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	08/27/2021

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37369 Based on observation, interview and record review, the facility failed to provide adequate supervision and ensure appropriate interventions were implemented to prevent falls with injury for one of three sample residents (1), reviewed for accidents. In addition, the facility failed to evaluate the effectiveness of the implemented interventions. This failed practice resulted in two separate hospitalization s for Resident 1 that sustained a brain bleed and a fractured rib after two subsequent falls. The lack of adequate supervision and accident prevention placed all residents at risk for injury. Findings include . Review of the facility's policy titled, Falls and Fall Risk, managing revised March 2018, stated staff would identify interventions related to the residents' specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling if the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. Resident 1 admitted to the facility on [DATE] with diagnosis of swelling of the brain from an infection which caused dizziness, impaired balance, coordination, and cognition impairment. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE], showed the resident required two-person extensive assist for transfer and ambulation. Resident 1 had severe cognition deficit. Review of Care Area Assessment (CAA) triggered from the admission MDS assessment, showed the resident was at risk for falls. Findings included the resident had multiple previous falls prior to admission to the facility related to diagnosis of brain swelling. Falls would be addressed on the care plan to avoid complications and minimize the risk to the resident. Review of hospital admission paperwork from 07/23/2021, showed Resident 1 had worsening impaired coordination and balance, and increased confusion. Nursing documentation from the hospital showed Resident 1 was a fall risk, unsteady on their feet, and was unable to call for assistance. Interventions implemented at the hospital included the use of a bedside alarm, and a remote video monitoring system. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the care plan with a focus dated 07/21/2021 (resident admitted [DATE]), showed resident was at risk for falls related to diagnoses of dizziness, impaired balance, and coordination. Interventions to include call light within reach, always wear non-skid footwear when out of bed, monitor for decline or improvement in mobility, and review and update fall risk assessment quarterly, post any fall and as needed. Review of Fall Risk assessment dated [DATE], showed the resident was high risk for falls. Review of an incident report dated 07/25/2021, showed the resident had an unwitnessed fall at 5:26 PM in their room. Resident 1 was found on the floor with the door closed. An intervention added was to include diversional activities when they were restless. Review of Physician Assistant (PA) progress note dated 07/26/2021, showed resident was cognitively impaired and needed fall precautions for impaired balance and coordination. Review of a skilled nursing note dated 07/25/2021 through 07/30/2021, showed safety concerns of the resident making several attempts to self-transfer, did not use their call light, and had multiple falls. Review of an incident report dated 08/02/2021, showed the resident had an unwitnessed fall at 7:44 PM in their room. The resident was found on floor. An intervention was added to move resident closer to the nurse's station. Review of an incident report dated 08/03/2021, showed resident had fallen at 3:30 PM in their room. Per the summary, the resident self-transferred from their wheelchair and fell backwards and hit their head on the floor. Resident 1 was sent to hospital resulting in a head injury. An intervention was added to install an anti-roll back device (the device prevents chair from rolling backwards) to wheelchair when the resident returned from hospital. Review of PA progress note dated 08/03/2021, showed the resident continued to experience recurrent falls with their wheelchair, still tried to get up and falls. Review of the Admission Nursing Database assessment dated [DATE] (Resident 1 readmitted on [DATE]), showed the resident had previous falls, and was not steady with transfers. Review of a Fall Risk assessment dated [DATE], showed the resident was a high risk for falls. Review of a physical therapy assessment dated [DATE], showed the resident was at risk for falls related to physical impairments and associated functional deficits, resident was unstable and unpredictable. Review of a care plan goal for falls dated 08/10/2021, showed the resident would not have any substantial injuries secondary to falls. The care plan interventions were not updated based on the risk factors identified upon the resident's re-admission; the anti-roll back device was not added to care plan. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of an incident report dated 08/11/2021, showed the resident had an unwitnessed fall at 7:40 PM in their room. The resident was found on the floor. An intervention was added to place bed against the right side of room to create boundaries. Review of a skilled nursing note dated 08/11/2021, showed the resident continued to attempt to self-transfer and did not use call light when needing assistance. Review of a PA progress note dated 08/12/2021, showed Resident 1 was hospitalized for seven days related to a brain bleed (resident was readmitted on [DATE]) sustained after fall and continued to experience recurrent falls. Review of a skilled nursing note dated 08/12/2021, showed the resident was a fall risk, did not remember to use call light. Review of a purchase order provided by facility; the anti-roll back device was not ordered until 08/13/2021. Review of an incident report dated 08/14/2021, showed the resident had an unwitnessed fall at 3:45 PM in their room. Resident was found on floor. A new intervention was added to place a sign in the resident's room to use their call light (even though it was documented the resident did not use their call light). This intervention was added to the care plan five days after the fall. Review of an incident report dated 08/15/2021, showed resident had an unwitnessed fall at 4:30 PM in their room. The nurse documented the resident was confused. Per the investigative summary, the resident was impulsive and had poor safety awareness with an inability to estimate their self-limitations. A new intervention was added to allow compassionate care visits daily, which was added to the care plan four days after the fall. Review of a PA progress note dated 08/16/2021, showed the resident had multiple falls and was very difficult to redirect with poor balance. Review of an incident report dated 08/17/2021, showed the resident had a fall at 12:20 PM in their room. The resident was found on floor; fall was unwitnessed and call light was not on. Per the investigative summary, an intervention was added to place resident on 15-minute checks, which was added to the care plan three days later. Review of the 15-minutes check forms showed empty entries, incomplete forms, undated pages, and one page was dated after resident discharged from the facility. Review of a PA progress note dated 08/17/2021, showed the resident continued to be a serious fall risk and very confused with cognition impairment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of an incident report dated 08/19/2021, showed the resident had a fall at 3:45 PM in their room, call light was not on. The nurse documented that the resident appeared to grab at something on ground and was wearing one shoe. The summary stated the resident was severely cognitively impaired. An intervention included to have therapy to assess the resident to use a grabber device and educated staff to ensure resident was always wearing non-skid footwear. The care plan did not reflect the intervention for therapy to assess the resident for the use of the grabber device. The care plan already reflected non-skid footwear as a previous intervention from admission on 07/23/2021. Review of care plan on 08/27/2021 showed the anti-roll back device was added to care plan on 08/19/2021. Review of a PA progress note dated 08/20/2021, showed Resident 1 had multiple falls and difficulty with redirection, poor balance, and falls. Review of a skilled nursing note dated 08/20/2021, showed the resident continued to attempt to self-transfer and did not use call light when needing assistance. In a phone interview on 08/23/2021 at 3:17 PM, with collateral contact (CC), stated sadly the resident was a tragic victim to the COVID vaccine, they were splitting their own firewood in May and now could not walk, they fall as soon as they stand. CC stated they had moved here to be closer, as the resident was having so many falls. Review of an incident report dated 08/23/2021, showed the resident had a fall at 4:20 PM in their room, unwitnessed, and the call light was not on. Per the investigation summary no neglect was identified because the care plan was being followed due to the anti-roll back device was functioning and in place. Review of an incident report dated 08/24/2021, showed the resident had a fall at 8:40 AM, and the call light was not on. Per the incident report, the resident stood up from their wheelchair, fell and received an enlarged bump to their forehead. Resident 1 was sent to the hospital via ambulance and was admitted to the hospital for rib fracture and collapsed lung. In an observation of the resident's room on 08/25/2021 at 8:45 AM, revealed Resident 1 was in the hospital. There was a wheelchair in the room, with no anti-roll back device observed on the wheelchair in the room, the bed against the wall, a front wheel walker, and a bed side commode with curved handles. There was a sign on bathroom door to remind the resident to use call light. In an interview on 08/25/2021 at 9:26 AM Staff A, Licensed Practical Nurse (LPN), stated the floor nurse does not update the care plans. If the resident was a high risk for falls upon admission, it would be reflected on the care plan. Staff A stated interventions were never removed they just add as a new one after each fall. Staff A stated, Resident 1 had a lot of falls, they were unable to follow directions. Staff A stated they had informed Staff E, Central Supply, to order the anti-roll back device for Resident 1; however, it had not been placed on the residents wheelchair as of this interview. Staff A confirmed the wheelchair in the room was Resident 1's. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 08/25/2021 at 10:59 AM, Staff F, Nursing Assistant Certified (NAC), stated Resident 1 was falling all the time, and the staff had difficulty figuring out what to do. Staff F stated, Resident 1 was a huge fall risk; staff would leave Resident 1 alone for five minutes and they would fall. In an interview on 08/25/2021 at 11:22 AM, Staff G, NAC, stated the care plan reflected if a resident was a high fall risk and what the interventions were. Staff G stated, Resident 1 would attempt to self-transfer often and had a lot of falls, staff would try to watch them from their doorway. In a phone interview on 08/26/2021 at 11:11 AM, Staff H, NAC, stated residents who admit as high fall risks were usually placed in rooms near the nurse station. Staff H stated Resident 1 fell all the time and staff would place the resident in their wheelchair near the nurse cart, but they would just stand up and staff would need to run and get them. Staff H stated, They (Resident 1) really needed constant supervision, like a 1:1. In an interview on 08/27/2021 at 9:25 AM, Staff E, stated the anti-roll back device was delivered yesterday, however due to the resident was out of the facility they placed it on another resident's chair. Staff E confirmed they ordered the device on 08/13/2021 and this was standard delivery time for that item. In an interview on 08/27/2021 at 10:08 AM, Staff I, Occupational Therapist (OT), stated Resident 1 was unpredictable, was quick without warning and was not able to communicate their needs. Staff I stated the resident needed to be in the staff direct view for supervision. In an interview on 08/27/2021 at 11:48 AM, Staff B, Registered Nurse (RN), stated Resident 1 was a very high fall risk and the staff tried to check on them every 15 minutes. Staff B stated, I think they probably needed one on one because they could fall in 15 minutes it was very hard to work with them, it's hard to observe them and I have to leave the medication cart, I am always moving I can't watch them all the time. In an interview on 08/27/2021 at 11:59 AM, Staff J, NAC, stated residents who were a high fall risk staff tried to check on them every 15-30 minutes. Staff J stated Resident 1 was different, they had only a two-minute memory otherwise they would try to get up and walk. Staff J stated, Resident 1 probably needed someone with them one on one. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 08/27/2021 at 12:50 AM, Staff K, LPN/Resident Care Manager (RCM), stated when a resident admitted from the hospital it was the RCM's job to review hospital notes, and the admission History and Physical (H&P). Staff K acknowledged Resident 1 was a high fall risk upon admission based on their medical history and information provided by the hospital. Staff K, stated they placed high fall risk residents in the rooms near the nurse station, provided frequent checks, fall mats, and non-skid footwear. Staff K stated they were not able to place Resident 1 in a room near the nurse station on admission as there were none available at the time. Staff K acknowledged the only high-risk intervention implemented to Resident 1 upon admission was non-skid footwear. Staff K acknowledged the anti-roll back device was not ordered until 08/13/2021 and did not provide any information as to what the facility did to ensure safety until the anti-roll back device was installed. Staff K did not offer a response when informed the 15-minute checks were not completed, were undated, and missing signatures. Staff K acknowledged they were responsible for completion of the summary for the fall on 08/23/2021, which included the anti-roll back device was operational. Staff K acknowledged they identified a trend, that Resident 1 was falling in the evening, however Staff K stated, they did not address this in the interventions. Staff K did not acknowledge or deny when informed the staff expressed Resident 1 needed a one to one as they were impulsive, quick and they were unable to watch them all the time. In an interview on 08/27/2021 at 1:30 PM, the Director of Nursing Services (DNS) stated the expectations for fall investigations was the cart nurse would initiate the incident report, gather witness statements from all staff working on the unit, and initiate an immediate intervention. The RCM was to assess the information based on the witness statements and evaluate effectiveness of the intervention(s) and updated the care plan. The DNS said they had not been reviewing fall trends, they had implemented a fall committee to start with the first meeting on day of this interview. The DNS acknowledged they reviewed hospital notes, and admission paperwork in addition to the assessments that were required and completed when a resident was admitted determining a resident's risk for falls. The DNS acknowledged Resident 1 should have been placed in a room near the nurse station, however stated there were none available at the time of admission. The DNS stated they could not control when the anti-roll back device was delivered and stated, if we don't have it, we can't add to the chair we can't be responsible for how long it takes to ship. The DNS did not provide any information as to what the facility was putting in place until the anti-roll back device was installed. The DNS acknowledge resident had several unwitnessed falls after returning from the hospital on 08/10/2021 and there was no way to determine if anti-roll back device would have affected the falls. The DNS acknowledged the intervention to place a sign for resident to use their call light was inappropriate, based on the nursing documentation that Resident 1 was unable to follow directions or use a call light. The DNS did not offer a response when informed of the 15-minute checks were not completed, were undated, and missing signatures for the fall on 08/17/2021. The DNS did not acknowledge or deny when informed the staff expressed Resident 1 probably needed a one to one as they were impulsive, quick, and unable to monitor all the time. The DNS acknowledged Resident 1 had twelve falls, two with significant injuries with hospitalization in the twenty-four days of their admission. The DNS acknowledged the interventions implemented were not specific or effective for Resident 1. Reference: (WAC) 388-97- 1060 (3)(g)