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	05/03/2023

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45987 Based on observation, interview, and record review, the facility failed to provide supervision for 1 (Resident 1) of 3 sample residents at risk for elopements who eloped from the facility and was missing for at least eight hours unbeknownst to staff. Resident 1 experienced harm when they left the building unsupervised, for several hours, and sustained a fall with multiple injuries that required further evaluation at the hospital. Findings included . According to the 04/13/2023 Admission Minimum Data Set (MDS-an assessment tool) Resident 1 admitted to the facility with diagnoses of non-traumatic brain dysfunction, traumatic brain injury (TBI), disorientation, history of falling, and muscle weakness. Resident 1 had severe cognitive and daily decision-making impairments, needed supervision on and off the unit, was not steady when walking, and had a history of falls and wandering. The 04/14/2023 Wandering Risk Assessment showed Resident 1 needed assistance with mobility and had a history of wandering. The 04/14/2023 At Risk for Elopement Care Plan (CP) showed Resident 1 was at risk for elopement and documented a goal for the resident not to wander out of the facility. The CP showed interventions to have a WanderGuard bracelet (a device used to alert staff to a resident leaving the facility or unit) in place. Review of a late entry nursing note dated 04/15/2023 at 2:14 PM showed Resident 1 eloped from the building around 6:30 AM, was found in the facility parking lot, and brought back into the building. The CP had been updated for Resident 1 to wear a WanderGuard to prevent Resident 1 from wandering out of the facility. The 04/27/2023 Facility Incident Report Investigation showed Resident 1 left the facility at 09:01 AM and was not identified as missing from the building until 5:00 PM. During an interview and observation on 05/03/2023 at 11:30 AM, Resident 1 was found wandering the halls on the third floor, alone. Resident 1 was observed with bruising around both eyes, had abrasions to their right forehead and nose, and complained about pain in their knees. When asked if they had a fall, Resident 1 stated, Yes, I hit my head. (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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/03/2023 at 1:00 PM, Staff B, Director of Nursing, stated Resident 1 had a TBI and was wearing a WanderGuard bracelet because Resident 1 was at risk for elopement. Staff B stated the facility administrative staff reviewed the video that showed Resident 1 walked out the front door, the alarm went off and a nurse came out and reset the alarm without going outside to see if a resident had left the facility. During an interview on 05/03/2023 at 1:10 PM Staff C, Central Supply Director, stated the video footage showed someone, a nurse or an aide, went out the front door and Resident 1 followed the staff member out the door. The alarm went off and Staff D, Licensed Practical Nurse, came out of Unit 1, turned off the alarm, looked around the inside of the lobby, did not go outside to look for a resident. Staff C stated the receptionist was not at the desk. During an interview on 05/03/2023 at 1:30 PM, Staff D stated they were unaware anyone had gone out the front door, did not know what the alarm was sounding for, and turned off the alarm. Staff D stated they assumed another resident in the lobby had tugged on the door. When asked what time the alarm sounded and what time Staff D turned off the alarm, Staff D stated they could not recall what time it was, but thought it was in the morning. During an interview on 05/03/2023 at 1:55 PM Staff A, Administrator, stated they could not recall or provide any information or documentation when the facility staff realized Resident 1 eloped from the facility. Staff A stated according to the video Resident 1 eloped from the facility at 9:01 AM. When asked what time the staff were aware that Resident 1 was missing, Staff A stated around 5:00 PM. When asked what time Resident 1 was found by the police, Staff A stated it was about 6:30 PM, but then Resident 1 was transported to the hospital for evaluation. During a phone interview on 05/03/2023 at 2:58 PM Staff E, Licensed Practical Nurse, stated they started their shift at 2:00 PM on 04/27/2023, did not see Resident 1 throughout their shift. About dinner time they were notified by the Staff J, (Resident Care Manager), that Resident 1 was missing from the facility. Review of the 04/27/2023 at 8:35 PM Nurse Progress Note showed Resident 1 was not in their room around 5:00 PM, staff looked in every room but were unable to find Resident 1 and activated a code yellow (missing person) drill. Review of the 04/27/2023 at 7:28 PM emergency room Provider notes showed Resident 1 was seen for a fall with a head injury, altered mental status, pain in both thighs and knees, and had been missing from the facility since the morning of 04/27/2023. Injuries noted were a moderate sized right frontal (forehead) scalp hematoma (a solid swelling of clotted blood under the skin surface) and swelling of both knees. REFERENCE: WAC 388-97-1060(3)(g)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 45987 Based on observation, interview, and record review the facility failed to maintain the hot water heaters in safe operating condition. This failure caused 3 (Residents 4, 7, and 8) of 6 residents to be unable to shower with hot water Findings included . <Resident 4> According to the 04/10/2023 Quarterly Minimum Data Set (MDS-an assessment tool) Resident 4 was assessed to require total dependence of one staff member for bathing, transfers, and personal hygiene. The MDS also showed it was very important to Resident 4 to be able to choose between a shower or a bed bath. Resident 4 stated they prefered a shower. The revised 04/10/2023 Activities of Daily Living (ADL) Care Plan (CP) showed Resident 4's goal was to maintain/improve grooming and personal hygiene. The CP showed Resident 4 was scheduled to have bed baths two times weekly and as needed. During an interview on 04/25/2023 at 11:15 AM Resident 4 stated the third floor did not have any hot water for the last two and a half weeks, and they received bed baths but not with hot water. The staff had to go to a different floor to get hot water and bring it up to the 3rd floor. Resident 4 stated they had a rash that was not clearing and wondered if it was related to not having hot water to wash it with. An observation at 11:10 AM on 04/25/2023 the hot water nob was turned on in Resident 4's room and left running during interview. At 11:15 AM the hot water was still cold to touch. <Resident 7> According to the 03/13/2023 Quarterly MDS Resident 7 was assessed to require partial/moderate assistance with showers and bathing. The 09/23/2022 ADL CP showed Resident 7's goal was clean, dry and odor free daily. The CP interventions showed one person assist with showers two times weekly. During an interview on 04/25/2023 at 11:36 AM Resident 7 stated the staff told Resident 7 they would have to have bed baths because there was no hot water on the third floor. An observation at 11:36AM on 04/25/2023 showed the hot water nob was turned on in Resident 7's room and left running during interview. At 11:40 AM the hot water was cold to touch. <Resident 8> According to the 03/10/2023 Annual MDS Resident 8 was assessed to require supervision and set up for bathing and it was very important to decide between showers and bed baths. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The revised 10/24/2022 ADL CP showed Resident 8's goal was to be clean, dry and odor free daily. The CP interventions showed one-person limited assist for shower, three times weekly. The CP showed Resident 8 preferred to shower themself after shower set up. During an interview on 04/25/2023 at 12:10 PM Resident 8 stated multiple staff stated there was not hot water available on the third floor, staff do not know how to reset the water system, and the breaker needs repaired. Resident 8 stated the lack of hot water bothered them because they must go down to a different floor to shower. They can no longer do that due to COVID on that unit, so now it had been over a week since they had a hot shower. At 12:10 PM on 04/25/2023 the hot water nob was turned on in Resident 8's room and left running during the interview. At 12:15 the water running was cold to touch, 5 minutes later. Additional observations on 04/25/2023 between 11:20 AM and 11:53 AM showed Rooms 112, 321, 200 hall dining room, and 1st floor bathroom with cold water after faucets left running for 2-4 minutes. During an interview on 04/25/2023 at 11:15AM Staff H, Registered Nurse, stated maintenance staff said they keep fixing the hot water issue. The unit 2 [NAME] has hot water for sure, we have been taking residents to 2 [NAME] unit until the COVID (define) outbreak started, now we cannot take residents down to the 2nd floor. During an interview on 04/25/2023 at 11:32 AM Staff F, Certified Nursing Assistant, stated unit 2 [NAME] had hot water. Staff F stated 2 [NAME] was the only unit with hot water and the other units had been bringing residents to their unit for showers. During an interview on 04/25/2023 at 11:37 AM Staff G, Maintenance Director, stated the facility received three bids on the hot water heater, all three companies stated there was something wrong with system. Staff G stated they do not believe the water heater received service properly, and now they system needed to be re-set every 30-45 minutes for hot water to be available in all areas of the facility. The facility was waiting for corporate approval to sign a contract and get the issue fixed. Staff G stated they trained multiple staff members on how to reset the hot water. When asked who the staff members were or was there an education sheet, Staff G stated no. During an interview on 04/25/2023 at 11:40 AM Staff A, Administrator, stated the hot water was working intermittently on the 1st and 3rd floors, there would be hot water available when the re-set button was pushed. Staff A stated we signed a contract with a company to fix it. When asked to see the contract Staff A could not find one. When asked, a second time, if there was a signed contract to fix the hot water Staff A stated there was not a signed contract. Documents showing education of staff on how to re-set the hot water heater, documents on the maintenance of the hot water heater, and the policy regarding hot water in the facility were requested but not provided when asked. During an interview on 04/25/2023 at 12:30 PM Staff A stated the issue with the hot water started 3-4 weeks ago, sometimes it goes days without being reset. Staff A stated the facility did not check water temperatures for hot water. When asked if the hot water issue had been reported to the State as required, Staff A stated no. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/25/2023 at 12:38 PM Staff G stated they do water temperature checks quarterly. When asked if the they had performed daily water temperature checks since the hot water heaters were not functioning properly, Staff G stated they had only done a couple water checks, Staff G provided logs for 4 days of water temperature checks out of 3-4 weeks without hot water in the month of April. During an interview on 04/25/2023 at 12:45 PM Staff A stated why would we check for water temperatures and need the Emergency policy for hot water, we have hot water. During a phone interview on 04/25/2023 at 3:37 PM Staff I, Regional Administrator, stated the hot water heater is working when it is re-set, sometimes they have an issue with the hot water heater, it needs some repairs, and it is not functioning perfectly. WAC 388-97-2100