| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505236 | A. Building<br>B. Wing | 08/02/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Edmonds Care | 21400 72nd Avenue West<br>Edmonds, WA 98026 |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12273<br><br>Based on observation, interview, and record review, the facility failed to thoroughly investigate falls or smoking incidents for 5 of 8 residents (Residents 1, 3, 6, 4 and 5) reviewed for allegations of abuse and neglect. Failure to obtain sufficient investigative information with which to identify root cause(s) and develop individualized plan of care placed the residents at risk for injuries from a repetitive incident and/or accidents.<br><br>Findings included .<br><br>The undated facility policy for the Prevention of Abuse and /or Neglect, defined neglect as the failure of the facility .to provide goods and or services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.<br><br>The undated facility procedure titled, Accidents and Incidents; Report, Investigation, Review and Analysis, identified the proper action following a fall included determining what may have caused or contributed to the fall, addressing contributing factors and revising the care plan .to reduce the likelihood of another fall.<br><br>FALL INCIDENTS<br><br>Resident 1<br><br>Resident 1 was admitted to the facility on [DATE], with multiple medical diagnoses, including vertigo (sensation of dizziness or loss of balance) and diabetes. The initial Minimum Data Set (MDS) assessment, dated 06/14/2021 noted the resident needed extensive assistance from 1 to 2 staff to complete the Activities of Daily Living (ADLs) such as transfers and toileting, frequently incontinent of urine and occasionally incontinent of bowel, and noted no toileting program was in place. The MDS noted the resident had experience a fall with fracture prior to admission, and the care area assessment noted a fall prevention plan was initiated.<br><br>Review of the accident incident log between 06/01/2021 and 07/19/2021, showed Resident 1 had three falls on 06/11/2021, 07/03/2021 and 07/11/2021. Review of the investigations associated with the falls, found each fall occurred while the resident was attempting to use the bathroom.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The investigation, dated 06/11/2021, noted Resident 1 was found on the floor in the room at 1:30 PM. The resident reported trying to use the bathroom when the fall occurred. The investigation did not include any interviews with direct care staff to determine when the Resident 1 was last assisted to the bathroom. The root cause analysis, concluded the fall was related to poor safety awareness, and concluded the resident was new to the facility and unfamiliar with the environment.<br><br>A fall investigation was initiated on 07/03/2021, after Resident 1 reported a fall while trying to get to the bathroom last night. The facility investigation did not include any staff interviews to determine if the staff were aware of the fall or what precipitating events occurred. The root cause analysis noted the resident self-transferred without assistance and fell . The conclusion noted the resident was impulsive and has poor safety awareness' and noted the care plan was updated. The only update found on the care plan was to add a date to reach the goal of decreased falls was a target date.<br><br>The next fall investigation, dated 07/11/2021, noted the resident was found on the bathroom floor at 5:30 AM. The investigation noted the call light was on, but did not identify how long the call light was on or which call light was sounding. There was no evidence any interviews were completed with direct care staff to determine what events occurred prior to the fall, such as when the staff had last checked on the resident or assisted her/him with toileting.<br><br>Lastly, a progress note, dated 06/30/2021, noted Resident 1 was found on the floor this morning. The fall was not identified on the state reporting log nor was there any investigation completed for that fall.<br><br>Resident 3<br><br>The resident was admitted to the facility on [DATE], with multiple medical diagnoses, chronic pain and diabetes requiring insulin management. The initial MDS assessment, dated 05/31/2021, documented the needed extensive assistance of 1 to 2 staff to complete ADL's (I.e; transfers, dressing, grooming, toileting, and hygiene) and needed supervision and stand by assistance to walk in the room and the facility.<br><br>Observation on 07/21/2021 at 12:10 pm showed Resident 3 lying on her bed. The resident reported she had problems receiving an appropriate diet, in that she did not eat meals delivered the previous days due to the kitchen sending foods that were not appropriate for a diabetic diet. The resident also reported that on the previous day, she had been left alone in the shower room and had a hypoglycemic event. The resident stated she did not get the foods she requested for breakfast and lunch, and did not eat all of her meals which may have contributed to the event.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident 3 stated she was mostly independent with ADLs. The resident said that during showers, she needed some assist with set up and supervision, and help washing her back. The resident said that the hypoglycemic (below normal blood sugar) event occurred while she was alone in the shower room (after set-up), she got weak and dizzy, and lowered herself to the floor. When the NA came back to check on the resident, the resident asked the NA to alert the nurse that she had low blood sugar. The resident said her blood sugar (BS) was 54. The nurse then directed the NA to get a glass of juice and added sugar to it before giving it to the resident to drink, to help bring bs back up to normal level. After drinking the juice, the resident requested to rest before transferring from the floor, and the staff again left the resident in the shower room. The NA returned and assisted the resident back into the shower chair and the shower was completed. When asked if she was usually left alone in the shower room, the resident stated she just needed a little help.<br><br>On 07/21/2021, at 12:40 PM, Staff D, RCM/RN, was asked if any concerns were reported by Resident 3. The staff explained he was aware of the concerns reported concerning not receiving food items requested. When asked about the facilities expectations for reporting and investigating falls, Staff D clarified that even if the staff intervene and assist with lowering a resident to the floor, an investigation should be initiated.<br><br>On 07/21/2021 at 2:05 PM, Staff G, Nursing Assistant, who had worked the previous day on Resident 3's unit was asked about assisting Resident 3 with a shower. Staff G stated after he provided set up, he left the resident alone in the shower room and when he returned, Resident 3 on the floor due to low blood sugar. He notified a nurse who came and checked the resident's blood sugar level. Staff G stated the resident denied having a fall, insisting the resident lowered herself to the floor.<br><br>Review of the clinical record between 07/20/2021 and 07/23/2021, showed that the hypoglycemic/fall event described by Resident 3 and Staff G was not documented anywhere in the record.<br><br>On 07/21/2021, at 2:20 PM, Staff D, the RCM/RN, responsible for supervising the resident's unit reported he was not aware of any hypoglycemic event. Staff D, then went to check with the Staff H, who reported the resident advised her s/he fall but was not aware of any of any report of hypoglycemic events. When asked about the policy to provide assist with showers, Staff D stated all resident were supervised in the shower area, and should never be left alone.<br><br>On 07/21/2021 at 4:00 PM, Staff B, Director of Nursing, indicated she had not been previously made aware of the event which occurred in the shower, including hypoglycemia symptoms, in where Resident 3 reported she lowered herself to the floor.<br><br>On 07/27/2021, at 2:05 PM, Staff H, Registered Nurse, confirmed that he responded to the request for help with resident 3 and identified a low blood sugar. When asked if he documented any of the events, he explained a entry should be in the progress notes. However, no such documentation was found in the record.<br><br>On 07/27/2021 at 3:45 PM, Staff B, DNS, also said residents should never be left in the shower room, even if they only needed set up and supervision. When asked for an investigation of the event involving Resident 3, Staff B said an investigation had been started, but not completed. A copy of the investigation information gathered thus far was provided when requested.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the investigation showed it was initiated on 07/21/2021, but did not identify the resident lowered herself to the floor after being left alone in the shower room. It documented Resident 3, told the LN (Staff J) s/he got dizzy from low blood sugar, lowered self to the floor and turned on the call light. There was no evidence the two staff, who responded to the event (Staff G and Staff H) were interviewed and/or their witness statements obtained to determine what the circumstances of the event were and where it occurred. The investigation information did not indicate whether the facility policy to not leave a resident alone in the shower room had been followed.<br><br>Even though the events were reported on 07/21/2021 to the DNS, the investigation had not been completed within 5 days nor was the incident reported to the state hotline. Not conducting a thorough investigation may have placed the resident at risk for a similar incident in the future.<br><br>Resident 6<br><br>The resident was admitted to the facility on [DATE], with multiple medical diagnoses including diabetes and dementia. The last annual MDS assessment, dated 05/04/2021, indicated the resident needed the physical assistance from staff to walk and indicated the resident had moderately impaired cognition.<br><br>A progress noted entry showed Resident 6 experienced a fall on 06/08/2021 at 7:24 AM. The licensed nurse was passing by the room when Resident 6 was observed to lose balance. The licensed nurse intervened and assisted the resident to the floor.<br><br>A progress note, dated 06/27/2021, showed staff were monitoring for latent injury r/t (related to) to assisted fall. No further information concerning that assisted fall could be found.<br><br>Review of the Accident/Incident reporting log entries from 06/01/2021 through 07/19/2021 did not list either of Resident 6's assisted falls.<br><br>On 07/21/2021 at 1:30 PM, Staff E, Registered Nurse, was asked about the facility practices concerning assisted falls. Staff E stated that all falls were investigated and logged, even if staff intervened and assisted a resident to the floor.<br><br>On 07/21/2021, Staff B, DNS, verified that all falls should be logged and investigated. When asked why the two assisted falls were not on the reporting log, she stated it was missed. When asked if the incidents were investigated, an investigation, dated 06/08/2021, was provided. The other assisted fall of 06/27/2021 did not have any investigation completed.<br><br>The facility did not ensure the two falls were reported on the accident/incident reporting log and did not do an investigation related to the assisted fall on 06/27/2021.<br><br>SMOKING INCIDENT<br><br>On 07/19/2021 at 2:45 PM, Staff C, Resident Care Manager (RCM) stated the facility had a non-smoking policy and said she was not aware of any residents in the facility who smoked.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident 4 was admitted to the facility on [DATE], with multiple medical diagnoses, including diabetes, below the knee amputation. The last annual MDS assessment, dated 06/18/2021, indicated the resident was alert and oriented and indicated the resident needed extensive assistance from 2 staff members to complete transfers, dressing, toileting, and used a wheelchair for locomotion.<br><br>Observation on 07/27/2021 at 3:40 PM showed Resident 4 lying on his bed, however he declined an interview stating he was sleepy.<br><br>A progress note, dated 07/13/2021 at 6:59 AM, documented last evening at around 9:30 resident was smoking in (his) room. The entry indicated the RCM went to talk to the resident, and that the DNS and the Social Worker were also notified.<br><br>On 07/27/2021 at 3:45 PM, Staff B, DNS, was asked about the progress note. Staff B stated that Resident 4 did not smoke in the facility. Staff B stated it was the roommate (Resident 5) who had been observed smoking in the room and said the progress note about Resident 4 was in error.<br><br>Review of Resident 5's record showed a progress note, dated 07/13/2021,regarding the following incident, Resident was smoking in (her/his) room with roommate plus a stranger who brought the cigarettes through the window. The entry further explained the RCM talked to the resident and the person who outside the window . The entry also documented the DNS and Social Worker were notified of the incident.<br><br>No additional information about the smoking incident was documented in the progress notes in either Resident 4 or Resident 5's records. Although the single progress note entry on 07/13/2021 in each resident's record noted the RCM went to discuss the issue with the residents, there no documentation indicating that a discussion actually occurred and/or what was discussed. The smoking incident was not listed on the facility reporting log and was not thoroughly investigated at the time it occurred.<br><br>Reference (WAC) 388-91 -0640 (6)(a)(b)(c) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13393<br><br>Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 3 of 5 residents receiving insulin (Residents 1, 6, and 5) who were reviewed for diabetic management. Failure to ensure consistent blood sugar monitoring and clear diabetic-management orders placed the residents at risk for possible adverse effects due to low and/or high blood sugars levels and other diabetic-related conditions.<br><br>Findings included .<br><br>Record review of the facility's policy titled, Diabetic Care, dated 01 09/09, showed staff were to clarify admit orders, including medications, parameters for notifying physician, diabetic testing .monthly nail care by licensed nurse.<br><br>Record review of the facility's policy titled, Treatment of Hypoglycemia and Hyperglycemia, dated 00 09/09, showed the standard of the facility was to obtain appropriate orders to provide proper care and treatment of the diabetic patient, such as parameters and treatment of hypoglycemic episodes.<br><br>RESIDENT 1<br><br>Resident 1 admitted on [DATE] with diagnoses including diabetes mellitus (DM).<br><br>Review of the hospital Transfer Orders, dated 06/07/2021, included the following diabetic medication order:<br><br>Lantus Solostar 100 units/mL Injection Pen, Inject 5 units under the skin every 12 hours.<br><br>Review of the active facility physician's orders included the following orders:<br><br>Lantus SoloStar Solution Pen-injector 100 UNIT/ML(Insulin Glargine) Inject 5 unit subcutaneously (SQ) before meals for Diabetic Mellitus. Prescriber Written Active 06/07/2021, Start Date=06/07/2021.<br><br>Check Blood Sugar. Notify physician if CBG results is less than 60 or more than 400. Prescriber Written Active 06/07/2021. The order did not show a Start Date.<br><br>Review of the June and July 2021 Medication Administration Records(MARs) showed the following order: Lantus SoloStar Solution Pen-injector 100 UNIT/ML(Insulin Glargine) Inject 5 unit subcutaneously before meals for Diabetic Mellitus.<br><br>The MAR insulin order showed only two administration times (0730 & 1630). There was no lunch administration time. Both administration times had a signature space and a space for BS (blood sugar) check/level. Each BS space showed an X and did not document a BS level from 06/07/2021 through 07/14/2021.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Further review of the MARs did not show any other order indicating the resident's BS readings were to be checked, with the frequency of checks, and documentation of BS checks.<br><br>Review of the electronic medical record did not indicate clarification of the Lantus insulin order and BS check frequency.<br><br>On 07/27/2021 at 3:30pm, Staff C, Registered Nurse, was asked whether BS were usually checked on a routine basis for residents who received insulin. Staff C stated that she would routinely check a resident's BS before administering insulin to make sure it was within normal parameters and safe to administer the insulin, and that the nurses should have done the same for Resident 1. Staff C also stated that nurses should have clarified BS orders/frequency when no BS levels were being documented.<br><br>On 07/27/2021 at 3:45PM, Staff B, Director of Nursing reviewed the resident's electronic medical record regarding Blood Sugar documentation summary and acknowledged that before 07/20/21 there were only 3 BS documented, on 06/09/2021, 06/09/2021, and 07/03/2021.<br><br>RESIDENT 6<br><br>Resident 6 admitted to the facility on [DATE] with diagnoses including diabetes.<br><br>Review of the June 2021 MAR showed the following order:<br><br>Insulin Lispro Inject 3 Unit (SQ) with meals for diabetes. Hold if BG < 100.<br><br>The MAR order showed only 2 administration times (0730 & 1730) with this order. There was no lunch administration time listed.<br><br>On 07/27/2021 at 02:50 PM, Staff E, Registered Nurse, was asked about the Lispro 3 Units SQ with meals order that only had 2 administration times listed for breakfast & dinner. Staff E stated that the order should have been clarified and more clearly written, ie. Lispro 3U with breakfast & dinner since there was also a separate Lispro 5U insulin order for lunchtime.<br><br>On 08/02/2021 at 04:15 PM, Staff B, DNS, stated that the order should have been clarified as to which meals the Lispro 3 Units should be administered.<br><br>RESIDENT 5<br><br>Resident 5 admitted to the facility on [DATE] with diagnoses including diabetes.<br><br>Review of the hospital Transfer Orders, dated 06/09/2021, included the following diabetic medication order:<br><br>Insulin Glargine Inject 18 units subcutaneously every day. Increase by 2 Units every 3 days until fasting blood sugar is 150 or less maximum [NAME] dose is 55 Units/day.<br><br>Review of the facility's physician orders show the following:<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Insulin Glargine Solution Pen-injector 100 UNIT/ML. Inject 18 unit subcutaneously in the morning for Dm 2(diabetes type 2).<br><br>Review of the June and July 2021 MARs showed the following order:<br><br>Insulin Glargine pen Injector 18 units subcutaneously in the morning for DM.<br><br>The MAR order showed the insulin administration time was 8 AM.<br><br>Review of the electronic medical record did not document staff clarification with the medical provider regarding the change from the hospital transfer order for daily Insulin Glargine (with increase/titration of insulin every 3 days until the resident's BS was at a specified level) to the facility's physician order for Insulin Glargine (without titration and BS checks for specified level).<br><br>Further review of the MARs/TARs did not show any orders indicating that Resident 5's BS level was to be checked and documented, BS parameters, instructions for treatment of episodes of high or low blood sugars, and/or routine diabetic nail care.<br><br>Interview on 08/02/2021 at 4:15 PM, Staff B, DNS, was asked regarding the process for admission orders for residents who have diabetes and receiving insulin. Staff B stated that usually a resident care manager (nurse) inputs the hospital transfer orders into the facility electronic medical record system, and then another nurse confirms the orders. Staff B stated that the nurses may need to clarify the diabetic medication orders and BS parameters (of when to notify) with the medical provider. In addition, the nurses should also put diabetic management related batch orders, such as routine diabetic nail care, BS parameters, and procedures for low/high BS levels into the electronic record system.<br><br>Staff B acknowledged that there were no orders regarding checking BS levels or the other routine diabetic management batch orders for Resident 5.<br><br>WAC Reference 388-97-1060 (1) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12273<br><br>Based on observation, interview, and record review, the facility failed to provide adequate supervision and/or implement interventions to prevent accidents for 4 of 6 residents (Residents 1, 3, 4, 5) reviewed for abuse or neglect. Failure to do so resulted in Resident 1 experiencing a fall with hip fracture, which was actual harm, and placed Resident 3 at risk for injury from future falls. In addition, failure to adequately supervise Residents 4 and 5 for unsafe smoking behaviors placed the residents at risk for potential burn injuries or environment safety hazards.<br><br>Findings included .<br><br>FALLS<br><br>Resident 1 was admitted to the facility on [DATE], with multiple medical diagnoses, including vertigo (sensation of dizziness or loss of balance) and diabetes. The initial Minimum Data Set (MDS) assessment, dated 06/14/2021, showed the resident needed extensive assistance from 1 to 2 staff to complete the Activities of Daily Living (ADLs) such as transfers and toileting, was frequently incontinent of urine and occasionally incontinent of bowel, and that no toileting program was in place. The MDS noted the resident had experienced a fall with fracture prior to admission.<br><br>On 07/21/2021 at 2:40 PM, Resident 1 was lying in bed in their room wearing a hospital gown. The right hip and upper thigh were bandaged with deep blue/black bruises extending out from under the bandages. When asked about the injury to the right hip, Resident stated, I miscalculated the steps when going up a flight of stairs. The resident was unable to recount the events leading to the hip fracture.<br><br>On 07/27/2021, at 3:00 PM, Resident 1 was lying in bed wearing a brief and hospital gown. The surgical incision was covered by bandages and deep-colored bruising was on the outer side of the right upper thigh. When asked about the injury and therapy, Resident 1 stated that she had not been up out of bed, was currently non-weightbearing, and was not able to stand yet.<br><br>The Care Area Assessments (CAA) completed in conjunction with the MDS, dated [DATE], documented the resident was at risk for falls and indicated a care plan was implemented to lessen the risk of falls. The CAA summary noted the resident was able to use a front-wheeled walker to ambulate short distances and that the resident was occasionally incontinent of urine.<br><br>The resident's care plan on admission did not identify the risk for falls or identify interventions to lessen the risk of a fall. The care plan for ADLs, initiated on 06/07/2021, indicated the resident was weight-bearing as tolerated with staff assist, and is not toileted.<br><br>Review of the accident incident log between 06/01/2021 and 07/19/2021 showed Resident 1 had three falls on 06/11/2021, 07/03/2021 and 07/11/2021.<br><br>The facility investigations of the three falls listed on the log, identified that each fall was associated with Resident 1 attempting to use the bathroom independently without assistance.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the investigation, dated 06/11/2021, documented Resident 1 was found on the floor in the resident's room. The resident reported she was trying to go to the bathroom. A progress note documented the fall occurred at 1:30 PM. The investigation concluded the fall was related to the resident being unfamiliar with the environment, as the resident was a new admit and was new to the facility. The investigation ruled out abuse and/or neglect.<br><br>A care plan for fall prevention, initiated on 06/11/2021, identified the resident as a fall risk and a Goal of decreased incidence of falls. The interventions included the following:<br><br>Keep call light in reach and encourage resident to use it for assistance as needed,<br><br>Frequent checks due to recent fall and for safety,<br><br>Keep needed items in reach,<br><br>Provide safe environment, clean, dry floors free of clutter, adequate light, a working and reachable call light, and personal items in reach.<br><br>A care directive was also initiated on the June 2021 Medication Administration Record (MAR) for licensed nursing staff to direct the Nursing Assistants (NA) to do safety checks on Resident 1 every two hours. According to the electronic medical record, the safety check task was consistently documented and completed.<br><br>In addition, the care plan for ADLs was updated on 06/11/2021 to include the following: One care staff to assist with ALL ADL's.<br><br>Review of a progress note, dated 06/30/2021, showed, resident was found on floor this morning. No additional information concerning this fall was found in the record.<br><br>Initial review of the incident log did not show the 06/30/2021 fall. And there was no evidence the resident's care plan was reviewed by staff to determine the effectiveness of the interventions and/or updated related to this fall.<br><br>The accident log did list a fall incident on 07/03/2021. The facility investigation documented that at 8:30 AM, Resident 1 told a Nursing Assistant (NA) that she had fallen during the night shift. The NA reported the incident and an investigation was initiated. The investigation documented the resident's statement, I fell last night close to my bed while trying to go to the bathroom and forgot to call for help at that time.<br><br>Attached to the investigation was a fall check list and a document titled, 10 questions to answer at the time of resident fall, both were blank. A fall scene investigation was also attached, which noted the resident was alone and unattended at the time of the fall and was trying to use the bathroom. The fall scene investigation noted there was no injury, and a skin assessment indicated there were no new issues. A blood sugar level check was completed, and the resident was monitored for neurological changes.<br><br>(continued on next page) |

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|---|---|---|---|
| | 505236 | A. Building<br>B. Wing | 08/02/2021 |

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| Edmonds Care | 21400 72nd Avenue West<br>Edmonds, WA 98026 |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The investigation report documented falls could be prevented in the future by reminding Resident 1 to call for help. It indicated falls should be immediately reported, and that care planning for basic needs was in place. The report also indicated that as needed pain medication was administered. The investigation summary statement, completed by Staff B, Director of Nursing, indicated abuse and neglect was ruled out, and that the resident's care plan would be reviewed.<br><br>Review of the care plan showed one change, initiated 07/08/2021, which was a care plan goal for decrease number of falls was added with a target date of 09/30/2021.<br><br>The next fall investigation, dated 07/11/2021, showed that when an NA went to answer the call light at 5:30 AM, Resident 1 was found on the floor in the bathroom, lying next to a walker. The resident reported she was dizzy and was trying to sit on the toilet. The investigation documented there were no observed injuries and indicated the resident was wheelchair bound.<br><br>The investigation summary statement, dated 07/14/2021, indicated x-rays were obtained on 07/12/2021 and found no injury. Due to the resident's continued complaints of pain, a second set of x-rays was completed on 07/14/2021. The x-ray results identified an acute femur fracture. Resident 1 was admitted for the surgical repair of the right hip fracture, and she was readmitted to the facility on [DATE].<br><br>The care plan was updated on 07/15/2021, with a new intervention to Cue/remind the resident to use call light for assist with transfers on each contact you have with her. And after readmission on 07/19/2021, the order for frequency of safety checks was increased to every hour.<br><br>On 07/19/2021 at 2:30 PM, Staff B, Director of Nursing Services, stated that a resident should be accurately assessed for needs at the time of admission. The DNS acknowledged that a resident identified as continent should have a care plan on admission in regards to meeting the resident's toileting needs.<br><br>On 07/21/2021 at 4:00 PM, Staff B indicated there were additional interventions, including assistive devices such as hip protectors, which could be implemented to reduce the risk of a fracture if a fall occurred.<br><br>The care plan interventions for falls (implemented 06/11/2021) were not effective, as evidenced by the pattern of repetitive falls trying to get to the bathroom. No additional fall interventions were implemented on the care plan until 07/15/2021, after the fall with fracture occurred. In addition, the initial nursing assessment, dated 06/07/2021, identified the resident was continent of bowel and bladder, but no toileting plan was initiated.<br><br>Not ensuring Resident 1 was provided with adequate supervision and/or assistive devices to lessen the risk of injury with falls, resulted in the resident sustaining a substantial injury, a hip fracture.<br><br>SUPERVISION DURING SHOWER<br><br>Resident 3<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Resident 3 was admitted to the facility on [DATE], with multiple medical diagnoses, chronic pain and diabetes requiring insulin management. The initial MDS assessment, dated 05/31/2021, documented the resident needed extensive assistance of 1 to 2 staff to complete ADLs such as transfers, dressing, grooming, toileting, and hygiene and needed supervision and stand by assistance to walk in the room and the facility. The assessment did not identify what assistance was needed with bathing, and noted no bathing services were provided during the 7 day assessment period.<br><br>Observation on 07/21/2021 at 12:10 pm showed Resident 3 lying on her bed. The resident reported she had problems receiving an appropriate diet, in that she did not eat meals delivered the previous days due to the kitchen sending foods that were not appropriate for a diabetic diet. The resident also reported that on the previous day, she had been left alone in the shower room and had a hypoglycemic event. The resident stated she did not get the foods she requested for breakfast and lunch, and did not eat all of her meals which may have contributed to the event.<br><br>Resident 3 stated she was mostly independent with ADLs. The resident said that during showers, she needed some assist with set up and supervision, and help washing her back. The resident said that the hypoglycemic (below normal blood sugar) event occurred while she was alone in the shower room (after set-up), she got weak and dizzy, and lowered herself to the floor. When the NA came back to check on the resident, the resident asked the NA to alert the nurse that she had low blood sugar. The resident said her blood sugar (BS) was 54. The nurse then directed the NA to get a glass of juice and added sugar to it before giving it to the resident to drink, to help bring bs back up to normal level. After drinking the juice, the resident requested to rest before transferring from the floor, and the staff again left the resident in the shower room. The NA returned and assisted the resident back into the shower chair and the shower was completed. When asked if she was usually left alone in the shower room, the resident stated she just needed a little help. When asked about the staff involved, the resident said those staff had not provided care on the unit (where she resided) and had never seen either of them before.<br><br>Then at 12:40 PM, Staff D, RCM/RN, was asked if any concerns were reported by Resident 3. The staff explained he was aware of concerns about food items requested that were not provided, and stated the Dietary Manager had visited Resident 3 the previous day. Staff D stated he was not aware of any other reported concerns. When asked about the expectations for reporting and investigating falls, he clarified that even if the staff intervened and assisted with lowering a resident to the floor, an investigation should be initiated.<br><br>On 07/21/2021 at 2:05 PM, Staff G, NA was asked about assisting Resident 3 with a shower. He stated the resident was left alone after providing set up in the shower room, and when he came back to check on Resident 3, she was found on the floor due to having low blood sugar. He stated the resident denied having a fall, and that the resident lowered herself to the floor. He stated the nurse who responded to the incident had said the resident's BS was 58 when checked. Staff G said the RN directed him to get a glass of juice and packets of sugar from the kitchen that then could be given to respond to the hypoglycemic event. Staff G stated it was okay to leave that resident in the shower room alone.<br><br>Review of the clinical record, progress notes, July 2021 MAR, and blood sugar records between 07/20/2021 and 07/23/2021 did not have documentation regarding Resident 3 being found on the shower floor with a low BS level, administration of juice with sugar in response to a hypoglycemic event, physician notification or of any follow-up monitoring.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 07/21/2021, at 2:20 PM, Staff D, RCM/RN, responsible for supervising the resident's unit stated he was not aware of any hypoglycemic event. Staff D, then went to check with Staff I, a Licensed Practical Nurse (LPN) assigned to Resident 3's unit, and stated the resident had told Staff I that she had a fall, but was not aware of any report of hypoglycemic events.<br><br>On 07/27/2021 at 2:05 PM, Staff H, RN, confirmed that he had responded to the request to check Resident 3's blood sugar while on the shower room floor. When asked if he documented the incident, he explained an entry should be in the progress notes. When asked if he could recall what the BS was when checked, Staff H said he could not recall exactly, but indicated that the resident's BS was below 60. When asked if he reported the incident to a physician, he stated he did not.<br><br>On 07/27/2021 at 2:20 PM, Staff D, RCM/RN, was asked if Resident 3 was to be left alone in the shower room, he stated they were not.<br><br>On 07/27/2021 at 3:45 pm, Staff B, DNS, stated all residents were provided with supervision in the shower room, even if they just needed set up. When asked for an investigation of the incident, Staff B stated an investigation was started, but had not yet been completed. (See F 610, for failure to conduct thorough investigations and taking action to prevent a similar occurrences.)<br><br>SUPERVISION FOR SMOKING SAFETY<br><br>On 07/19/2021 at 2:45 PM, Staff C, Resident Care Manager (RCM) stated the facility had a No-Smoking policy and said she was not aware of any residents in the facility who smoked.<br><br>Resident 4<br><br>The resident was admitted to the facility on [DATE], with multiple medical diagnoses, including diabetes and below the knee amputation. The last annual MDS assessment, dated 06/18/2021, indicated the resident was alert and oriented, and needed extensive assistance from two staff to complete ADLs such as transfers, dressing, toileting, and used a wheelchair for locomotion.<br><br>Observation on 07/27/2021 at 3:40 PM showed Resident 4 lying on his bed, however he declined an interview stating he was sleepy.<br><br>A progress note, dated 07/13/2021 at 6:59 AM, documented, Last evening at around 9:30 resident was smoking in (her/his) room. The note indicated the RCM went to talk to the resident, and that the DNS and Social Worker were also notified.<br><br>On 07/27/2021 at 3:45 PM, Staff B, DNS was asked about the progress note. Staff B stated that Resident 4 did not smoke in the facility. Staff B stated it was the roommate (Resident 5) who had been observed smoking in the room and said the progress note about Resident 4 was in error.<br><br>Resident 5<br><br>The resident was admitted to the facility on [DATE] with multiple diagnoses including diabetes. Resident 5 then transferred to a hospital on 07/18/2021, and did not readmit to the facility.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A progress note, dated 07/13/2021, showed the following, Resident [5] was smoking in his room with roommate [Resident 4] plus a stranger who brought the cigarettes through the window. The entry further explained the RCM talked to the resident and the person outside the window The note also documented the DNS and Social Worker were notified of the incident.<br><br>Although the progress notes documented the smoking in the room incident had occurred, there was no documented monitoring of those residents for unsafe smoking behaviors afterwards.<br><br>(Also refer to F 610 for Failure to Investigate.)<br><br>.<br><br>WAC Reference 388-97-1060(3)(g) |