STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505296	A. Building B. Wing	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis of Bellingham	3121 Squalicum Parkway Bellingham, WA 98225

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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 - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37369 Based on interview and record review the facility failed to implement their abuse and neglect policy regarding identifying and investigating potential allegations of abuse and neglect in a timely manner for one of seven (1) residents reviewed for abuse and neglect. This failure to timely report and investigate allegations of abuse placed the residents at risk for negative outcomes related to potential abuse and neglect. Findings included . Review of the facility's policy titled, Abuse Prevention Policy and Procedure, revised 07/01/2020 showed that mandated reporters are to immediately report to their onsite supervisor and the State Hotline number when they have reasonable cause to believe abuse or neglect has occurred. Resident 1 was admitted [DATE] with diagnosis to include lumbar fractures. According to the Admission Minimum Data Set assessment dated [DATE], Resident 1 was cognitively intact and able to make their needs known. Review of the incident investigation dated 07/13/2021, showed that two nursing assistants assisted Resident 1 to use the restroom and helped them up to the edge of the bed by assisting them to a sitting position and braced their shoulders and bilateral lower extremities per their request. Review of a progress note created on 07/13/2021 with an encounter/effective date on 07/12/2021, Staff H, Physician's Assistant (PA), documented that, During the visit she told me that one of the nursing aids staff lifted her by the neck when transferring to the toilet, that she started having neck pain and thinks that she has a dislocation. Review of the nursing progress note created 07/13/2021 for an encounter date on 07/12/2021, Staff M, Licensed Practical Nurse (LPN), documented that, Resident stated she was hurt in a transfer the previous night. She said she was pulled up by her neck. Resident had increased pain this shift and was unable to sit up right to eat and take medications appropriately. Resident stated she did not want to talk to this nurse. Nurse let her know communication would be made to management. Communication was made. In an interview on 07/27/2021 at 10:45 AM, Resident 1 stated that they were pulled up in bed by their neck on night shift. Resident 1 stated they reported the incident to a staff member but could not recall who it was. (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 - Few	In an interview on 08/02/2021 at 11:17 PM, Staff H stated that they were informed of the allegation that Resident 1 was pulled up by their neck in bed before they saw Resident 1. Staff H stated they were a mandated reporter and received abuse training 03/01/2021. They stated that if a resident made an allegation of abuse or neglect that they would report it to the state hotline, but they would not report it to the building as not to break the resident's confidence in themselves. Staff H stated that they would get more information from the resident and then report it to the hotline, if they felt it was necessary. Staff H stated that treatment was offered to Resident 1 but that they declined. Staff H stated that they saw the resident on 07/12/2021 but the facility would not have seen the dictated note until 07/13/2021 because of the dictation and transmission process. In an interview on 08/02/2021 at 12:27 PM, Staff M stated that in the morning of 07/12/2021, Resident 1 reported that two aides had pulled them up by her neck. Staff M stated, I got busy and didn't want to forget to report it, so I wrote on the communication board (an internal tool the facility used for staff communication) so someone would talk to her. I didn't think anything else about it, I assumed they got the message. I'm not gonna lie I didn't start an investigation because she makes so many allegations that I wanted someone to talk to her first. I was looking for guidance even though I was busy. In an interview on 08/02/2021 at 2:10 PM, Staff F, Registered Nurse/Resident Care Manager, stated that any allegation of abuse and neglect should be called to the state hotline within two hours. Staff F stated that they had worked on 07/11/2021 and no allegation was reported, and that the allegation was reported to them from the Physical Therapist on 07/13/2021 and then the investigation process started. Staff F stated that Staff H and Staff M should have reported the allegation when Resident 1 reported it to them. Staff F stated that on 07/12/2021 at 8:09 AM, a communication was documented by Staff M for a staff member to communicate with Resident 1 regarding an incident. In an interview on 08/05/2021, the Director of Nursing Services stated that if the resident reported the allegation to any person in the building that it should have been reported to the management staff and should have been called into the State Hotline as everybody was a mandated reporter. Reference: (WAC) 388-97-0640 2(b)5

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37369 Based on interview and record review, the facility failed to complete a thorough and complete investigation for one of seven residents (1) reviewed for abuse and neglect. This failure prevented the facility from identifying the extent and nature of the occurrence and placed residents at risk for abuse and neglect. Findings included . Review of the Nursing Home Guidelines The Purple Book dated October 2015, included that the investigation should end with the identification of who was involved in the incident, and what, when, where, why, and how the incident happened including the probable or reasonable cause. It should also allow the nursing home to determine if the allegations were true or not true. Review of the facility's policy titled, Abuse and prevention Policy and Procedure, revised 07/01/2020, showed that the investigation will include at a minimum the following steps: - Identification of the parties involved; - Identification of witnesses; and - Interview of all parties involved, including the resident (if interviewable). This may include signed and dated statements from individuals in their own words that described the incident. Resident 1 admitted [DATE] with diagnosis to include lumbar fractures. According to the Admission Minimum Data Set assessment dated [DATE], Resident 1 was cognitively intact and able to make their needs known. In an interview on 07/27/2021 at 10:45 AM, Resident 1 stated, When I asked to be taken to the bathroom one aide was in front of me and one was in back of me, and the one in the back pushed me so hard that I had instant pain down my back, into my neck and across to my shoulders and into my chest. I was sitting on the edge of the bed. This happened the same day that the facility where the resident lived prior, came to see them. On 07/27/2021 at 2:36 PM, this surveyor reported the allegation that Resident 1 had made to the Administrator and Staff L, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM). Review of the investigation dated 07/23/2021 (the day of the allegation even though the facility did not know of the allegation until 07/27/2021 when reported by the surveyor), showed that the resident stated the allegation of abuse involved two male aides that had toileted them (the resident), pushed them back, and caused excruciating pain to their extremities. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the investigation showed no evidence that the two male nursing assistants were identified in the allegation to substantiate or unsubstantiate the allegation. The investigation showed lack of witness statements from the staff or other residents to determine the credibility of the allegation. The potential for further abuse was heightened as the two male caregivers were not identified and possibly continued to work with other vulnerable adults. In an interview on 08/02/2021 at 1:32 PM, Staff F Registered Nurse (RN)/RCM, stated that all allegations of abuse and neglect were investigated and called into the state hotline within two hours if the allegation could not be unsubstantiated at that time. Staff F stated that if there was a staff member involved in an allegation that they should be suspended pending the outcome of the investigation. Staff F stated that information from the alleged victim, the alleged perpetrator, other residents, and staff members were gathered to complete the investigation. In an interview on 08/05/2021 at 1:00 PM, the Director of Nursing Services (DNS) stated that the process to investigate allegations of abuse and neglect were to protect the resident, report to the Department of Social and Health Services, investigate by obtaining witness statements from staff and other residents, and talking to the resident. The DNS stated that a plan should be developed and evaluated. The DNS stated that when she reviewed Resident 1's investigation she noted that it was not complete and thorough. Reference: (WAC) 388-97-0640 (6)(a)(b)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37369 Based on observation, interview, and record review the facility failed to provide care and services to prevent pressure ulcers for two of three sampled residents (2, and 3) reviewed for pressure ulcers (PU). The facility failed to implement, monitor, and evaluate effectiveness of interventions for Resident 2 who was identified to be at risk for pressure ulcers on admission. This failure caused harm when Resident 2 developed two Stage III pressure wounds to their coccyx (tailbone). Resident 3 was identified to be bed ridden and at risk for pressure ulcers on admission and the facility did not implement, monitor, or evaluate interventions for Resident 3 resulting in a Stage II blister to their heel. This failed practice caused harm to Resident 2 and placed Resident 3 and other residents at risk for the development of a pressure ulcer. Findings included . The Resident Assessment Instrument (RAI) Manual defined the stage of a PU as followed: - A Stage II PI (ulcer) was described as a partial thickness loss of the skin. - A Stage III PI (ulcer) was described as a full thickness loss of the skin. Review of facility policy titled, Avamere Living-Weekly Skin Audit Guidelines, revised 08/25/2020, showed on admit, the licensed nurse will perform a skin assessment for early identification of skin breakdown or areas that are at risk for development of pressure injuries. Review of the facility's policy titled, Prevention of Pressure Injuries, revised in April 2020, showed the purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors .Review the residents care plan and identify the risk factors as well as interventions .Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team .Select appropriate support surfaces based on the residents risk factors, in accordance with current clinical practice .Review the interventions and strategies for effectiveness on an ongoing basis. RESIDENT 2 Resident 2 admitted to the facility on [DATE] with diagnoses to include diabetes, and a right below the knee amputation (BKA). Review of resident's Admission Minimum Data Set Assessment (MDS) dated [DATE], showed the resident required two-person extensive assistance for bed mobility, transfers, dressing, and toilet use. They were incontinent of bowel and bladder. A Care Area Assessment (CAA) trigger (areas that required care plan interventions) revealed the resident was at risk for developing a PU's and this concern would be addressed on the care plan. Review of the resident's nursing admission assessment completed on 05/07/2021, showed Resident 2 admitted with surgical skin impairment to their right knee and right hip. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's Braden Scale for Predicting Pressure Sore Risk (an assessment tool to determine a resident's risk for developing PU's), dated 05/07/2021, showed the resident was at risk for PU development. Review of the care plan focus problem dated 05/07/2021, stated the resident was admitted to the facility with actual impairment to skin integrity related to their surgical wound (R) BKA. Interventions included to report any new skin impairment to the licensed nurse, complete weekly skin assessment, and to keep their skin clean and dry. The care plan did not identify the resident was at risk for PU development. Review of a progress note dated 05/11/2021 at 11:45 PM, showed the resident had refused cares, required reapproaching and education on skin care. The refusal of care or education to the resident was not addressed on the care plan. Review of May 2021 Documentation Survey Report v2 (a type of computerized report) showed the resident was offered a bath or shower eleven times and refused nine times. Refusal of care was not addressed on the care plan. Review of incident report dated 07/13/2021 at 6:30 AM, showed the resident had two new PU's to their coccyx area. The incident report stated the resident spent extended amounts of time in bed throughout the day and evening. Review of a progress note dated 07/13/2021 at midnight, Staff H, Physician's Assistant (PA), documented there was a decubitus ulcer near coccyx most likely related to resident continuously sitting. Review of a wound team progress note dated 07/20/2021, showed Staff G, wound physician, documented the resident had two PU's near the coccyx area. Wound one measured 1.2 centimeter (cm) x 1.5 cm x 0.1 cm and was staged as a Stage III PU. Wound two measured 3.5 cm x 2.0 cm x 0.1 cm and was staged as a Stage III PU. In an interview on 07/27/2021 at 11:06 AM, Staff A Nursing Assistant Certified (NAC), stated they used the care plan to provide the correct type of care for residents such as positioning, and turning schedules. Staff A stated if the resident had a skin issue it would be on the care plan, or the nurse would let them know. In an observation and interview on 08/02/2021 at 9:38 AM, Resident 2 was sitting in their chair. The resident stated they did not come into the facility with a sore on their bottom. They said one of the staff members informed them and they (staff) were doctoring it now. The resident stated the wound had been there for a few weeks and was painful when they change the dressing. The resident reported they were in their wheelchair or bed most of the time. Resident 2 had pain to the right hip, so staff encouraged them to not lie on the sore hip, so they laid on their back instead. The resident reported nurses do not look at all their skin weekly, they just look at wounds when they had one. In an interview on 08/02/2021 at 9:56 AM, Staff B, NAC, stated they use the interventions on the care plan for skin prevention. Staff B stated for prevention they made sure the resident was dry. The residents with current skin impairments or pressure ulcers would be repositioned and have an alternating pressure mattress (APM). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 08/02/2021 at 10:05 AM, Staff C, NAC, stated Resident 2 was lying in bed a lot for a long time, recently they had become more independent and were now in their wheelchair (w/c) a lot. Staff C reported the resident could be reluctant to change positions, once they are up, they are up. In an interview on 08/02/2021 at 12:05 PM, Staff D, Licensed Practical Nurse (LPN), reported they have skin prevention interventions such as repositioning, and weekly skin checks. Staff D stated if a resident was at risk for skin impairment, they would put in the care plan for repositioning, weekly skin checks, and notify of any changes. If a resident had a new PU, nursing would complete a skin/wound assessment and refer the resident to the wound team for further evaluation and treatment. Staff D stated the shower aids completed the skin check form and gave it to the nurse weekly. In an interview on 08/02/2021 at 1:20 PM with Staff E, Registered Nurse (RN)/MDS nurse, stated if there was a PU CAA triggered, they check to ensure the issue was addressed on the care plan or they would communicate to the Resident Care Manager (RCM) to see if these issues needed to be addressed on the care plan. We all know it only takes two hours for a PU to develop, so if a resident had multiple triggers the issue needed to be addressed on the care plan as soon as possible. In an interview on 08/02/2021 at 1:32 PM, Staff F, RN/Resident Care Manager, RCM, stated they identified residents at risk for skin impairment on admission using the Braden Assessment and assessing the residents risk factors. They would address this in the care plan. Staff F stated if a resident was at risk for PU's, they should implement a positioning schedule, sage boots (a type of pressure relieving foot device) or a APM (alternating pressure mattress) to decrease pressure. Staff F stated if the MDS assessment triggered the resident was at risk for PU's, the MDS nurse would contact the RCM to address it in the care plan. Staff F agreed Resident 2 triggered to be at risk for PU development on their admission MDS assessment, and no interventions were addressed on the care plan for prevention. In an interview on 08/03/2021 at 2:39 PM, Staff G stated Resident 2 had a lot of stuff going on and was not very mobile for a long time. In an observation and interview on 08/05/2021 at 8:58 AM, the resident was in their w/c and expressed frustration regarding an open area to their BKA site which was preventing the use of prosthetic device and working with therapy. The resident did not admit to the facility with a pressure ulcer and was identified at risk on their admission assessment. The facility failed to implement an individualized care plan to direct caregivers to prevent two stage III PU's two months after the resident admission. RESDIENT 3 Resident 3 admitted to the facility in 04/15/2021, transferred from another facility, with diagnosis of spinal stenosis (abnormal pressure to the spine), kidney disease, hypothyroidism (slow functioning thyroid), and dementia. Review of Admission MDS assessment dated [DATE], showed the resident was a two-person extensive assistance for bed mobility, dressing, toileting, and personal hygiene. The resident had severe cognitive impairment and was identified as at risk for developing a PU. The CAA triggered for PU's to be addressed on the care plan. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of History and Physical dated 04/09/2021 showed resident was bed ridden. Review of the admission Braden assessment completed on 04/15/2021, showed the resident was at risk for skin impairment. Review of a care plan focus problem dated 04/16/2021, showed the resident was at risk for impairment to skin integrity related to deconditioning and had fragile skin. Interventions included to keep the skin clean and dry, Licensed Nurse (LN) to complete weekly skin assessment, and report new impairments to the nurse. No preventative care plan interventions were addressed such as repositioning, or supportive devices to relieve pressure or what the CAA assessment identified. Reviewed of Resident 3's Nursing Admission assessment dated [DATE], showed no open skin areas to resident's right heel. Review of the physician orders beginning in May 2021 through July 2021, showed no directives to address prevention of PU's. Review of the skin/wound evaluation dated 07/13/2021, showed the resident had a new Stage II PU to their right heel measuring 3.4 cm x 2.8 cm. Review of care plan on 07/27/2021, did not address the resident's refusals to get out of bed. In an interview on 07/27/2021 at 1:15 PM, Staff I, NAC/shower aide, stated they did not discover the PU to the resident's right heel, another staff member had, but was unable to remember who. In an interview on 07/27/2021 at 1:05 PM, Staff K, Nursing Assistant Registered, stated the staff would report any new skin issues to the nurse. Staff K stated Resident 3 refused repositioning a lot. In an interview on 08/02/2021 at 10:15 AM, Staff J, NAC, stated that skin prevention was in the resident's care plan and new changes would be given to them in report. Staff J stated Resident 3 refused to get out of bed often. The staff had difficulty encouraging them to get out of bed or repositioning. Staff J reported they were informed to elevate the resident's foot after the resident developed pressure injury. In an interview on 08/02/2021 at 12:05 PM, Staff D stated the shower aide found the resident's blister and informed nursing staff. Staff D stated the resident did not have repositioning, or supportive devices to relieve pressure until after the PI was discovered. Staff D stated the resident would only accept care in bed, which was not addressed in the care plan. In an interview on 08/02/2021 at 1:32 PM, Staff F stated the resident admitted with risk factors included lack of mobility and a decline in cognition. Staff F stated based on the resident's admission assessments they should have implemented scheduled repositioning, APM, sage boots and to elevate the resident's heels. Staff F stated the previous MDS nurse did not inform RCM's regarding CAA triggers who were responsible to update care plans based on results of the assessment. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 08/05/2021 at 1:12 PM, the Director of Nursing Services (DNS) stated the expected process for skin prevention was nursing would complete a Braden Risk assessment on admission and they put interventions in place to prevent, such as positioning, and additional interventions if they were needed. If the MDS assessment identified the resident was at risk, this was another opportunity to address the risk factors and then care planned them accordingly. The DNS stated the CAA triggers were previously completed by the MDS nurse; however, this was not effective and now the expectation was the MDS nurse would email the RCM's and they would determine if they needed to be addressed on the care plan. The DNS stated the process for addressing PU's would be to notify all parties, get a treatment order, wound referral, and create an incident report in risk management to rule out neglect. Reference: (WAC) 388-97-1060 (3)(b)