Printed: 11/25/2024 Form Approved OMB No. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505296	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2022	
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 0600 Level of Harm - Actual harm Residents Affected - Few	and neglect by anybody. **NOTE- TERMS IN BRACKETS IN	AVE BEEN EDITED TO PROTECT Condition of the record review, the facility failed to entility failed to protect and adequately as an an agency nurse's aides background neet the resident's needs. This failure of an ademotional distress from endured lity staff failed to protect residents from potential abuse to continue. The facility staff failed to protect residents from potential abuse to continue. The facility abused Resident 21. These failures nued abuse and resulted in harm for R I injury, fear, mental anguish, agitation use, Neglect, Exploitation and Misapprotect residents from abuse, neglect is conduct employee background checks of the tree from any further harm discharting guidelines for abuse & neglect is conducted to ensure DNS or Admin will on alert status. The diagnoses to include chronic respirate ta Set (MDS) assessment, the resident	onfidential of the control of the co	

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

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 505296

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505296	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2022	
NAME OF PROVIDER OR SUPPLIER St Francis of Bellingham		STREET ADDRESS, CITY, STATE, ZI 3121 Squalicum Parkway Bellingham, WA 98225	l '	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)	
F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a progress note on 07/10/2022 at 11:22 PM, showed Resident 1 reported that yesterday (07-09-2022) a Nurse's Aide Certified, (NAC) grabbed them by their arm from the toilet to their wheelchair (w/c) and left a bruise. They stated that it was a man who helped them. An (unidentified) NAC reported this to the nurse that the resident had a bruise on their left deltoid (upper arm) area. The bruise was 2.5 centimeters (cm) long and 0.05 cm wide. The bruise was pink/blue in color. The resident was to be assessed for latent injuries. The nurse on call, the DNS and the resident's daughter was notified.			
	had purple discoloration on their le	1/2022 at 6:37 PM, showed a skin asse ft deltoid (which measured 9 centimete st and a 2 cm by 2 cm bruise to their ri	rs by 5 centimeters), a 9 centimeter	
	Review of the facility report to the s	state hotline on 07/10/2022 at 11:15 PM	1, showed	
	Resident 1 reported to their nurse, that yesterday on 07/09/2022, Staff O, Agency NAC, grabbed them by their arms from the toilet to their wheelchair (w/c) and left a bruise. The report showed Staff O was off the floor during the investigation. In an interview on 07/28/2022 at 2:17 PM, Staff N, Registered Nurse (RN), stated that Resident 1 had no skin issues or bruises right now. Staff N stated when there was an abuse allegation, staff were to start a ri management, get statements from staff, report the allegation to the state, the DNS, and Administrator. Stawere to protect the resident. The person who was involved needed to be suspended until the investigation was complete. The resident was placed on alert charting to monitor them. In an interview on 07/28/2022 at 2:57 PM, the DNS stated they started the investigation on 07/09/2022. The DNS stated Staff O had not been suspended as they did not have clear insight from the resident. The DNS stated Resident 1 was unsure of the staff's gender, skin tone and type of hat the staff wore. The DNS stated Staff O continued to work at the facility since then. The DNS acknowledged there was no background che obtained for Staff O upon hire and until 07/27/2022. They acknowledged there was no review of the employee file or background information as part of the investigation. The DNS was asked about bruising to Resident 1's left chest and right knee discovered on 07/11/2022. The DNS stated they were unaware of those bruises and confirmed they were not included in the investigation. The DNS stated Resident 1's skir was very fragile due to chronic prednisone use and they considered the blood pressure cuff could have be the cause of the bruising. The DNS agreed the resident thought this incident to occur and remained consistent in reporting that staff grabbed them and caused the bruising. The DNS acknowledged other resident's skin was not assessed to ascertain if other residents were affected at the time of the investigation.			
	(continued on next page)			

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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 0600 Level of Harm - Actual harm Residents Affected - Few	their left arm bruise was about gon Resident 1 stated the bruise was fr not know their name. They stated to ra woman so when they were on At that time, he responded man the nurse came into give me pills after the man. I do not want them back I years. I can barely get a bump and stated, Do you know what that is fr need to be careful; my skin is fragil A review of Staff O's employee file check obtained until 07/27/2022, tw residents. Review of the schedule showed St. less supervision and oversight; nig 07/09/2022, and double shifts (PM 07/15/2022, 07/16/2022, 07/19/2022 RESIDENT 21 Resident 21 admitted to the facility the Quarterly MDS assessment dat Review of a progress note on 07/20 had an outburst against another revyelling, Your bad, your bad. Reside There were no interventions docum. Review of a social services note or charting for potential signs of psychhad informed the guardian of the all RESIDENT 4 Resident 4 admitted on [DATE] with	revealed date of first shift was 07/05/20 venty-two days after beginning work under the following shifts on event shifts on 07/05/2022, 07/06/2022, 07/06/2022, 07/06/2022, 07/06/2022, 07/06/2022, 07/20/2022 pM, 07/22, 07/20/2022, 07/22/2022 and night shift) on 07/12/2022 and night shift) on [DATE] with diagnoses to include A ted [DATE], they had severe cognitive of 100/2022 at 12:42 AM, showed on or arous ident coming out of their room. Resident 4 was redirected/distracted while Remember to protect Resident 21 or other in 07/26/2022 at 4:54 PM, showed Residual control of 100/26/2022 at 4:54 PM, showed Residual	ole bruise on their left upper arm. toilet. The resident stated they did t, they could not tell if it was a man un or a woman. Resident 1 stated, s going to die. He hurt me. My saw the bruise. I told them about gile. I have been on Prednisone for the right knee bruise. Resident 1 m door when coming out. They 1022. Staff O had no background supervised around vulnerable 123. Staff O had no background supervised around vulnerable 133. Staff O had no background supervised around vulnerable 134. Staff O had no background supervised around vulnerable 135. Staff O had no background supervised around vulnerable 136. Staff O had no background supervised around vulnerable 137. Staff O had no background supervised around supervised around vulnerable 137. Staff O had no background supervised supervised supervised aroun

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St Francis of Bellingham 3121 Squalicum Parkway Bellingham, WA 98225				
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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the state hotline report on 07/27/2022 at 7:44 AM by the DNS, stated Resident 4 had an outburst directed towards Resident 21. The progress note read that Resident 4 yelled at Resident 21 coming out of their room in the hall Your bad, your bad. Resident 4 was redirected away from the resident. The DNS reported the incident was a pattern of behavior that had occurred three times in last few months. The action reported to prevent reoccurrence was the residents were immediately separated. There was no other plan or interventions in place to protect Resident 21 or other residents from Resident 4.			
		directed staff to assure Resident 21 wakeep Resident 4 away from Resident 2		
	In an observation on 07/26/2022 at door from Resident 21's room.	9:40 AM, Resident 4's room was located	ed across the hall and down one	
	In an interview on 07/29/2022 at 9:18 AM, Staff R, NAC stated they tried to keep Resident 4's keep them away from Resident 7. Staff R stated there was no warning when Resident 4 was upset. They commented Resident 4 gets irritated easily, it was sudden, and the resident can around with you then yell. Staff R stated they were unaware of any recent altercations with R commented Resident 4 had just been placed on every 15-minute checks again. Staff R state had been on 15-minute checks for a super long time prior. Staff R said they attempt to redire they were around them.			
	In an interview on 07/29/2022 at 11:29 AM, Staff S, NAC, stated Resident 4 was in and out of thei sometimes gets set off. Staff S said they placed Resident 4 back on 15-minute checks to monitor resident and to prevent a resident-to-resident altercation. Staff S stated there was no warning with resident, they just (made snapping motion with their fingers). They stated it can be hard to watch the as they have a lot of residents who require two-person assist or require all care to be completed in In an interview on 07/29/2022 at 12:40 PM, Staff I, Social Services stated Resident 4 was impulsive.			
	had verbal aggression against other again. Staff I stated they put interve	er residents. Staff I stated the resident ventions in place on the care plan.	was placed on 15-minute checks	
	In an observation on 07/29/2022 at 11:11 AM, Resident 21 was in the solarium when Resident self-propelled into the room in their wheelchair. No staff were present. Staff were observed to be the solarium and were not aware the residents who had been involved in a resident-to-resident were alone, unsupervised in the solarium from 11:11 AM until 11:33 AM.			
	(continued on next page)			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0600 Level of Harm - Actual harm Residents Affected - Few	expectation for resident-to-resident residents, report to the hotline, investigation and the staff could go on alert characters with Resident 4, and they have resident 4 was no longer on 15-mi supervision, but the staff could do a Staff Q acknowledged that the recessift when staff are preoccupied. Stacknowledged they had heard Resident when the incident report invest 07/29/2022 at 11:23 PM. The progresident. The resident wheeled the resident in the hall (Resident 4) become resident came around the corner at resident who shouted at Resident 4 escalation. The incident investigation on 07/26 triggered by but did not include how Resident 21 for further altercations room. Although, Resident 21 had cognitive person in similar circumstances wo		e resident, maintain safety of all m safe and then evaluate the plan. ed. Staff Q stated they identified a Staff Q was unsure when and why would be irritated with one-on-one carts by their rooms . something. g busy dinner time and change of to have more supervision. Staff Q ervised in the solarium. It is note for Resident 4 on en verbally assaulted by another for the solarium when another esident. The other resident was e in the solarium, the same er quick before she gets away! The is could be safe without further ent 4 from other residents they are sideration of room moves to protect and often self-propels past their express their feelings, a reasonable ou're bad when at their doorway,

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For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all allege **NOTE- TERMS IN BRACKETS I- Based on observation, interview ar for three of four residents (1, 21, ar fall with major injury, and a resident resident-to-resident altercation to residents. These failed practices Finding include. Review of the facility policy titled, A revised April 2021 stated the facility mistreatment, or misappropriation of harm during investigations. Review of the facility policy titled, A Investigating revised April 2021 sta neglect is suspected .interview other reviews all events leading up to the boards are notified and documente Review of the [NAME] State Nursin included the resident's record must plan for and meet the resident's ne resident's needs. Included the guid and Reporting for nursing homes, t involved in the incident, and what, or reasonable cause. RESIDENT 32 Resident 32 admitted to the facility liver), and pressure ulcers to sacru Review of the Admission Minimum two persons assist for transfers. The Review of the resident's Activities of was deconditioned. The care plant The resident required maximum as	full regulatory or LSC identifying informati	to conduct a thorough investigation lity failed to thoroughly investigate a led to investigate the fall and the orther actions necessary including the risk of recurrence and protect ry, and neglect. Propriation Prevention Program le incidents of abuse, neglect, rotect residents from any further propriation - Reporting and ed staff member when abuse or alloyee provides care or services. Evant professional and licensing Sixth Edition, (October 2015), incident to enable staff to identify, inately plan for and meet the neident Identification, Investigation in the identification of who was not happened including the probable planetes, cirrhosis (disease of the lower back and tailbone). ATE], showed the resident required inition with no rejection of care. 7/08/2022, showed the resident and pivot into a wheelchair or chair, eir private area and clothing

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(X4) ID PREFIX TAG	(4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the investigation fall sum Registered (NAR), reported that the the restroom from their bed with a sthe resident was pulling their painvestigation failed to recognize the leave until the investigation was conterview other residents that Staff licensing board after determination 32's fall with significant injury. In an interview on 07/28/2022 at 9: 05/23/2022. Staff E stated they we was not clear on the procedure. Stansistance Register (NAR) for an an In an interview on 07/28/2022 at 3: guide for floor staff) for their reside requested to use the restroom, and ambulate and walked the resident of fell forward. In an interview on 07/28/2022 at 12 T, NAR did not follow the care planneglect. Staff F confirmed they did the facility did not report Staff T's like RESIDENT 21 Resident 21 admitted on [DATE] we Quarterly MDS, the resident had see RESIDENT 4 Resident 4 was a long-term resident pseudobulbar effect, major depress dated [DATE], the resident had sig toward others (threatening others, as last assessment. Review of a progress note for Resident 10 to 11 PM (07/25/2022) F	mmary dated 07/09/2022 showed that S e resident had fallen in the restroom affornt wheeled walker (FWW) on 07/09/2011 ints down, they lost their balance and fat the fall was an allegation of neglect. Impleted, leaving other residents at risk T had provided care for. The facility fail was made that Staff T did not follow the 31 AM, Staff E, Licensed Practical Number on the prepared for the accident that ocal aff E was unaware they were supposed allegation of neglect. 13 PM, Staff T, NAR stated that they refuse at the beginning of their shift. Staff I they saw the FWW in the room, they also to the restroom. Staff T stated that the state that the staff cense to the Department of Health. 2:28 PM, Staff F, Director of Nursing Selections and the properties of the properties of the properties of the diagnoses to include Alzheimer's discovere cognitive impairment. In the who admitted on with traumatic brain sive disorder, and anxiety. According to inficant cognitive impairment with verbase screaming at others, cursing at others) and the selection of the properties of the propertie	taff T, Nursing Assistant ter they had walked the resident to 2022 at 1:40 AM. Staff T stated that ell forward onto the floor. The The facility failed to place Staff T on for injury. The facility failed to led to report Staff T to the state the care plan that led to Resident See (LPN) stated they were hired on curred when Resident 32 fell and to suspend Staff T, Nursing Reviewed all the Kardex's (Care T stated when the resident assumed the resident was able to resident then lost their balance and Revices (DNS) confirmed that Staff spend Staff T for the allegation of T had also provided care with, and Sease. According to the 06/22/2022 In injury, impulse disorder, To the Quarterly MDS assessment all behavioral symptoms directed occurred one to three days, same off E, LPN, documented, On or ther resident (Resident 21) coming

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 21's medical record showed no progress note about the incident or resident assessment for injury. The first progress note about the incident was on 07/26/2022 at 4:54 PM. Failure to monitor resident following an incident of alleged abuse placed residents at risk for delayed identification of psychosocial outcomes such as fear of staff, and delayed identification of latent injuries related to the incident.		
	Review of a witness statement by Staff E, LPN on 07/25/2022 stated the nurse could recall that around 9 to 10 PM Monday they were at their medication cart documenting the care of another resident when they heard Resident 4's voice. The resident was in their wheelchair attempting to go back to their room. As Resident 4 turned the corner to go back out of the solarium, the nurse stated they assumed (Resident 4) was startled by Resident 21. Staff E documented they did not see the beginning of the altercation. Staff E noted Resident 21 began yelling aggressively, You get away, you're bad, get away. Staff E documented possibly two or three Nursing Assistant Certified (NAC) discreetly separated the residents and added those NACs were privy to the whole situation.		
The incident investigation was started on 07/26/2022 by Staff F, DNS. The 07/26/2022 rather than 07/25/2022. The immediate intervention showed stand ensure immediate safety. There were no statements included from the or around that time as it was close to change of shift. There was no interviet there were other concerns of this nature. There was no room move consideration had rooms on the same hall, across from one another and one room down. Resident 4 was put back on 15-minute checks due to the outburst and need residents that they were triggered by.			taff were to separate the residents e nurses' aides present on the shift iew of other residents to ascertain if deration when Residents 4 and 21 n. The plan on 07/30/2022 was
	Review of Resident 4's care plan d no documentation one on one was	irected staff to provided one on one as provided to protect Resident 21.	needed for Resident 4. There was
	involving Resident 4 and 21. Staff of staff are to protect the residents, m	1:42 AM, Staff Q, stated they heard the Q stated the expectation when resident paintain safety of all residents, report to and evaluate the plan. The resident was	to resident altercations occur was the hotline, investigate and
	Review of a progress note dated 07/29/2022 at 11:23 PM, included with the investigation of the altercation between Resident 4 and 21 on 07/25/2022, showed Resident (21) was verbally assaulted by another resident. Resident 21 wheeled themself from their room and was heading for the solarium when another resident in the hall (4) became agitated and swung their fist at the resident. Resident 4 was separated from Resident 21, however at 10:50 PM, while Resident 4 was in the solarium, the same resident (Resident 4) came around the corner and began shouting, Shoot her! Shoot her quick before she gets away!' Resident 4 was quickly removed so both residents could be safe without escalation.		
	Resident 4 was placed on 15-minu 21.	te checks on 07/30/2022, five days afte	er the first incident with Resident
		idents, and thoroughly investigate the footsparate incidents on 07/29/2022 in a	
	Reference WAC 388-97-0640(6)(a))	
	(continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	accidents. **NOTE- TERMS IN BRACKETS H Based on observation, interview ar three of three residents (4, 7 and 2 interventions were implemented to This failed practice resulted in harm intervention, and a right shoulder fr for the repeat behavior of verbal ag the necessary supervision/monitori failure to adequately supervise Res residents, resulted in harm to Resid the residents at risk for fear, isolatif decreased quality of life. Findings include . <falls> Review of the facility's policy titled, interventions related to the resident RESIDENT 32 Resident 32 admitted to the facility liver), and pressure ulcers to sacru Review of the Admission Minimum 07/09/2022, showed the resident re impaired cognition with no rejection Review of the hospital discharge so the hospital after a fall that occurre closed fracture to the right hip that Review of the resident care plan w Living (ADL) related to decondition wheelchair or chair, toileting maxim ambulation to only occur with thera</falls>	ummary dated 07/13/2022 showed that d at the facility. The summary showed required surgical repair and a fracture with a focus dated 07/08/2022 showed thing with interventions to include transferum assist with cleaning their private and	ONFIDENTIALITY** 15406 ovide adequate supervision for cy failed to ensure appropriate e residents (32), reviewed for falls. hip fracture that required surgical cility failed to recognize the high risk I individual risk factors or provide to reviewed for supervision. The off verbal aggression towards other verbal assault. This failure placed ack of feelings of safety and March 2018, stated staff will identify the resident from falling. March 2018, stated staff will identify the resident from falling. ATE] that was started on some the resident had been admitted to the resident was admitted for a off the right upper arm. The resident had Activities of Daily ers to be a stand pivot into a rea and clothing management, and

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	505296	B. Wing	07/29/2022	
NAME OF PROVIDER OR SUPPLII	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE	
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F 0689	Review of the Occupational Evaluation and Plan of Treatment dated 07/08/2022 showed that toileting should be contact guard assist with a transfer from wheelchair to toilet.			
Level of Harm - Actual harm	Review of the investigation fall sum	nmary dated 07/09/2022 showed that S	taff T, Nursing Assistance Register	
Residents Affected - Few	restroom from their bed with a front	ad fallen in the restroom after they had t wheeled walker (FWW) on 07/09/2022 down, they lost their balance and fell fo	2 at 1:40 AM. Staff T stated that as	
	present on the day the resident adr	55 AM, Staff U, Nursing Assistant Certi mitted to the facility on [DATE]. Staff U nducting an assessment on the residen	stated they recalled the therapist	
	explained to them that the resident	should only ambulate with therapy at t	his time as the resident would lose	
	resident using a stand and pivot to	to Staff U, if the resident needed to use the wheelchair and take into the restro	om, then to stand and pivot on to	
	the toilet. Staff U stated they recalled reporting this conversation with the therapist to the next shift when they gave report at the end of their shift that day.			
	nurse on duty when the resident had down and told me Resident 32 had	2 at 9:31 AM, Staff E, Licensed Practical their fall on 07/09/2022. Staff E stated fallen in the bathroom. Staff E stated the away the resident fell forward and land	ed that Staff T, NAR flagged them hat Staff T had taken the resident	
	In a phone interview on 07/28/2022 at 3:13 PM, Staff T, NAR stated that they review all the Kardex's (Care guide for floor staff) for their residents at the beginning of their shift. Staff T stated when the resident requested to use the restroom, and they saw the FWW in the room, they assumed the resident was able to ambulate and walked the resident to the restroom. Staff T stated that the resident then lost their balance and fell forward.			
	the assessment made by the Occu	00 PM, Staff V, Director of Rehabilitation pational Therapist evaluation that was y ambulate with the therapy department	completed on 07/08/2022 that	
	In an interview on 07/28/2022 at 12:28 PM, Staff F, Director of Nursing (DNS) stated that Staff T, NAR had ambulated the resident from the bed to the restroom with only an FWW. Staff F confirmed that the resident care plan was specific that they were to only ambulate with the therapy department due to the resident had balance issues. Staff F confirmed that Staff T, did not follow the care plan, which resulted in the resident had lost their balance, fell on to the bathroom floor, and obtained a right hip fracture that required surgical intervention, and a right upper arm fracture.			
	RESIDENT 4			
	(continued on next page)			

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505296	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2022
NAME OF PROVIDER OR SUPPLIER St Francis of Bellingham		STREET ADDRESS, CITY, STATE, ZI 3121 Squalicum Parkway Bellingham, WA 98225	P CODE
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agence.		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	revealed Resident 4 was admitted hemiparesis following cerebral infa disorder, blindness left eye, repeat brain injury. Review of the quarterly Minimum Desident 4 was severely impaired of 15 (score of 0-7 indicates severe locomotion on the unit, and walking corridor. Resident 4 required exten moving on and off the toilet and on surface-to-surface transfer (transfe assistance. Resident 4 had experied Review of a Nursing Care Note data revealed, this LN [licensed nurse] won their left side by their bed and the socks and no shoes, pajama botton could not remember how they got the found at that time, no bruising, sweresident able to bear weight to their staff changed their socks to non-sk head on the floor and denied any paressage, placed a fax communitor to monitor latent injuries, and started was at moderate risk for falls, has incontinent, was unsteady, and experience of a Nursing Care Note data [interdisciplinary team] meets to diswearing non-skid footwear when at bed contributing to them slipping at non-skid strips next to bed to provide Review of the Care Plan dated 10/2 Resident 4 is at moderate risk for fall the goal was they will not sustain in history of refusing to wear non-skid Encourage Resident 4 to wear non-skid Enco	Record in the electronic medical record to the facility on [DATE]. Resident 4's crction (stroke) affecting right dominant ed falls, shortness of breath, anxiety divided falls, shortness of the fall of the falls, shortness of the falls, shortn	date (ARD) of 04/22/2022 revealed ental Status (BIMS) score of 5 out uired supervision for transfers, ed assistance walking in the sing. Resident 4 was not steady I they were not steady with but able to stabilize without prior MDS assessment. under the Progress Notes tab resident on the laying on the floor to relate to what happened and I for any injuries, and none were sisted up and back to their bed, the ve both UE [upper extremities]. The ident did not remember hitting their was notified via phone call and left dent was placed on alert charting necks, and reported to next shift. Assessment tab revealed Resident last six months, was frequently ling. Frogress Notes tab revealed, IDT Identified that they were not so to wear regular socks when in tracking system] order placed for ping. Care plan updated. The place their call light within reach

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505296	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
		A. Building B. Wing	O7/29/2022
NAME OF PROVIDER OR SUPPLIER St Francis of Bellingham		STREET ADDRESS, CITY, STATE, ZIP CODE 3121 Squalicum Parkway Bellingham, WA 98225	
For information on the nursing home's pla	an to correct this deficiency, please cont	act the nursing home or the state survey a	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			to the floor in Resident 4's room: m. There were no non-skid strips m. There were no non-skid strips m. There were no non-skid strips mg on the bed on their side. There Director, stated they ordered and or install the non-skid strips this (RN) Resource Nurse, stated but had a history of increased supervision. Staff A exide. Staff A stated re-educating distrips had been applied to the list. by the facility, revealed a work is room. Review of the Completed cility, revealed the non-skid strips applied to the floor in Resident 4's 4's room. The surveyor did not here were no non-skid strips on the linto Resident 4's room. Both Staff ey had applied the non-skid strips

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505296	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2022
NAME OF DROVIDED OR SURDIJED		STREET ADDRESS, CITY, STATE, ZI	P CODE
	NAME OF PROVIDER OR SUPPLIER		PCODE
St Francis of Bellingham		3121 Squalicum Parkway Bellingham, WA 98225	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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	Resident 4 was a long-term resider	nt who admitted on with traumatic brain	injury, impulse disorder,
Level of Harm - Actual harm		e laughing and or crying), major depres m Data Set assessment dated [DATE],	•
	cognitive impairment with verbal be	ehavioral symptoms directed toward oth	ners (threatening others, screaming
Residents Affected - Few	at others, cursing at others) occurre	ed one to three days, same as last asse	essment.
	Review of Resident 4's care plan developed on 12/16/2020, showed problematic behavior characterized by ineffective coping with history of resident to resident (altercations) derived from Cognitive impairment due to cerebral infarction (stroke) and history of traumatic brain injury (TBI) and Pseudobulbar Affect (PBA). The goal updated on 04/28/2022 was for reduced incidents of agitated behavior verbal & physical aggression and abuse, history of agitation resulted in refusals of care and medications. One of the interventions implemented on 05/02/2022 was for staff to provide one on one care as needed. Review of an incident report on 06/16/2022 at 5:25 PM, showed Resident 4 was sitting in the solarium door when Resident 7 asked Resident 4 to move so they could get through. Resident 4 became verbally aggressive towards the other resident, observed by the licensed nurse who was at the nurse's station. The nurse and other staff on the floor immediately separated both residents. The DNS was notified, and the resident was placed on alert. The incident report showed Resident 4 had been experiencing mood and emotional changes secondary to diagnosis and repeatedly declining psychotropic medications. Recommendations were staff to check on resident's routinely when they were out of their room or propelling their wheelchair to ensure Resident 4's pathway was clear from obstacles. Maintenance and safety committee were to address the solarium area to ensure this area is set up for management of high resident flow in doorway. Activities was to consider taking group activities to the large dining room with transportation escort assistance for increased participation and safety. The investigation noted Resident 4 had physically aggressive behavior on 07/30/2021 and 08/19/2021.		
	overwhelming emotions overnight, yelling and aggressive behaviors.	6/27/2022 at 3:00 AM, showed Resider crying and laughing at the same time to the on one time spent, refused evening as resident behaviors are steadily escaped.	hen having swift mood changes to g meal out of anger. Note place in
	walker around the unit living room a Resident 4 began calling Resident here! Staff CC, LPN, Staff BB, NAC Resident 4 then stood up quickly al between the two. Staff BB grabbed back to their room. Staff E, LPN wa nurse's station several times overn	07/04/2022 at 11:48 PM, showed Resi area when several patients were watch 7, a c**ks****r and saying You are a modern and Staff Z, RN, all ran when they he and started to walk toward Resident 7 in I Resident 4's wheelchair and stood bel as assigned to be one on one with Resi ight to make snide comments about the ch resident had started the aggression	ing television quietly when onster! You should not even be ard the angered words exchanged. anger. Staff Z put themselves in hind them and redirected them dent 4. Resident 7 came to the e situation that occurred. The nurse

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NAME OF PROVIDER OR SUPPLIER St Francis of Bellingham		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Actual harm Residents Affected - Few			ole in between them and Resident 4 and escorted the other resident out ley were given ice cream and 1 on lery 15-minute checks pending mill fresident 7 was in there. The solarium concurrently change Pre-admission Screening don 07/05/2022 to include int 7. The report showed Resident 4 lent 4 was allowed to enter the loot in the solarium with Resident 4 lem. Residents were to be solarium enter the loot in the solarium with Resident 4 lem. Residents were to be solarium enter to sleep. No further instances for the loot in the solarium with lems and least at the nurse's station 4 was sitting in the solarium and leastly aggressive toward Resident 7. In chasing Resident 7 into the least redirected them to their rooms. Int 4 on 07/05/2022 at 2:48 PM, recent verbal altercation with lesident was outside of their room lear resident involved in verbal while in the Solarium if resident (7) least to try and prevent future lare out of their room. The larce of the other one. Long term	

			NO. 0930-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505296	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2022	
NAME OF PROVIDER OR SUPPLIER St Francis of Bellingham		STREET ADDRESS, CITY, STATE, ZIP CODE 3121 Squalicum Parkway Bellingham, WA 98225		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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	Review of a progress note for Resident 4 by Staff AA, Physician's Assistant on 07/08/2022 at 12:26 PM, showed a psychological assessment for impulse disorder and pseudobulbar affect. The provider noted the resident had increased behaviors recently, and had altercations with another resident, possibility of turning violent and need to be better controlled. Residents' behaviors had been getting progressively worse since discontinuation of Depakote on 04/13/2022. Resident 4 was on 15-minute checks August 2021 to April 2022 and was no longer receiving this level of supervision Review of a progress note for Resident 4 on 07/25/2022 at 11:33 PM, Staff E, LPN, documented, On or around 10 to 11 PM (07/25/2022) Resident 4 had an outburst against another resident (Resident 21) coming out of their room. Resident 4 became hostile and started yelling, Your bad, your bad. Resident 4 was			
	redirected/distracted while the Resident 21 was being comforted. RESIDENT 7			
	Resident 7 was a long-term resident with delusional disorder and generalized anxiety. According to the 05/06/22 Quarterly MDS showed the resident is independent with Activities of Daily Living. The resident demonstrated verbal behavioral symptoms directed toward others the past 1 to 3 days.			
	Review of the care plan developed on 12/06/2021 for Resident 7 showed the resident had a potential psychosocial well-being problem related to poor interaction with other residents.			
	In an interview and observation on 07/26/2022 at 9:55 AM, Resident 7 was sitting on the edge of their bed stating they were going to shoot the [NAME]. In observations on 07/26/2022 at 11:08 AM, 07/27/2022 at 9:58 AM, 07/29/2022 at 9:02 AM, Resident 7 was up ambulating independently with their 4wheeled walker in the halls with no staff supervision.			
	In an interview on 07/28/2022 at 2: this time.	15 PM, Staff N, RN stated there were r	no residents on 15-minute checks at	
	In an interview on 07/28/2022 at 2:31 PM, Staff A, RN stated Residents 4 and 7 are not on one-to-one supervision or every 15-minutes checks. Staff A said Resident 7 had a history of resident-to-resident altercations and spent most of the time in their room but came out in the evenings. Staff A said Resident 4 had a history of resident-to-resident altercations and liked to go to the solarium in the evening time.			
	be in proximity of each other. Staff physical aggression. Staff M stated Resident 4 was more active in the	36 PM, Staff M, RN agency, stated Re M stated they had seen both residents I Resident 7 was more mobile and comight but does come out sometimes in ift as there is extra help with administration manage appropriately.	babble at each other but no nes and goes from their room and the day. They stated supervision of	
	(continued on next page)			

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olan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)			
Bellingham, WA 98225 's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES		ident 7 was evaluated and has was to be on Q 15 minutes checks idents 4 and 7 got irritated just with haviors. Staff F was asked how the re ambulatory and had altercations ion. Staff F said the first altercation pattern now. Staff F stated the staff cknowledged the three incidents elated to dinner and shift change, ident did not occur between these. Thas behaviors and runs around racting does not work well. Ilinical Services, (RDCS) stated lity should have a plan in place to a pattern of altercations with diged more could be done to ace carts by their rooms. Staff Q Resident 7 was more the victim Resident 4 is there more that wed problematic behavior in which and pounds their walker. The goal ys approach resident calmly and emain calm, assure safety of ression toward staff, pounding	
	IDENTIFICATION NUMBER: 505296 R SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by In an interview on 07/28/2022 at 3: altercations on 06/21/2022, 07/04/2 calmed substantially and was not a for supervision after the 07/05/2022 line of sight of each other and they staff were to provide adequate sup- in the solarium, which was a high tr in June was thought to be isolated, were to supervise both residents w occurred between 5:25 PM and 6:0 Staff F could not state how the staf- same two residents. In an interview on 07/29/2022 at 9: the hallways yelling at staff. Staff R In an interview on 07/29/2022 at 11 they were unsure why Resident 4 or keep residents safe and maintain it Resident 4 and 7 and they occurred prevent altercations and suggested stated their expectation was more set In an interview on 07/29/2022 at 12 with Resident 4. Staff I said the alter Resident 7. Review of a care plan problem for I the resident acts characterized by i will be reduced incidents of agitate unhurriedly, be careful to not invad- residents and staff, and refer to soo walker against doors and persevera Resident 7 did recall the 07/04/202 during the night to discuss it. The re RESIDENT 21 Resident 21 admitted on [DATE] wi Quarterly MDS, the resident had se	A. Building B. Wing R STREET ADDRESS, CITY, STATE, ZI 3121 Squalicum Parkway Bellingham, WA 98225 Dan to correct this deficiency, please contact the nursing home or the state survey. SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying informati In an interview on 07/28/2022 at 3:12 PM, Staff F, DNS stated Residents altercations on 06/21/2022, 07/04/2022 and 07/05/2022. They stated Resident 4 for supervision after the 07/05/2022 incident. Staff F stated Resident 4 for supervision after the 07/05/2022 incident. Staff F commented that Resiline of sight of each other and they both had robust care plans for their be staff were to provide adequate supervision with Resident's 4 and 7 who at in the solarium, which was a high traffic area, across from the nurse's stat in June was thought to be isolated, but they have definitely established a were to supervise both residents when they are near each other. Staff F accurate between 5:25 PM and 6:00 PM which was a busy time for staff r Staff F could not state how the staff was to ensure another resident to res same two residents. In an interview on 07/29/2022 at 9:22 AM, Staff R, NAC stated Resident 7 the hallways yelling at staff. Staff R stated Resident 7 and Resident 4 inte In an interview on 07/29/2022 at 11:42 AM, Staff Q Regional Director of C they were unsure why Resident 4 came off 15-minute checks and the facility and the staff and a staff. Staff R stated do distant supervision or pl stated their expectation was more supervision for these residents. In an interview on 07/29/2022 at 12:45 PM, Staff I, Social Services stated with Resident 4. Staff I said the altercations occurred in the solarium and I Resident 7. Review of a care plan problem for Resident 7 initiated on 03/08/2022 show the resident acts characterized by ineffective coping: verbally aggressive, will be reduced incidents of agitated behavior. Staff were directed to alway unhurriedly, be careful to not invade residents' personal space, redir	

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NAME OF PROVIDER OR SUPPLIED		STREET ADDRESS CITY STATE 71	ID CODE
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	IP 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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a witness statement by \$10 PM Monday they were at their in Resident 4's voice. The resident waturned the corner to go back out of Resident 21. Staff E documented the began yelling aggressively, You ge Nursing Assistant Certified (NAC) of the whole situation. In an interview on 07/29/2022 at 11 involving Resident 4 and 21. Staff of staff are to protect the residents, in develop a plan to keep them safe a provider was notified. Review of a progress note dated 00 between Resident 4 and 21 on 07/2 resident. Resident 21 wheeled ther resident in the hall (4) became agit Resident 21, however at 10:50 PM came around the corner and begar was quickly removed so both resident. The facility failed to implement app	Staff E, LPN on 07/25/2022 stated the redication cart documenting the care of the solarium, the nurse stated they as the solarium, the nurse stated they as they did not see the beginning of the altot away, you're bad, get away. Staff E of discreetly separated the residents and stated they separated the residents and stated the expectation when resident aintain safety of all residents, report to and evaluate the plan. The resident was 17/29/2022 at 11:23 PM, included with the 18/2/2022, showed Resident (21) was verified from their room and was heading atted and swung their fist at the resident, while Resident 4 was in the solarium, a shouting, Shoot her! Shoot her quick ents could be safe without escalation.	nurse could recall that around 9 to of another resident when they heard back to their room. As Resident 4 sumed (Resident 4) was startled by tercation. Staff E noted Resident 21 locumented possibly two or three added those NACs were privy to are was a verbal altercation to resident altercations occur was the hotline, investigate and is to go on alert charting and the altercation erbally assaulted by another for the solarium when another int. Resident 4 was separated from the same resident (Resident 4) before she gets away!' Resident 4