STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505182	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Mount St Vincent	4831 35th Avenue Southwest Seattle, WA 98126

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 46479 Based on interview and record review, the facility failed to identify and resolve grievances for 1 (Resident 70) of 1 residents reviewed for grievances. This failure placed residents at risk for reoccurrence of issues and a diminished quality of life. Findings included . <Facility Policy> According to the facility's 09/2024 revised Resident Grievance Policy, the facility would promote resident autonomy and self-directed care and services. The policy showed the facility would seek to respond to resident concerns with respect to care and treatment, the behavior of staff and other residents. Residents had the right to file grievances verbally or in writing and receive a written decision regarding their grievance. The policy showed facility staff would acknowledge grievances received verbally and in writing and provide assurance there would be follow up. <Resident 70> According to the 10/11/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 70 was understood and could understand others during conversation. This MDS showed Resident 70 did not have impaired memory or cognitive ability. This MDS showed Resident 70 had verbal behavioral symptoms toward others during the assessment period. The MDS showed Resident 70 had diagnoses including a progressive neurological disorder, depression, and a mood disorder. Review of Resident 70's 10/18/2024 Potential for altered behavior . care plan showed interventions that staff would assess the resident for triggers of behavior and allow the resident to make choices and preferences about their care. This care plan showed Resident 70 required all care to be completed with two staff members (care in pairs) present. Review of a 01/02/2025 nursing progress note showed Resident 70 was verbally abusive toward Staff ZZ (Certified Nursing Assistant - CNA), telling the staff member to get out of the resident's room. This progress note stated Resident 70 became upset when Staff ZZ did not answer their call light during the shift. Review of a 01/04/2025 nursing progress note showed on the evening shift of 01/04/2025, Resident 70 was upset at Staff ZZ for propping their door open with their foot while another CNA was providing care to Resident 70. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/03/2025 at 1:21 PM, Resident 70 stated they had issues with Staff ZZ. Resident 70 stated Staff ZZ did not respect the resident's boundaries. When I want my door shut, [Staff ZZ] will use [their] foot to prop it open a bit. Resident 70 stated their incontinence briefs were often uncomfortable and they needed a lot of help from staff to adjust the briefs. Resident 70 stated Staff ZZ was not patient with them when they needed their brief adjusted. Resident 70 stated they were care in pairs and Staff ZZ would often rush the other staff caring for the resident. Resident 70 stated they made a report to the ombudsman about Staff ZZ yesterday. In an interview on 01/07/2025 at 3:02 PM, Staff ZZ stated they worked evening shift and there were only two CNAs on evening shift. Staff ZZ stated Resident 70 required care in pairs and Staff ZZ was the shadow for the primary CNA for Resident 70. Staff ZZ stated Resident 70 made accusations toward them every time they worked with Resident 70. Staff ZZ stated they reported these accusations to their nurse and to Staff B (Director of Nursing). Review of the facility's grievance log provided by the facility on 01/02/2025 showed the last grievance received was 12/08/2024 and was not regarding Resident 70. There were no other grievances logged for December 2024 or January 2025. In an interview on 01/09/2025 at 1:03 PM, Staff D (Social Services Director) stated they were the grievance officer. Staff D stated grievances were typically filled out for issues of missing items and complaints about care givers. Staff D stated they recently provided an in-service to floor staff regarding the grievance process and that grievances were everyone's responsibility. Staff D stated it was their expectation if a resident complained about a staff member, a grievance form would be completed. Staff D stated Resident 70 had complaints in the past regarding care givers and stated the resident does not seem to trust most staff. In an interview on 01/10/2025 at 12:20 PM, Staff B stated staff could fill out a grievance if a resident complained about staff. When asked how a grievance was tracked and followed up on if it was not documented, Staff B stated they rounded every day and followed up with residents regarding the progress of issues brought up. Staff B stated Resident 70 had issues with most care givers. When Staff B was asked why Staff ZZ was still being assigned to care for Resident 70, Staff B stated they were doing the best they could. REFERENCE: WAC 388-97-0460. . 51791

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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	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on interview and record review, the facility failed to protect a resident's right to be free from abuse for 1 of 5 sample residents (Residents 110) reviewed for abuse. Resident 110 experienced psychological harm when they were touched inappropriately without consent by a staff member and continued to ruminate on the incident. This failure placed other residents at risk of sexual, verbal, and mental abuse, psychological harm, and diminished quality of life. Findings included . <Facility Policy> The facility's Abuse Prohibition and Prevention policy dated 01/2024, all residents receiving care and services at the facility had the right to be free from mistreatment including sexual, physical, mental, and verbal abuse. The policy defined sexual abuse as non-consensual sexual contact of any kind. The policy showed when a resident made an abuse allegation against a caregiver, that caregiver would be placed on administrative leave until the conclusion of the investigation. The policy showed if the allegation was substantiated appropriate corrective action would be taken. <Resident 110> According to the Admission Minimum Data Set (MDS - an assessment tool) dated 11/14/2024, Resident 110 had intact memory and experienced social isolation on rare occasions. The assessment showed Resident 110 required partial to moderate assistance with transferring from a chair to a bed and supervision/touching assistance for moving in bed. The MDS showed Resident 110 had a fractured right hip. The MDS showed Resident 110 was over [AGE] years old, and of petite stature. (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	Review of the facility's investigation dated 12/27/2024, showed the incident was reported to the facility on [DATE] and took place on 12/24/2024. The investigation showed the facility was notified by Resident 110's collateral contact that when they visited Resident 110 on Christmas Day 2024, the resident informed them that a male caregiver entered their room, kissed them, and attempted to climb into the bed . The investigation showed Resident 110 could demonstrate they knew the nationality of the caregiver, but they did not recognize them from any prior assignments on the unit. The investigation showed there was nothing in Resident 110's medication regimen contributing to the incident and noted Resident 110 journaled daily. The facility's investigation did not include Resident 110's journal entries but assessed that the habit of daily journaling made Resident 110 a reliable reporter. The investigation showed Staff D (Social Services Director) presented Resident 110 with a photo array of all staff working the third floor the morning of 12/24/2024 and the resident without hesitation identified Staff I (Certified Nursing Assistant - CNA) as the person who kissed them and tried to get into their bed, and Staff I was immediately removed from the schedule. The 12/27/2024 investigation showed Staff B (Director of Nursing) and Staff F (Director of Clinical Operations) interviewed Staff I via telephone and informed Staff I they were not permitted to return to the facility. Staff I had a vague recollection of working with Resident 110. The 12/27/2024 investigation concluded the incident occurred in the early morning of 12/24/2024. The 12/27/2024 investigation concluded that due to Resident 110's alert and oriented status, intact memory, daily journaling, and ability to without hesitation identify Staff I, it was reasonable to believe the resident's account was accurate and Staff I likely acted in an inappropriate manner toward the resident. In an interview on 01/02/2025 at 9:41 AM, Resident 110 was asked if they had any concerns with their care at the facility. Without hesitation, Resident 110 immediately directed the conversation to a specific incident that occurred before Christmas the prior month (10 days prior). Resident 110 stated a facility caregiver kissed them and tried to climb into their bed. Resident 110 stated nothing further happened, and they later told a family member who notified the facility. Resident 110 stated they knew the staff member was dismissed by the facility because of their behavior after Resident 110 made the allegation. In interviews on 01/08/2025 at 10:01 AM and 01/09/2025 11:22 AM, Resident 110 on both occasions recalled the incident unprompted. Resident 110 stated they were not fearful, but when asked how they felt, the resident consistently brought up the inappropriate touching/kissing incident. In an Interview with Staff B and Staff F on 01/08/2025 at 3:12 PM Staff B stated the facility used Washington State's Purple Book (nursing home guidelines for prevention of, protection from, and identification, investigation, and reporting of abuse.) Staff B stated the facility concluded Resident 110's claim was substantiated by the facility's investigation and Staff I was dismissed. Refer to: F607, F609, and F610. REFERENCE: WAC 388-97-0640 (1).

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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** 42203 Based on interview and record review, the facility failed to effectively implement policies addressing the prohibition and prevention of abuse for 2 of 5 residents (Residents 110 and 95) reviewed for abuse and one supplemental resident (Resident 124). The failure to implement abuse prohibition and prevention policies placed residents at risk for verbal and mental abuse, psychosocial harm, and diminished quality of life. Findings included . <Facility Policy> The facility's 01//2024 Abuse Prohibition and Prevention policy showed all residents receiving care and services at the facility had the right to be free from mistreatment including sexual, physical, mental, and verbal abuse. The policy defined sexual abuse as non-consensual sexual contact of any kind. The policy showed if the allegation was substantiated appropriate corrective action would be taken. The policy showed all suspected and alleged violations would immediately be reported to all required agencies. The policy showed when a resident made an allegation of suspected or alleged abuse, a thorough investigation would be completed. The policy showed a thorough investigation would include interviews with any witnesses and document details of the alleged event. The policy showed the facility would document the details of the occurrence in the record of all affected residents, including immediate interventions. <Resident 110> Review of a 12/27/2024 facility investigation of an incident reported to the facility on [DATE] showed the incident took place on 12/24/2024. The investigation substantiated Resident 110's allegation that they were kissed/inappropriately touched by Staff I (Certified Nursing Aide). The investigation did not indicate that Law Enforcement or the State's Department of Health were notified as per facility policy (and regulation.) The investigation did not include a background check for Staff I. The investigation did not include any interviews with any other potential witnesses or victims, neither facility staff nor residents as per facility policy. The investigation did not show if Staff I had worked on any other units and did not include a screening of other potentially affected residents. In an Interview on 01/08/2025 at 3:12 PM Staff B (Director of Nursing) stated the facility used Washington State's Purple Book (nursing home guidelines for prevention of, protection from, and identification, investigation, and reporting of abuse.) Staff B stated the facility concluded Resident 110's claim was substantiated by the facility's investigation and Staff I was dismissed. Staff B stated they did not report Staff I's inappropriate touching/abuse allegation to Law Enforcement or the Department of Health, as required. In an interview on 01/09/2025 at 10:29 AM Staff A (Administrator) stated the background inquiry, unit assignments, and resident interviews should have been included in the investigation for the investigation to be thorough. <Resident 95> (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation into a 12/24/2024 incident showed an incident occurred at 4:30 PM and was categorized as a non-injury fall. The investigation showed Resident 95 stated they tripped on themselves and bumped their head. The investigation included no witness interviews from other staff or residents. In an interview on 01/09/2025 at 11:07 AM Resident 95 characterized the incident as a slip on liquid on the ground thrown by another resident, rather them tripping and falling. Resident 95 stated Staff U (Long Term Care Registered Nurse) worked that shift. Resident 95 stated Staff U's their head was turned away but came to assist the resident within a minute. Resident 95 stated a dietary aide, or CNA was also present but could not recall whom as they were shaken up in that moment. Resident 95 stated they did not recall facility staff interviewing them as to what happened. <Resident 124> In an interview on 01/03/2025 at 12:37 PM Resident 124 reported to a surveyor that in the morning of the prior day (01/02/2024) in the 300 North dining room they backed their wheelchair into someone who cussed at them loudly and walked away. Resident 124 stated Staff U witnessed the incident, patted them on the head and told them to calm down. The allegation was immediately reported to Staff A who stated the facility would investigate the incident and provide the investigation once complete. Review of the 01/02/2025 investigation into this allegation showed this investigation did not include witness statements as directed by the facility's policy from other staff or residents in the area at the time who may have been able to confirm or refute Resident 124's experience of the incident. In an interview with Staff A and Staff B on 01/10/2025 at 10:45 AM Staff A stated the investigations for Residents 95 and 124 should have included witness statements from other potential staff and resident witnesses. Refer to F600, F609, & F610. REFERENCE: WAC 388-97 -0640(2).

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on interview and record review, the facility failed to ensure local Law Enforcement (LE) was notified for reasonable suspicion of a crime for 1 of 5 residents (Resident 110) reviewed for abuse. The failure to notify LE after substantiating an allegation of inappropriate touch/abuse placed residents at risk for verbal and mental abuse, psychosocial harm, and diminished quality of life. Findings Included . According to Appendix D of Washington State's Department of Social & Health Services Purple Book (Nursing Home Guidelines on prevention and protection, incident identification, investigation, and reporting), incidents involving staff-to-resident concerns must be reported to LE. Appendix D showed that circumstances where findings were made against licensed, certified, or registered health care workers the State Department of Health (DOH) must be notified. <Facility Policy> According to the facility's 01/2024 Abuse Prohibition and Prevention policy, all suspected and alleged violations would immediately be reported to all required agencies. <Resident 110> According to the Admission Minimum Data Set (MDS - an assessment tool) dated 11/14/2024, Resident 110 had intact memory and experienced social isolation on rare occasions. The assessment showed Resident 110 required partial to moderate assistance with transferring from a chair to a bed and supervision/touching assistance for moving in bed. The MDS showed Resident 110 had a fractured right hip. In an interview on 01/02/2025 at 9:41 AM, Resident 110 was asked if they had any concerns with their care at the facility. Resident 110 immediately directed the conversation to a specific incident that occurred before Christmas the prior month (10 days prior). Resident 110 stated a facility caregiver kissed them and tried to climb into their bed. Review of the facility's investigation into this allegation showed the incident was reported to the facility on [DATE] and took place on 12/24/2024. The investigation substantiated Resident 110's allegation that they were abused by Staff I (Certified Nursing Assistant) who was immediately dismissed. The investigation did not indicate that LE was notified for reasonable suspicion of a crime, or that DOH was notified of Staff I's conduct. In an interview on 01/08/2025 at 3:12 PM. Staff B (Director of Nursing) stated the facility used the Purple Book for guidance on investigation and reporting. Staff B confirmed they were a mandated reporter. Staff B stated they did not report the incident to DOH or LE according to the Purple Books guidance. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a follow up report filed with DSHS' Complaint Resolution Unit on 12/30/2024, Staff B reported the facility identified Staff I was the caregiver Resident 110 made an allegation against. Staff B's report misspelled Staff I's name and gave Staff I's middle name as their first name, and first name as their middle name in the report. Refer to: F600, F607, and F610. REFERENCE: WAC 388-97-0640(5)(a).

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on interview and record review, the facility failed to thoroughly investigate reportable incidents for 2 of 5 sample residents (Residents 110 & 95) reviewed for abuse, and one supplemental resident (Resident 124). The failure to thoroughly investigate allegation of abuse placed residents at risk of verbal and mental abuse, psychosocial harm, and diminished quality of life. Findings included . <Facility Policy> The facility's Abuse Prohibition and Prevention policy dated 01/2024, defined sexual abuse as non-consensual sexual contact of any kind. The policy showed when a resident made an allegation of suspected or alleged abuse, a thorough investigation would be completed. The policy showed a thorough investigation would include interviews with any witnesses and document details of the alleged event. The policy showed the facility would document the details of the occurrence in the record of all affected residents, including immediate interventions. <Resident 110> According to the Admission Minimum Data Set (MDS - an assessment tool) dated 11/14/2024, Resident 110 had intact memory and experienced social isolation on rare occasions. The assessment showed Resident 110 required partial to moderate assistance with transferring from a chair to a bed and supervision/touching assistance for moving in bed. The MDS showed Resident 110 had a fractured right hip. In an interview on 01/02/2025 at 9:41 AM, Resident 110 was asked if they had any concerns with their care at the facility. Resident 110 immediately directed the conversation to a specific incident that occurred before Christmas the prior month (10 days prior). Resident 110 stated a facility caregiver kissed them and tried to climb into their bed. Review of the facility's investigation into this allegation showed the incident was reported to the facility on [DATE] and took place on 12/24/2024. The investigation substantiated Resident 110's allegation that they were touched inappropriately by Staff I (Certified Nursing Assistant) who was immediately dismissed. The investigation included Staff I's CNA credentials but did not include a background check to show if Staff I had any disqualifying history that should have prevented them from working at the facility. The investigation showed Staff B (Director of Nursing) interviewed Staff I via telephone and included a statement from Staff D (Social Services Director). The investigation did not include any interviews with any other potential witnesses or victims, neither facility staff nor residents. The investigation did not show if Staff I had worked on any other units and did not include a screening of other potentially affected residents. The investigation showed it was completed by Staff T (Unit Manager, Registered Nurse) who worked at a sister facility but was acting as interim unit manager, and signed off by Staff B. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview at 01/08/2025 at 3:12 PM with Staff B, Staff F (Director of Clinical Operations), and Staff A (Administrator), Staff F stated they provided the copy of the investigation to Staff A to give to surveyors. Staff F stated Staff T did the investigation on site and Staff F retrieved the investigation from a digital folder and provided all the investigative materials available. Staff A stated they would verify if any witness/potential victim interviews were completed but believed Staff D (Social Services Director) did so and provided whatever documentation they could locate. Staff A stated they did not know if other staff were interviewed as potential witnesses. Staff A stated they would verify what assignments Staff I received when they worked at the facility. Staff A stated they would locate Staff I's background check. On 01/08/2025 at 3:29 PM Staff A called Staff T who stated they spoke with the nurse on duty on the unit, and Staff D, but no CNAs. Staff D stated they wrote a progress note to document they interviewed the residents with intact memories on Resident 110's unit (300 North). On 01/09/2025 at 10:29 AM Staff A provided documentation of Staff I's assignments. This documentation showed between 10/23/2024 through 12/27/2024 Staff I worked on seven of the facility's nine units. Staff A provided a printout of the email showing Staff D attempted to interview five residents, all on the 300 North unit. Of those five residents, Staff D documented two residents were unable to be interviewed, one of which was due to the resident's advanced dementia. Staff A also provided Staff I's background inquiry and stated they reached out to Staff I's staffing agency to obtain the background information. Staff A stated residents on the six other units should have been, but were not, interviewed to determine if they were witness to, or negatively impacted by Staff I's conduct. Staff A stated the background inquiry, unit assignments, and resident interviews should have been included in the investigation. <Resident 95> According to the 11/06/2024 Quarterly MDS, Resident 95 had intact memory and impaired vision. The MDS showed Resident 95 had no delusions or hallucinations and exhibited no behavioral symptoms. The MDS showed Resident 95 used a cane and a walker to assist their ambulation. The MDS showed Resident 95 had no falls since the prior assessment. In an interview on 01/02/2025 at 9:28 AM Resident 95 described that on Christmas Eve, 2024 at dinner time they intervened when a resident threw a hot beverage at Resident 124. Resident 95 stated they slipped on the spilled beverage, fell and banged their head on the edge of a table. Resident 95 stated they experienced no negative outcomes from the fall and head bump. Resident 95 was unsure of the exact name of the resident who threw the beverage but could provide identifying details. According to a 12/24/2024 progress note Resident 95 had an unwitnessed fall on 12/2024 after slipping and bumping their head. Review of the facility's December 2024 Incident Log showed a 12/24/2024 entry for Resident 95 that indicated the resident had a fall. There was nothing logged showing a resident-to-resident interaction occurred. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's investigation into the 12/24/2024 incident showed the incident occurred at 4:30 PM and was categorized as a non-injury fall. The investigation showed Staff U (Long Term Care Registered Nurse) found Resident 95 on the dining room floor near the television. The investigation showed Resident 95 stated they tripped on themselves and bumped their head. The investigation included no witness interviews from other staff or residents. The investigation was completed by Staff T but was not signed by either Staff T or Staff B. In an interview on 01/09/2025 at 10:57 AM Resident 124 corroborated Resident 95's recollection of the incident. Resident 124 stated a resident threw a hot beverage at them after they sat in the resident's favorite chair, and Resident 95 slipped on the spilled drink while trying to intervene. Resident 124 stated Staff U was the nurse on duty at the time. Resident 124 stated Staff U patted them on the head and told them to avoid the resident. In an interview on 01/09/2025 at 11:07 AM Resident 95 stated Staff U was working that shift, but their head was turned away, but came to assist the resident within a minute. Resident 95 stated a dietary aide or CNA was also present but could not recall whom as they were shaken up in that moment. Resident 95 stated they did not recall facility staff interviewing them as to what happened. Resident 95 reaffirmed they slipped and did not trip. Resident 95 expressed frustration that the facility's characterization of the incident could negatively impact their independence, which was important to them. In an interview with Staff A and Staff B on 01/10/2025 at 10:45 AM Staff A stated the investigation did not but should have included statements from potential witnesses. Staff A stated the dining room where the incident occurred was typically occupied throughout the day. Staff B stated that Resident 95 gave a very different description of what happened when originally interviewed, and there was no way to prove what happened. Staff B was unsure why Resident 95 changed their story. When asked if there would be clearer understanding of what happened if other residents and staff were interviewed, Staff B said witness interviews would be helpful to determine what happened. Staff B stated that in their role as Director of Nursing, they were ultimately responsible for ensuring investigations were thorough. <Resident 124> According to the 01/04/2024 Quarterly MDS, Resident 124 had adequate speech and vision and moderate memory impairment. The MDS showed Resident 124 exhibited no behavioral symptoms and did not experience hallucinations or delusions. In an interview on 01/03/2025 at 12:37 PM Resident 124 reported to a surveyor that in the morning of the prior day (01/02/2024) in the 300 North dining room they backed their wheelchair into someone who cussed at them loudly and walked away. Resident 124 stated Staff U witnessed the incident, patted them on the head and told them to calm down. The allegation was immediately reported to Staff A who stated the facility would investigate the incident and provide the investigation once complete. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505182	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Mount St Vincent	4831 35th Avenue Southwest Seattle, WA 98126

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 01/02/2025 investigation showed Resident 124 backed their wheelchair into another resident on the unit who blurted a common expletive. The investigation showed Staff B interviewed Staff U via telephone. Staff U stated to Staff A who stated the incident occurred when the second resident was trying to pass behind Resident 124. Staff U denied any physical contact between the two residents. Staff B also called Staff BB (RN) who interviewed the other resident. The investigation did not indicate Staff BB was present at the time. The investigation included a statement from Staff D who interviewed Resident 124 who stated the other resident bumped into them and cussed at them. Staff D's statement showed Resident 124 informed them Staff T comforted them and patted them on the shoulder rather than their head. Staff D stated they interviewed the other resident who could not recall the incident. The investigation ruled out abuse as the incident was witnessed and Resident 124 made differing statements. The investigation did not include witness statements from other staff or residents in the area at the time who may have been able to confirm or refute Resident 124's experience of the incident. The investigation showed it was completed by Staff F, Staff B, Staff A, and Staff T. No staff signed off on the investigation as complete. In an interview with Staff A and Staff B on 01/10/2025 at 10:45 AM Staff A stated the investigation should have included witness statements from other potential staff and resident witnesses. REFERENCE: WAC 388-97-0640 (6)(a)(b).