STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505017	A. Building B. Wing	09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Care Center	2821 South Walden Street Seattle, WA 98144

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - 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** 32466 Based on interview and record review, the facility failed to ensure four (Resident 1, 2, 3, & 4) of 4 residents reviewed for abuse, were free from physical abuse when an unsupervised resident wandered into other residents' rooms. The facility's failure to supervise Resident 1 and implement adequate measures to protect Resident 2, 3, and 4 from abuse, resulted in emotional and physical harm to Resident 1, and posed potential risk of psychological harm to Resident 2, 3, and 4 and had the potential to affect other residents. Findings included . The facility's April 14, 2020 policy and procedure for abuse and neglect prevention included .Every resident has the right to be free from abuse in all forms. Residents must not be subjected to abuse by anyone, including, but not limited to employees, other residents . Resident 1 Resident 1 admitted to the facility on [DATE] according to the 5/23/20218 Minimum Data Set (MDS, an assessment tool). Staff assessed Resident 1 with long and short-term memory problems, severely impaired ability to make decisions, disorganized thinking and difficulty focusing. According to the 01/02/2021 annual MDS, the resident had disabling conditions including, Alzheimer's Dementia and wandering behavior. According to this MDS, Staff assessed the resident to be dependent on one person for supervision with Activities of Daily Living (ADLs) including redirecting and cueing when Resident 1 wandered into other residents' rooms. The MDS documented Resident 1 had severely impaired cognition. As a result of this assessment the facility developed 01/21/2021 Care Area Assessments (CAA) that included staff's recognition of Resident 1's continued wandering behavior into residents' rooms. Staff determined they would redirect the resident and cue the resident to stay away from and out of residents' rooms. The 09/07/2021 quarterly MDS described Resident 1 as displaying a severely impaired ability to make decisions, was continuously inattentive, and exhibited disorganized thinking. (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 0600 Level of Harm - Actual harm Residents Affected - Few	According to the 03/18/2020 abuse prevention Care Plan (CP), Resident 1 was, At risk for injury to themselves or others due to the resident's wandering behavior into residents' rooms and bathrooms, contributing to male residents increased behaviors to act out. Staff were instructed to implement interventions that included but were not limited to; set the resident up in a rocking recliner to watch television, provide the resident with a stuffed animal, supervise to prevent resident to resident altercations, walk three time a shift with supervision, provide snacks and allow (resident) to relax in rocking chair or bed, remove resident from area of other residents and closely observe, and redirect if found in another resident's room. Resident 4 According to the 08/23//2021 quarterly MDS Resident 4, male resident, had diagnoses of paralysis, and a diagnosis that required antipsychotic medication. Staff assessed Resident 4 to have problems with communication, no memory problems, and physical symptoms such as scratching themselves but no behavior directed at staff or other residents. Resident 3 According to the 08/23/2021 quarterly MDS, Resident 3 had diagnoses of arthritis and a fracture, was moderately impaired for decision-making, exhibited verbal symptoms such as screaming at others, and required supervision and set-up for all activities of daily living. Resident 2 The 06/21/2021 MDS indicated Resident 2 had a diagnosis of heart disease, was severely impaired for decision-making, exhibited disorganized thinking, and required supervision and set-up for all activities of daily living. First Incident Review of the 08/08/2021 Incident Investigation Report (IIR) showed that, at 10:40 AM on 08/08/2021, Staff E, RN, heard Resident 1 from Resident 2's room, speaking with a loud voice and instructing Resident 2 to sit down. When Staff E entered Resident 2's room, Staff E found Resident 1 sitting in Resident 2's wheelchair. According to the 08/08/2021 IIR Resident 2 was not happy when Resident 1 wandered into their room. Resident 2 got upset and got up from lying down and asked Resident 1 to leave the room. As Resident 1 was being assisted to leave the room by Staff E, Resident 2 followed Resident 1 and hit Resident 1 with a slipper to the right side of the face. Review of the investigation report conclusion dated 08/08/2021, showed no documentation to support the facility revised Resident 1's CP or implemented new interventions to prevent further resident to resident altercations. The impermissible action that caused Resident 2 to become upset and react to Resident 1 with physical abuse and at the same time suffer emotional distress was the fact Resident 1 entered Resident 2's room without permission. Resident 2 did not want Resident 1 in their room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Second Incident Review of the IIR dated 08/20/2021 showed on 08/20/21 at 8:35 AM (11 days after the first incident) another resident to resident altercation occurred. Staff F (CNA), observed Resident 3 hitting Resident 1 on the right arm with a walking cane, when Resident 1 wandered into Resident 3's room. According to the IIR, Resident 1 was noted to touch their right arm and grimace in pain. Staff I, RN, assessed Resident 1 with redness to the resident's right arm. According to the 08/20/2021 investigation report summary, Resident 1 was re-assessed to be confused, wandering and inappropriate with unwanted sexual behavior towards male residents, this indicated an increased risk for Resident 1 to experience altercations with other residents. A reasonable person would be upset if an intruder entered their home. Resident 3's room was his home and Resident 1 was the intruder. Although Resident 1 was struck and injured physically and emotionally by two residents, review of Resident 1's CP showed no indication that the facility developed or revised Resident 1's CP or implemented interventions to prevent further resident to resident altercations. Review of Resident 1's progress notes from January 2021 to August 2021, showed Resident 1 exhibited increased wandering behaviors on a daily basis during the day and evening shifts. Third Incident Observation on 09/13/2021 at 3:00 PM, showed Resident 1 wandering in the hallway without supervision. Observation at 3:20 PM, showed Resident 1 entering Resident 4's room uninvited, without knocking. After entering the room, Resident 1 sat on the chair adjacent to Resident 4's head of the bed. Further observation showed, no staff redirected Resident 1 from wandering into Resident 4's room. This was inconsistent with Resident 1's 03/18/2021 CP, which instructed staff, to redirect or cue the resident when the resident wandered into other resident's rooms. There was also no observation of a rocking recliner chair or a stuffed animal in the resident's room to be used as diversion for wandering. On 09/13/2021 at 3:45 PM, Resident 4 was asked, by Staff C, a Registered Nurse (RN), how he felt when Resident 1 wandered into Resident 4's room. Resident 4 mumbled angrily and stated, (using hands, and facial gestures due to anger and difficulty speaking) Resident 1 always wanders into (my) room uninvited. The fact Resident 4 became upset after Resident 1 repeatedly entered Resident 4's room against Resident 4's will demonstrated the facility ignored physical and emotional abuse of all four residents involved in the most recent incidents as described above. Staff Interviews In an interview on 09/13/2021 at 3:50 PM, Staff G (CNA) the CNA regularly assigned to care for Resident 1, acknowledged Resident 1 entered other residents' rooms uninvited. Staff G stated that, Resident 1 especially wandered into male residents' rooms. Staff G stated that it was difficult to monitor Resident 1 all the time as Staff G had other residents that required care. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 09/27/2021 at 2:45 PM, in an interview, Staff C, Resident Care Manager (RCM), stated they were not sure what interventions to initiate, as Staff C was new on the job and was in training at the time of incident the first two incidents. Staff C further stated they never witnessed any resident to resident altercation. In an interview on 09/27/2021 at 3:30 PM, Staff B, Director of Nursing Services (DNS) was asked how the facility ensured Residents were protected from abuse. Data was requested but none provided. Staff B stated that, the facility was experiencing a staffing shortage and was doing its best. In an interview on 09/26/2021 at 9:00 AM, Staff A (Administrator) acknowledged staff did not put in place adequate measures to protect Residents 1, 2, 3, and 4 from physical or emotional abuse. Reference WAC 388-76-0640(1)