STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505202	A. Building B. Wing	08/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Skilled Nursing and Rehabilitation	4430 Talbot Road South Renton, WA 98055

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29644 Based on observation, interview and record review, the facility failed to implement abuse and neglect policies and procedures for 4 (Residents 1, 2, 3 & 4) of 5 residents reviewed for incidents. The failure to investigate incidents to rule out abuse / neglect and report to the State Agency (SA) as required placed all residents at risk for for unidentified abuse / neglect, and / or injury. Findings included . 46472 Resident 1 According to the 07/01/2022 Admission Minimum Data Set (MDS - an assessment tool) Resident 1 admitted to the facility on [DATE] with diagnoses of stroke, dementia, repeated falls, and traumatic fractures. Resident 1 had severe cognitive and daily decision-making impairments, no behaviors, and no rejection of care. The resident was incontinent of bowel and bladder and required extensive assistance for bed mobility, transfers, and toileting. The 07/18/2022 5 Day MDS showed Resident 1 did not have any falls or fractures since the 07/01/2022 Admission MDS was completed. According to the 07/12/2022 Hospitalist Discharge Summary Resident 1 was admitted to the hospital on 07/02/2022 from the skilled nursing facility (SNF) after sustaining a fall with hip fracture. Resident 1 required surgical repair of the fractured hip and was discharged back to the SNF on 07/12/2022 for continuation of short-term rehabilitation. Review of the July 2022 Facility Incident Reporting Log (a required reporting log) showed Resident 1 had a fall on 07/02/2022 at 9:50 AM in the resident's room, there was no injury, the origin of the fall was established, the care plan (CP) was updated, and no report was provided to the SA. During an interview on 08/01/2022 at 2:05 PM, Staff B (Director of Nursing) stated the facility was required to call into the SA any incidents were there was a suspicion or allegation of abuse / neglect, any substantial injuries where abuse / neglect was suspected, and any falls with substantial injury where abuse / neglect was suspected. Staff B stated that the fall with hip fracture Resident 1 sustained on 07/02/2022 was not called into the SA because they knew how it happened, the resident got up and fell . (continued on next page)

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/01/2022 at 3:57 PM, Staff B was unable to provide a completed facility Investigation that ruled out abuse / neglect for Resident 1's 07/02/2022 Fall with fracture and stated that the Resident Care Manager (RCM) was working on it and had not yet completed it. Staff B stated that the expectation was for investigations to be completed within five days of the incident. Review of the July 2022 Facility Incident Reporting Log showed Resident 1 a second fall on 07/22/2022 at 6:44 PM in the resident's room and sustained a superficial injury to surface layers of skin. The origin of the fall was established, the CP was updated, and no report was provided to the SA. During an interview on 08/01/2022 at 4:17 PM, Staff B stated that an incident report was started, but no investigative documents showing root cause analysis, staff interviews, record review, or that abuse / neglect was ruled out for Resident 1's 07/22/2022 fall with head injury were completed. Staff B stated the facility did not call the 07/22/2022 fall with head injury into the SA because they knew the cause of the injury, that the resident fell , and the injury was not substantial. An observation on 07/29/2022 at 12:03 PM showed Resident 1 sitting up in a wheelchair being escorted by 2 visitors. The resident had significant bruising to the entire left side of their face and a tan colored bandage on the left cheek. During a 08/01/2022 interview at 12:35 PM, Resident 1's Responsible Party (RP) stated their last visit with Resident 1 was on 07/30/2022. While driving to the facility they were notified via telephone that Resident 1 had fallen from the wheelchair. On 08/01/2022, Staff B was only able to provide the initiated 07/30/2022 fall incident report, but an investigation had not been started to rule out if abuse or neglect had occurred. On 08/01/2022 at 4:35 PM Staff C (Corporate Nursing Officer) stated the fall with hip fracture Resident 1 sustained on 07/02/2022 and fall with head injury Resident 1 sustained on 07/22/2022 should have been called into the SA timely and was not. Staff C stated the facility investigations for Resident 1's fall were not completed and should have been, including root cause analysis, updated interventions based on the root cause, and abuse/neglect ruled out as a factor for the incident. Resident 2 On 07/29/2022 at 1:46 PM, Resident 2 was observed in bed with their RP at bedside. Resident 2 was not able to answer questions asked, but moaned and acknowledged they were in pain with movement. An oxygen concentrator was observed at bedside with oxygen tubing attached. In an interview on 07/29/2022 at 1:46 PM, Resident 2's RP stated on 07/21/2022 at 10:30 PM they received a call that Resident 2 fell out of bed and they were enroute to the hospital. The RP stated they were not told Resident 2 used or needed oxygen. The RP stated that Resident 2 said they had a box on their face, tried to remove it, got tangled up and fell out of the bed. Review of resident's record showed a 06/18/2022 Physician Order for oxygen as needed and it was discontinued on 07/15/2022. Review of the June 2022 and July 2022 Treatment Administration Records (TARs) showed no documented use of the oxygen. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the July 2022 Facility Incident Reporting Log showed Resident 2 had a fall on 07/20/2022 at 10:52 PM in the resident's room and sustained a substantial injury (fracture). The origin of the fall was established, the CP was updated, and Staff B notified the SA. Review of the 07/21/2022 Un-witnessed Incident Investigation showed Resident 2 fell out of bed at 7:30 PM and was transported to the hospital where the resident was diagnosed with right femur (thigh bone) fracture. Review of a 07/21/2022 7:58 PM Nurses Note showed Resident 2 fell out of bed at 7:45 PM and the nurse noted that the resident's right femur appeared to be injured, possible fracture as it had a weird bend between the knee and hip. The nurse documented they, Called for an ambulance and they were not able to come for over an hour so they suggested calling 911. During an interview on 08/01/2022 at 2:37 PM, Staff B stated that 911 should be called when a resident needs to go to the emergency room right away, including instances of major trauma, pain, and / or obvious deformities. Review of the 07/21/2022 Fall Scene Investigation Report (FSIR) showed Resident 2 was dry but soiled with feces when found on the floor but the investigation did not address when the last time Resident 2 received care / toileting assistance. Included with the investigation was two Nursing Assistant witness statements, both of whom said they did not see Resident 2 in the three hours prior to the resident being discovered on the floor. The FSIR showed the plan to prevent future falls was to keep the bed in the lowest position although the factors at the time of the fall showed the bed was found at the normal height. The 07/24/2022 Investigation Summary / Conclusion showed the bed was in the low position and Nursing Assistant staff stated they changed the resident prior to the fall incident with no time or date provided. The post fall assessment showed Resident 2 had no incontinence and the resident's brief was clean and dry. According to the Point of Care (direct care staff documentation) Resident 2 last received toileting/personal hygiene care on 07/21/2022 at 11:43 AM. The resident ate 51-75% lunch, which was documented at 1:00 PM. No dinner meal was documented as offered or refused. During an interview on 08/01/2022 at 2:05 PM, Staff B stated the Nursing Assistant staff perform their duties, but documentation of care provided continued to be an issue. During an interview on 08/01/2022 at 2:47 PM, Staff B stated that Resident 2's bed was expected to be in a low position, I would not assume it was high. Resident 3 According to the 07/08/2022 Quarterly MDS Resident 3 had mild cognitive impairment, verbal behaviors that significantly disrupted the care provisions and living environment of others, and diagnoses including stroke with paralysis, depression, and anxiety. Resident 3 required extensive assist with bed mobility, transfers, and toileting. The 06/09/2022 Fall CP showed Resident 3 was at risk for falling and the goal was to be free from falls. The CP showed one intervention dated 06/09/2022 that the resident was educated to use the call light for all needs. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/29/2022 at 11:37 AM, Resident 3 initially stated they fell during the weekend and split their head open on the baseboard heater while Staff E (Certified Nursing Assistant) was providing care. Resident 3 then stated they fell because their roommate, Resident 1, got up out of bed, walked over to the wall and pulled out the electrical cords for Resident 3's bed control and air mattress. Resident 1 then walked over to Resident 3's table at their bedside and threw all their belongings on the floor. Resident 3 was very distressed by the actions of Resident 1 and while trying to reach over to pick up what Resident 1 tossed on the floor, they fell . When Resident 3 was asked what the facility did in response to their roommate's actions, Resident 3 stated nothing. In an interview on 07/29/2022 at 11:45 AM Staff E stated on 07/24/2022 they responded to Resident 3 yelling for help, found Resident 3 on the floor with blood coming from somewhere on the back of their head. Staff E stated Resident 3 told them that they were trying to pick up their personal belongings off the floor because Resident 1 threw them on the floor and unplugged Resident 3's bed and air mattress. Staff 3 verified the devices were unplugged and Resident 3's belonging were on the floor at the time of the fall. Staff E got the nurse and the nurse called 911. Review of a 07/24/2022 10:00 AM Nurse Progress Note showed Resident 3 was found lying on the floor screaming for help and landed on their left side after trying to reposition themselves independently and sustained a laceration on the back of their scalp. First Aid was provided and Resident 3 was sent to the hospital for evaluation. A 07/24/2022 11:23 PM Nurse Progress Note showed Resident 3 returned to the facility from the hospital and described Resident 3 as very anxious, more than they had ever seen. Review of the July 2022 Facility Incident Reporting Log showed Resident 3 fell on [DATE] at 11:47 AM in the resident's room, and sustained a superficial injury to surface layers of skin. The origin of the fall was established, the CP was updated, and no report was provided to the SA. In an interview on 08/01/2022 at 2:30 PM Staff B was unable to provide a facility investigation to rule out abuse / neglect or clarification as to the root cause of the fall due to conflicting information. Staff B stated the investigation was not conducted but should have been. Staff B verified there were no interventions implemented after the fall but should have been. Resident 4 During an interview on 07/29/2022 at 2:23 PM, Resident 4 stated the facility staff were not giving them the correct dosage of their medication that controls their seizure disorder and believed this error caused them to have a seizure while they were in bed. During the siezure they fell on the floor and hit their head. Review of the July 2022 Facility Incident Reporting Log showed Resident 4 fell on [DATE] at 10:46 AM in the resident's room, there were no injuries sustained, the origin of the fall was established, CP was updated, and no report was provided to the SA. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 07/16/2022 fall incident report showed Resident 1 was found on floor next to the bed at 6:15 AM by the CNA (Certified Nursing Assistant) and day nurse on rounds. The reporter documented it looked like the resident had a seizure because they were drowsy and not able to talk and had a history of uncontrolled seizures. The reporter documented no injury was found but the resident had a small trickle of blood coming from left side of their mouth, concluding the resident likely bit themselves during the seizure. The report showed Resident 4 was unable to say what happened due to their increased drowsiness, but once fully awake agreed they had a seizure and rolled out of bed. The report did not include statements from the staff assigned to Resident 4's care that day. The facility did not address or question how long the resident was on the floor prior to being found during morning rounds, the last person to see the resident safely in the bed, last care provided, or thuroghly investigate for possible triggers that may have contributed to the seizure / fall. The report summary dated 07/18/2022 concluded it was reasonable to believe that abuse / neglect did not occur and the resident was aware of the incident. The document then showed the resident didn't know what happened during the time of the fall, possibly resident may have had a seizure, and no change of medication .that could have predisposed the fall. A 06/17/2022 Physician Order for Resident 4 directed Licensed Nurses to administer the anti-convulsant (medication to control seizures)150 mg (milligram) tablet, give on tablet daily at bedtime for seizure. An observation on 08/01/2022 at 3:45 PM of the anti-convulsant bubble pack cards dispensed by the pharmacy showed that two different cards were dispensed to the facility for the same order. One card was packaged with one 150 mg tablet in each bubble and the other showed there were three 50 mg tablets in each bubble. During an interview on 08/01/2022 at 3:50 PM, Staff C stated that the order written and the medication card should always match to decrease incident of medication errors and when they don't, it should be clarified the nurse administering the medication. Review of the July 2022 Medication Administration Record (MAR) showed the anti-convulsant 150 mg tablet was not administered as ordered on the evenings of 07/15/2022, 07/16/2022, and 07/17/2022. A 07/15/2022 Nursing Administration Note showed the nurse was unable to give the medication because the pharmacy could not get the medication and they said it should arrive on the 07/18/2022. On 07/16/2022 the medication was not administered because the medication was not available from the pharmacy until the 18th. On 07/17/2022 the medication was not administered because they were still waiting for the pharmacy to bring the medication. Review of a 07/18/2022 3:47 AM Nursing Note showed the seizure medication did not arrive at the facility, but the resident's friend told the nurse they brought some of the medication at admission and it was put in the facility safe. The nurse documented a plan to retrieve the medication from the safe in the morning. During an interview on 08/01/2022 at 3:39 PM, Staff B stated that when a medication was not available, staff were to notify the provider, call and notify the pharmacy, if applicable request a therapeutic interchange, assess and place resident on alert monitoring. Review of Physician Orders showed a 07/19/2022 order for a blood serum level of the anti-convulsant medication to determine if the medication level in the blood was at a therapeutic level. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the July 2022 Treatment Administration Record (TAR) showed the 07/19/2022 lab order was documented as done. Review of the record showed the 07/20/2022 the lab was drawn, but unable to be processed. The order request was subsequently discontinued and no blood level for the medication was obtained. During an interview on 08/01/2022 at 3:39 PM, Staff B stated that the investigation was not completed. During an interview on 08/01/2022 at 3:39 PM Staff B stated that investigations were not done for Resident 1's incidents on 07/02/2022, 07/22/2022, Resident 3's incident on 07/24/2022, or Resident 4's incident on 7/16/2022. During an interview on 08/01/2022 at 4:29 PM, Staff B stated the facility process for post fall investigations was for the floor nurse to initiate a fall packet and enter the incident report into the electronic record. The Resident Care Manager (RCM) then followed up and did the investigation. The RCM was then expected to review it with the Director of Nursing by the fifth day. Staff B stated they discussed incidents every morning in the morning meetings. When asked why they did not ensure investigations were completed timely, Staff B stated, I'm behind. REFERENCE: WAC 388-97-0640(2)(5)(6)(a)(c).

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F 0689 Level of Harm - Actual harm 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** 29644 Based on observation, interview, and record review the facility failed to provide adequate supervision to ensure resident safety for 4 (Resident 1, 2, 3 & 4) of 5 residents reviewed for accidents. The failure to conduct fall risk assessments, identify and implement fall prevention interventions, conduct root cause analyses after resident falls resulted in harm for Resident 1 who sustained a hip fracture and head injury on two separate unsupervised falls, harm for Resident 2 who sustained a hip fracture, psychosocial harm for Resident 3 who fell after distress caused by the behavior of their roommate, and placed all residents at risk for repeated falls, the potential for significant injury, and diminished quality of life. Findings included . Resident 1 According to the 07/01/2022 Admission Minimum Data Set (MDS - an assessment tool) Resident 1 admitted to the facility with diagnoses of stroke, dementia, repeated falls, and traumatic fractures. Resident 1 had severe cognitive and daily decision-making impairments, no behaviors, and no rejection of care. The resident was incontinent of bowel and bladder and required extensive assistance for bed mobility, transfers, and toileting. The 06/26/2022 Fall Care Plan (CP) showed Resident 1 was at risk for falls and a goal to not sustain serious injury from falling. The CP showed interventions to keep the call light within reach, meet the care needs and follow the facility Fall Protocol. The CP did not include any person-centered specific fall interventions to help prevent falls. Fall One Review of a 06/30/2022 Nurse Progress Note showed Resident 1 was having episodic behaviors, was independent with bed mobility, and was ambulating with staff short distances using a front wheeled walker (FWW). Review of a 07/02/2022 Nurse Progress Note showed Resident 1 was sent to the hospital after an unwitnessed fall and possibly sustained a hip fracture. The progress note did not specify details of the event or injury. Review of the 07/12/2022 Hospitalist Discharge Summary showed Resident 1 was admitted to the hospital on 07/02/2022 from the skilled nursing facility (SNF) after sustaining a fall with hip fracture. Resident 1 required surgical repair of the fractured hip and was discharged back to the SNF on 07/12/2022 for continuation of short-term rehabilitation. Review of Resident 1's clinical record showed the resident was not re-assessed for Fall Risk after readmission to the facility. Review of the 07/18/2022 5 Day MDS incorrectly showed Resident 1 had not fallen since the previous 07/01/2022 MDS Assessment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Review of the July 2022 Facility Incident Reporting Log (a required reporting log) showed Resident 1 had a non-injury fall on July 2, 2022 at 9:50 AM in the resident's room, the origin of the fall was established, and the care plan was updated. Review of the 07/14/2022 updated Fall CP showed a recent fall on 07/02/2022 with a hip fracture and no new person-centered CP interventions or revisions to prevent falls. Fall Two According to a 7:00 PM 07/22/2022 Incident Note Resident 1 had an unwitnessed fall at 3:30 PM. The resident was found lying face down and had hit their head. The responder stated the resident's bed was in the high position and the Resident's roommate reported Resident 1 was observed playing with their bed controls causing the bed to go to a high position, then rolled over the edge of the bed to the floor. Resident 1 was provided first aid for the wound to their head. An observation on 07/29/2022 at 12:03 PM showed Resident 1 sitting up in a wheelchair being escorted by 2 visitors. The resident had significant bruising to the entire left side of their face and a tan colored bandage on the left cheek. The visitors pushed the resident's call light to summon staff to assist the resident and at 12:04 PM a caregiver answered the light and assisted the resident to bed. A 07/29/2022 review of Resident 1's clinical record showed no post Fall Assessment to re-evaluate the resident's fall risk and the Fall CP showed no updates or revisions to the resident's fall interventions to prevent falls. In an 08/01/2022 interview at 12:35 PM Resident 1's Responsible Party (RP) stated the facility notified them the resident fell on [DATE]. The RP stated the facility said they would make sure the bed control was stored out of the resident's reach. The RP stated during visits they noticed the bed control was not stored out of the resident's reach. The RP stated they had a conference with the facility on 07/27/2022 and the facility said they wanted to move Resident 1 to a room closer to the Nurses' station to help prevent falls but it had not happened yet. Observations on 07/29/2022 at 12:39 PM and 08/01/2022 at 1:58 PM showed Resident 1 lying in bed and the bed control remote clamped to the bottom sheet. Review of the 07/28/2022 Written Notice of Room Change form showed the effective date of the room change as 07/29/2022 due to medical necessity for better monitoring. This room change did not occur. The observation on 08/01/2022 at 1:58 PM showed Resident 1 in the same room. Review of the census showed the resident was in the same room since 07/12/2022. Fall Three During the 08/01/2022 interview at 12:35 PM, Resident 1's RP stated their last visit with Resident 1 was on 07/30/2022. While driving to the facility they were notified via telephone that Resident 1 fell from the wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Review of Resident 1's clinical record showed a 07/31/2022 Physician Order (PO) that Resident had a non-injury fall on 07/30/2022 and directed nursing to make a progress note twice daily for 3 days to assess for further injury and continue Neurological checks (an assessment tool to rule out a brain injury) until complete. Review of Resident 1's Nursing Progress Notes on 08/01/2022 showed twice daily nursing post fall evaluations were not documented in the clinical record. Further review of the resident's record showed no post Fall Assessment re-evaluation and no CP updates or revisions implemented to prevent falls. On 08/01/2022 at 3:45 PM, Facility Incident Investigations for Resident 1's three falls were requested. A 07/02/2022 Fall Incident Report was provided by Staff B (Director of Nursing) on 08/01/2022 at 4:00 PM. The Incident Report was not complete. There was no investigation into the root cause of the fall, no acknowledgement of the injury sustained from the fall or that the resident was hospitalized , no re-assessment of the resident's fall risk, no identified plan of action to help prevent future falls, no indication of CP considerations, and no summary of findings that abuse and neglect had been ruled out. Staff B was not able to provide an investigation for the falls on 07/22/2022 or 07/30/2022. In an interview on 08/01/2022 at 4:23 PM Staff B stated the facility did not complete a root cause analysis and Investigation for Resident 1's falls on 07/02/2022, 07/22/2022, or start an investigation for the fall on 07/30/2022 but they should have. Staff B was unable to provide documentation of re-assessment of the resident's fall risk or additional interventions implemented after each fall. Staff B was unable to provide a rational for why Resident 1 had not been moved to a room closer to the nurse station on 07/29/2022 as planned, which may have contributed to Resident 1's fall on 07/30/2022. Resident 2 Review of the 06/25/2022 Admission MDS showed Resident 2 required extensive two person assistance with bed mobility and had no falls prior to admission. The 07/12/2022 Discharge return anticipated MDS showed Resident 2 had moderately impaired cognition. Review of the 07/19/2022 Entry Tracking MDS showed the resident readmitted to the facility following a hospital stay with less than six months to live. During an interview on 08/01/2022 at 2:05 PM, Staff B stated the nursing staff were expected to complete an All-Inclusive Admission Assessment (AIAA) with each admission, readmission, and quarterly. Staff B stated the AIAA included the fall risk assessment and when completed generated the Baseline Care Plan (BCP). Staff B stated fall risk assessments were also done after each fall, triggered when the incident report was initiated in the electronic record. During an interview on 08/01/2022 at 2:37 PM, Staff B stated the 06/18/2022 AIAA for the Resident 2's first admission was the only AIAA completed. Staff B was unable to provide an AIAA for the 07/19/2022 readmission. Review of the 06/18/2022 AIAA showed Resident 2 was assessed as a high fall risk. The associated 06/18/2022 BCP listed a goal that resident would not sustain serious injury through the review date. Interventions included, follow facility fall protocol. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	During an interview on 08/01/2022 at 2:05 PM, Staff B stated the facility fall protocol was standard; assess the resident for injury, report to the doctor, notify family, begin the investigation process and put interventions in place. Review of the resident's record showed the 06/18/2022 CP was discontinued or deactivated on 07/15/2022. Review of the 07/28/2022 CP showed a problem of Poor Safety Awareness and the only intervention listed was instructions for staff to leave bed in low position while unattended, which was added on 07/29/2022. During an interview on 08/01/2022 at 2:37 PM, Staff B stated that they did not find a safety or fall CP initiated before the resident's fall on 07/21/2022. Review of the 07/21/2022 Un-witnessed Incident Investigation showed Resident 1 fell out of bed at 7:30 PM and was transported to the hospital where the resident was diagnosed with right femur (thigh bone) fracture. Review of the 07/21/2022 Fall Scene Investigation Report report showed interventions to prevent future falls included, placement of mobility bars on both sides of the bed to help them change position. Review of the 07/24/2022 Summary/Conclusion showed the planned intervention upon the resident's return to the facility to issue a specialized air mattress with bolsters or anything to prevent the resident from rolling out of bed while sleeping. On 07/29/2022 at 1:46 PM, Resident 2 was observed in bed with their RP at bedside. Resident 2 was not able to answer questions asked, but moaned and acknowledged they were in pain with movement. The bed was observed without side rails or grab bars, no fall mats were observed on the floor, and no specialized mattress with bolsters in pllace. During an interview on 07/29/2022 at 1:46 PM, Resident 2's RP stated on 07/21/2022 at 10:30 PM they received a call that Resident 2 fell out of the bed and was enroute to the hospital. The RP stated Resident 2 was in the hospital until 07/28/2022, and discharged to the facility with orders for bed rails and fall mats while at the facility. The RP stated on the evening of 07/28/2022 the facility staff said they would find the resident bed rails and fall mats but it has not happened yet. During an interview on 07/29/2022 at 4:00 PM, Staff A (Administrator) stated they would make sure the resident received the ordered equipment. Review of 07/28/2022 Physician Orders showed directions to install bilateral side rails to enhance bed mobility, and a low air loss mattress with side bolsters and mobility bars for increased independence. Review of the July 2022 Treatment Administration Record (TAR) showed directions to install bilateral side rails, which was initialed as done on 07/29/2022 at 1:20 AM. Review of at 07/30/2022 3:21 AM Nurses Note showed the bed was delivered with air mattress and bed mobility bars but not installed. According to the note, Resident is difficult to move and only 2 staff here tonight so will wait until day staff come and help. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505202	A. Building B. Wing	08/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Skilled Nursing and Rehabilitation	4430 Talbot Road South Renton, WA 98055

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F 0689 Level of Harm - Actual harm Residents Affected - Some	During an interview on 08/01/2022 at 2:47 PM Staff B stated they called hospice on 07/29/2022 to verify they were going to deliver the bed which was a delayed a bit. The current bed was to be in the low position and staff were to conduct frequent rounding for safety until the new bed was delivered. During an interview on 08/01/2022 at 2:47 PM Staff B stated that the nurse should have, but did not call and notify them of staffing concerns. Resident 2 passed away at the facility on 07/31/2022. Resident 3 According to the 07/08/2022 Quarterly MDS Resident 3 had mild cognitive impairment, verbal behaviors that significantly disrupted the care and living environment of others, and diagnoses including stroke with paralysis, depression, and anxiety. Resident 3 had no falls, was incontinent of bowel and bladder, and required extensive assist with bed mobility, transfers, and toileting. The 06/09/2022 Fall CP showed Resident 3 was at risk for falling and the goal was to be free from falls. The CP showed one intervention dated 06/09/2022 that the resident had been educated to use the call light for all needs. In an interview on 07/29/2022 at 11:37 AM, Resident 3 stated they fell on the weekend and split open the back of their head. Resident 3 stated that their roommate, Resident 1, got up out of bed alone and walked over to the wall and pulled out the electrical cords for Resident 3's bed control and air mattress the the electrical socket. Resident 3 stated that Resident 1 then walked over to Resident 3's bedside table and threw all of Resident 3's belongings on the floor. Resident 3 stated this was very distressing to them and so they tried to roll over toward their paralyzed side to pick up their belongings off the floor, fell off the bed, and hit their head on the baseboard heater. Resident 3 stated the nurse called an ambulance and they spent the remainder of that day in the emergency room . Resident 3 stated the facility did nothing to help prevent Resident 1 from touching their belongings and wanted Resident 1 moved. In an interview on 07/29/2022 at 11:45 Staff E (Certified Nursing Assistant) stated on 07/24/2022 at around 9:30 AM they heard Resident 3 yelling. Upon entering Resident 3's room, Staff E stated Resident 3 was on the floor between the window and the bed and there was blood on the floor. Staff E stated Resident 3 told them they fell trying to pick up their personal belongings off the floor because Resident 1 threw their belongings on the floor and unplugged their bed and air mattress. Staff E stated they went and got the Nurse and the Nurse called 911. Staff E verified the devices were unplugged and Resident 3's belonging were on the floor at the time of the fall. Review of 07/24/2022 Physician Order directed Nursing staff to monitor the laceration to the back of Resident 3's head until the wound had resolved. A 07/24/2022 Fall Risk Assessment showed Resident 3 was a high risk for falling. The clinical record showed no evidence of root cause findings or additional CP interventions to help prevent future falls and ensure the safety of both Resident 1 and Resident 3. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	In an interview on 08/01/2022 at 2:30 PM Staff B stated the facility investigation for Resident 3's 07/24/2022 fall was not completed and should have been. Staff B stated there were no interventions added to Resident 3's CP and implemented to help prevent future falls but there should have been. Resident 4 Review of the 06/23/2022 Admission MDS showed Resident 4 was alert and oriented, required one-person extensive assist with bed mobility, two-person extensive assist with transfers, and had not history of falls. Review of the 06/20/2022 CP showed Resident 4 was at risk for falls and listed standard interventions done for all residents, not person-centered specific fall interventions to help prevent falls or injuries from falls, based on the resident risks. During an interview on 07/29/2022 at 2:23 PM, Resident 4 stated that they had a seizure while in bed, fell on the floor and hit their head. Review of a 07/16/2022 6:41 AM Nurse Progress Note showed at 6:15 AM Resident 4 was found on the floor next to the bed. Resident 4 appeared to have had a seizure and rolled off the bed. Three staff assisted the resident back to bed. The resident had a small trickle of blood coming from left side of mouth that the nurse contributed to biting themselves during the seizure. Review of the Fall Risk Assessment Worksheet dated 07/17/2022 showed Resident 4 was assessed as a high fall risk. The assessment showed the resident did not have any cognitive or behavior indicators including periods of altered perception or awareness of surroundings, no periods of lethary, and no episodes of disorganized speech. Review of the 07/16/2022 incident report showed the bed was in a low position. The 07/18/2022 incident summary showed the resident sustained no injury and denied hitting their head. Interventions included educating the resident on pre-seizure signs and symptoms, to report those signs to the nurse, conducting frequent rounding, to ask resident if they need anything, and provide assistance as needed. The use of a fall mat at bedside due to a history of seizures was not added to the CP until 07/18/2022. The CP was not revised to include the additional interventions identified in the incident summary. During an 08/01/2022 interview at 2:07 PM Staff B stated it was their expectation that a resident fell be re-assessed for fall risk and have specific interventions implemented to help prevent falls. Staff B stated the residents should be assessed for fall risk on admission, quarterly, and as needed when they fall. Staff B stated it was their expectation that the resident's CP address their fall risk, be updated with the appropriate interventions based on the root cause of the fall, the resident to be placed on alert to monitor their condition, and the investigation process initiated. Staff B stated they were responsible for ensuring the fall investigations process was completed. During an interview on 08/01/2022 at 2:07 PM, Staff C (Corporate Nursing Officer) stated they recently identified issues with fall investigations and had a new post fall incident and reporting form, which they planned to implement. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	REFERENCE: WAC 388-97-1060(3)(g). 46472