development Coordinator/Staffing Coordinator stated the facility needed more staff to meet the residents' needs in a manner that was safe and promoted each resident's rights and well-being. Reference: (WAC) 388-97-1660(1)(a)(c)(i)(ii)(iii)

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F 0835 Level of Harm - Actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 39651 Based on interview and record review, the facility Administration failed to effectively manage the facility in compliance with state and federal regulatory requirements. The facility Administration failed to ensure compliance and implementation of written policies and procedures and provide adequate oversight to facility staff related to Accident prevention/Supervision, Resident Rights, Sufficient Nursing Staff, Grievances, and Infection Prevention and Control. These failures caused harm to Residents 1, 2, 4, 16, 3, 10, 11, 13 and 14 and placed the other residents at risk for harm related to ongoing abuse and neglect. Findings included . On 02/09/2022 at 6:35 PM, an Immediate Jeopardy (IJ) situation was identified related to CFR 483.25 - F689 - Free of Accident Hazards/Supervision/Devices, including a substandard Quality of Care (SQC) related to CFR 483.12 F600 - Free from Abuse and Neglect. CFR 483.25 - F689 - Free of Accident Hazards/Supervision/Devices On 02/09/2022 at 6:45 PM, both Staff A Administrator and Staff B Director of Nursing stated the IJ situation related to F689 - Free of Accident Hazards/Supervision/Devices could have been avoided if staff were adequately trained and followed Residents 1, 2 and 3's care plan. Staff B also stated the facility's lack of an effective system in ensuring staff and new hires were educated and trained to access care plans/Kardex (care directives) had contributed to the accidents that could have seriously injured the residents. A review of Resident 1's incident on 01/25/2022, Resident 2's incident on 02/08/2022 and Resident 3's incident on 01/29/2022 showed each incident could have been avoided if the facility staff provided the required supervision and followed and implement each resident's care plan/care directives. The facility Administration's lack of oversight and ensuring staff were adequately trained in accessing, reading, and implementing each resident's care plan, caused harm to Resident 1 and 2 who suffered physical and psychosocial harm related to the incidents and placed all three residents (Residents 1, 2 and 3) at increased likelihood of serious harm, injury, impairment and/or death related to avoidable accidents and falls. CFR 483.35 - F725 - Sufficient Nursing Staff A review of the facility Staffing Pattern from 01/02/2022 to 02/01/2022 completed by Staff B showed the facility did not meet the required number of staff needed to meet the needs of the residents for that timeperiod as determined by the facility assessment. (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Some	On 02/09/2022 at 5:30 PM, Staff B, DNS stated the facility had a Staffing Contingency Plan and were short of NACs. The facility's Staffing Contingency Plan showed it was missing specific and detailed plans on how the facility would operate and effectively utilize available resources and implement staffing management according to the facility's emergency plan. The contingency plan also lacked specific plans or interventions on which resident care and services would be affected and/or modified, including the duration and how the facility would document and monitor the resident's response and potential negative implications to the resident's overall well-being. The facility's Staffing Contingency Plan did not address and specify what plan of action would be modified or implemented for basic care needs, including the prevention of abuse and neglect. On 02/09/2022 at 5:35 PM, both Staff A, Administrator and Staff B, DNS stated they were not aware that the Contingency Staffing Plan should include specific and detailed information or that it should have been incorporated in the facility assessment and the facility's emergency procedure plan. Both Staff A and Staff B stated that they were aware of the staffing concerns in the facility and were doing what they could to meet the needs of their residents. However, Staff A and Staff B stated the facility recently opened a COVID-19 unit with at-least 10 residents with active COVID-19 infection. Both Staff A and Staff B did not provide an answer as to why the facility, who had urgent staffing needs, struggled to meet the needs of their current resident population, opened a COVID-19 unit which added more workload and pulled more resources and available staff to be assigned to care for newly admitted residents. The Administration's failure to have sufficient nursing staff caused harm to Residents 4, 16, 3, 10, 11, 13 and 14 who reported psychosocial harm and neglect of care by the facility staff by waiting long hours (1-2 hours or longer) before receiving basic care and services, including toileting needs and brief changes. Additionally, the Administration's lack of action and oversight related to the staffing needs of the facility placed all residents in the facility at risk for harm and unmet care needs. CFR 483.10 - F585 - Grievances On 02/09/2022 at 12:05 PM, Resident 5 (Resident Council President) stated she and the Resident Council group were aware and had reported an on-going concerns and complaints from residents about lack of staff. A review of the Resident Council minutes from November 2021 to January 2022 showed no evidence that the facility had documented and/or addressed the staffing complaints and grievances from the Resident Council Group. Additionally, a review of the facility's grievance log from November 2021 to February 01, 2022 showed no documented grievance and/or concerns related to staffing shared and reported by the Resident Council. On 02/09/2022 at 1:05 PM, both Staff A, Administrator and Staff B, DNS reviewed the Resident Council Minutes from November 2021 to January 2022, and stated there was no documentation and/or follow-up notes related to the staffing concerns and grievance reported by the Resident Council. Staff A stated she was responsible for providing oversight to the Resident Council process. However, Staff A stated she was not sure as to why the staffing concerns reported by the Resident Council group was not documented in the minutes and why there was no follow-up or resolution from the facility. Both Staff A and Staff B stated that any concerns or grievances by the Resident Council group should have been documented in the minutes and should have been addressed and followed-up on by the facility. (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Some	The facility Administration's lack of oversight and actions on the Resident Council concerns and grievances, including the lack of an effective system in documenting and making sure follow-ups were made and grievances were reviewed and investigated as required placed all residents of the facility at risk for harm and unmet care needs. CFR F883.80 - F880 - Infection Prevention and Control A review of the facility's COVID-19 screening log for January 2022 showed that Health Care Personnel (HCPs), including staff and visitors, were not being screened properly for COVID-19 prior to entering the facility and providing care and services to the residents. Screening logs from 01/01/2022 to 02/01/2022 showed that employees, visitors, and other HCPs were not screened properly for signs and symptoms of COVID-19 but were allowed to enter the facility. The screening log was missing information, including whether the HCPs and visitors had COVID-19 signs and symptoms, most recent COVID-19 test/result, and COVID-19 vaccination status. On 02/01/2022 at 1:00 PM, both Staff A, Administrator and Staff B, DNS stated they were responsible in making sure that COVID-19 screening for all HCPs was done correctly based on CDC (Center for Disease Control) recommendation and their own policies and procedures. Both Staff A and Staff B stated that all HCPs and visitors should have been screened properly for COVID-19 prior to allowing entry to the facility to prevent and minimize the increased risk of COVID-19 transmission to residents and staff. The facility's Administration's failure to provide an adequate oversight to the facility's Infection Control COVID-19 prevention placed all residents of the facility at risk of acquiring COVID-19 infection. Reference: (WAC) 388-97-1620(1)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39651 Based on interview and record review, the facility failed to implement an effective infection control program related to the required screening of healthcare personnel (HCP) and/or visitors for COVID-19 (a highly communicable infection) for an entire month (January 2022) reviewed. These failures placed residents of the facility at risk of acquiring COVID-19 infection. Findings include . According to the Centers for Disease Control (CDC), COVID-19 is an illness caused by a virus (coronavirus) that can spread from person to person. The CDC also stated that a person can become infected from respiratory droplets when an infected person coughs, sneezes or talks. Symptoms of COVID-19 included: Fever or chills, Cough, Shortness of breath or difficulty breathing, Fatigue, Muscle or body aches, Headache, New loss of taste or smell, Sore throat, Congestion or runny nose, Nausea or vomiting and Diarrhea. The CDC guidelines for COVID-19 included the following: Screen all Health Care Personnel (HCP) at the beginning of their shift for fever and symptoms of COVID-19. Actively take their temperature and document absence of symptoms consistent with COVID-19. Healthcare Personnel (HCP): HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel). A review of the facility policy titled, [NAME] Center Policy and Procedure Screening of Staff and Visitors dated and revised on 01/2022 showed the purpose of the policy was to identify anyone entering the facility, regardless of their vaccination status, who pose risk of COVID-19 transmission to our residents and/or staff. The policy directed the facility staff to screen everyone who enters the facility for signs and symptoms of COVID-19. The policy showed that the facility's screening tool would be reviewed by staff for completeness to ensure that the person being screened did not have signs or symptoms of COVID-19, had no high risk/direct unprotected exposure to COVID-19 and had been recently tested per the recent guidelines. The screening tool directed the facility staff to screeners are required to take the person's temperature, verbally ask the screening questions to both visitors and employees immediately upon entry to the facility and complete the form. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's COVID-19 screening log for January 2022 showed that HCPs were not being screened properly for COVID-19 prior to entering the facility and providing care and services to the residents. Screening logs from 01/01/2022 to 02/01/2022 showed that employees, visitors, and other HCPs were not screened properly for signs and symptoms of COVID-19, but were allowed to enter the facility. The screening logs were missing information, including whether the HCPs or visitors had COVID-19 signs and symptoms, a most recent COVID-19 test/result, and COVID-19 vaccination status. On 02/01/2022 at 11:00 AM, Staff C, Receptionist, stated all employees and visitors should be screened for signs and symptoms of COVID-19 and asked for any known exposures, recent testing dates and vaccination status. Staff C also stated that all staff knew they should screen and answer all questions on the screening form before entering the facility. Staff C stated she was not sure why these procedures were not followed and why the screening logs had dates in which the COVID-19 screening were not done properly. On 02/01/2022 at 11:30 AM during a joint record review, Staff B, Director of Nursing (DNS) stated that HCPs and visitors should have been screened properly as directed by the facility policy and screening log procedures. Staff B also stated the HCPs should have answered all the questions in the screening log, including a temperature check, date of COVID-19 test, and vaccination status, and the screener should then determine if the HCP or the visitor could enter the facility or not. According to Staff B, leaving the screening log blank or by simply putting a line was not acceptable, as it could mean a lot of things. A review of the facility's infection line listing report submitted to the Department of Health and Local County Health Jurisdiction showed the facility had a COVID-19 outbreak involving at least 16 employees. The infection line listing report showed that at least 10 employees were at the facility during the infectious period of COVID-19 infection. On 02/01/2022 at 1:00 PM, both Staff A, Administrator and Staff B, DNS stated that all HCPs and visitors should have been screened properly for COVID-19 prior to being allowed entry to the facility. Both Staff A and Staff B stated that all COVID-19 screening questions should have been answered as directed by the facility policy. Staff A and Staff B stated that HCPs and visitors who were not screened appropriately for COVID-19 should have not been allowed in the facility, as it increased the risk of COVID-19 exposure/transmission of COVID-19 between staff, residents and/or visitors. Reference: (WAC) 388-97-1320 (1)(a)(b)(2)(a)(b)