STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505017	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Care Center	2821 South Walden Street Seattle, WA 98144

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure each resident received assessed level of supervision and assistance to prevent accidents for 1 of 5 sampled residents (Resident 1) reviewed. Resident 1 experienced harm when they rolled off the bed when they were repositioned without the assessed two caregiver assistance, landed on the floor, and sustained three fractures to their hip, knee, and back, and required an increase in pain medications. This failure placed other resident at risk that required assistance with Activities of Daily Living (ADLs). The facility's Abuse Prohibition and Prevention policy updated November 2016, showed the facility complied with Federal and State Requirements by training, protecting, and preventing abuse and neglect.According to the admission Minimum Data Set (MDS-an assessment tool) dated 05/09/2025, the assessment showed Resident 1 required substantial/maximal assistance with bathing and bed mobility. Diagnosis included Paraplegia (paralysis of the lower half of the body), seizure disorder, respiratory failure, and multiple other comorbidities. The Care Plan, dated 5/03/2025, showed, Resident 1 was dependent on two staff members for repositioning and turning in bed.Review of Resident 1's Kardex with admission date of 5/23/2025, showed Resident 1 was dependent on two staff for repositioning and turning in bed.Review of the hospital Discharge summary, dated [DATE], showed Resident 1 sustained a fracture of their hip, right kneecap, and a fracture of the spinal column in the mid-back.Review of the facility's investigation dated 07/25/2025, showed the assigned CNA, Staff C, provided care without a second staff member in attendance. The investigation showed the fall could have been prevented if the plan of care was followed and the failure to follow the plan of care resulted in harm to the resident and put all residents at risk.Review of the facility's investigation dated 07/25/2025 showed Staff C, CNA, stated they initiated care independently, without a second staff member, that resulted in Resident 1's fall off the bed and subsequent fractures.Review of July's 2025 Medication Administration Record (MAR) showed Resident 1's pain level increased after the fall that required an increase in pain medications and pain management, that included narcotic pain medications.In an interview on 08/01/2025 at 2:07 PM, Staff A, Director of Nursing, stated they would expect the CNA to review the Kardex prior to giving care to the resident to prevent injuries. Staff A stated the Kardex is always available for the CNAs to read, that two caregivers could have prevented the fall and subsequent injuries, and that education was inadequate.In an interview on 08/01/2025 at 2:14 PM, Staff B, Administrator, stated this incident happened because staff did not follow the plan of care and that two care givers could have prevented the fall.During an interview and observation on 08/01/2025 at 1:22 PM, Staff D, (CNA), stated they had received a reminder to do their training prior to their return to work, that they had worked the day before, and started at 06:00 AM on 08/01/2024 but were just starting the training. During an interview and observation on 08/01/2025 at 1:40 PM, Staff E stated they had received almost daily reminders to complete their training but their log in did not work and had not completed the training. Observation of text reminders observed on Staff E's phone.During an interview and observation on 08/01/2025 at 1:45 PM, Staff F stated, they did not recall having received education, that they had a text reminder that the specified training was due on July 30th, and they had not completed it.Review of the facility provided Kardex Protocol training, dated 08/01/2025, showed Staff D, Staff E, and Staff F had not initiated or completed their training prior to their return to work. Same report showed only 75% of the CNA staff had completed the training. REFERENCE: WAC: 388-97-1060 (3)(g)