STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Providence Mount St Vincent		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0626 Level of Harm - Actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44296 Based on interview and record review, the facility failed to permit 1 of 3 residents (Resident 1) reviewed for hospitalization to return to the facility after a facility-initiated transfer to the emergency room (ER). Resident 1 experienced psychological harm when they experienced a two-week long hospitalization delay while another nursing facility could be arranged for discharge, anxiety related to being placed in an unfamiliar environment, expressions of fear of homelessness and hopelessness when the facility failed to permit the Resident 1 to return to the facility and resume residency when they were medically cleared by the hospital to discharge. Findings included . Review of the 10/22/2024 Quarterly Minimum Data Set (MDS, an assessment tool) showed Resident 1 had a chronic, progressive neurological disease, was cognitively intact, had a feeding tube in their abdomen for nutrition, required assistance from staff for all personal care and mobility. Review of a facility nurse progress note, dated 01/15/2025 8:40 PM, showed the emergency room (ER) nurse called the facility nurse to give a status report on Resident 1 who was ready for discharge from the ER. The note showed the ER was ready to send Resident 1 back to the facility by ambulance. The progress note showed the facility nurse notified the ER nurse that Resident 1's room was cleared of all their belongings and the room was no longer available as directed by the facility management. The progress note showed the ER charge nurse confirmed Resident 1 would then be admitted to the hospital instead of returning to the facility. Review of a facility physician progress note, dated 01/20/2025 for an assessment completed on 01/15/2025, showed Resident 1 required a higher level of medical treatment that could not be provided at the facility. The note showed the physician directed the facility staff to send Resident 1 to the ER for evaluation of a possible abdominal infection and a required replacement of the feeding tube. (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 0626 Level of Harm - Actual harm Residents Affected - Few	In an interview on 01/24/2025 at 4:15 PM, Staff A (Administrator) stated Resident 1 went to the ER for a blockage in their feeding tube and there was concern by the facility physician about an infection. Staff A stated Resident 1's representative declined a bed hold due to the cost, but the facility would readmit Resident 1 to an available long-term bed when Resident 1 was medically stable to return. Staff A stated they had received messages from and made calls to the hospital and was told Resident 1 was admitted . Staff A stated they were not aware if the hospital sent a referral to the facility to arrange Resident 1's return home. Staff A stated the facility admissions team usually follows up with the hospital to have residents return when they were ready for discharge from the hospital. In an interview on 01/28/2025 at 4:40 PM, Staff D (Admissions Assistant) stated on 01/15/2025 an internal communication directive was sent that Resident 1 would not be readmitted from the hospital. Staff D stated they received and reviewed the hospital referral on 01/16/2025 for Resident 1 to return to the facility. Staff D stated they informed the hospital discharge coordinator on 01/16/2025 that the admissions staff was not allowed to bring Resident 1 back to the facility. In an interview on 01/29/2025 at 3:51 PM, Collateral Contact 1 (CC1, Hospital Discharge Coordinator) stated Resident 1 arrived at theER on [DATE] for a dislodged feeding tube, the tube was replaced on that day and Resident 1 was supposed to return to the facility on [DATE]. CC1 stated Resident 1 did not need to be admitted to the hospital but remained in the hospital from 01/15/2025 until 01/29/2025. CC1 stated they had a phone call on 01/16/2025 with the facility admissions assistant who stated the facility would not accept Resident 1 back. In an interview on 01/30/2025 at 12:38 PM, Resident 1's Representative (RR) stated they received a phone call and voice mail from Resident 1 on 01/15/2025 at 8:33 PM. RR1 stated Resident 1 was crying and stated in their message I am at the end of my rope .I am at the hospital . I had my tube replaced . I have been dumped . I no longer have a place to live . as soon as I left, they were packing up my stuff .the reason they were pushing me out the door today was so they could pack me up and now I am homeless .I don't know .I'm flat out giving up . I do not care whether I live . I can't live anymore . I am staying overnight; they lied to me about getting an ambulance to go home. The RR stated they spoke with Resident 1 on the phone on 01/16/2025 and described Resident 1 as very discouraged, talking about suicide, resenting all the mistreatment she had received. The RR stated Resident 1 explained they did not want to go to the ER and wanted to schedule an appointment to have the tube replaced but their request was refused and Resident 1 was sent to the ER against their will. The RR stated they only heard from the facility social worker on 01/15/2025 to ask about a bed hold but there was no other contact made to have Resident 1 return to their home. The RR stated Resident 1 left the hospital and went to a different nursing facility on 01/29/2025 and they did not have a phone. In an interview on 01/30/2025 at 1:17 PM, Collateral Contact 2 (CC2, Hospital Physician) stated they had a conversation with Resident 1 on 01/15/2025 after Resident 1 was informed they would not be returning to the facility. CC2 stated Resident 1 explained they were upset and not given any notice of going to the ER, Resident 1 stated they were frustrated and felt like the facility was planning to move them without talking to them about it. CC2 stated Resident 1 was tearful and said they were dumped at the hospital and did not know what to do now. CC2 stated they called the facility twice, left one voicemail to ask for a call back, and did not receive any calls from the facility. (continued on next page)

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F 0626 Level of Harm - Actual harm Residents Affected - Few	In an interview on 02/07/2025 at 11:45AM, Staff E (Resident Care Manager) stated they could not find any discharge transfer sheets or progress notes in Resident 1's record. Staff E stated they worked on the transfer of Resident 1 to the ER with another nurse. Resident 1 was transferred about 8:00 AM. Staff E stated they called the hospital ER nurse to provide information about the feeding tube and relay concerns of infection. Staff E stated they do not make any decisions about when or if residents return from the hospital. Staff E stated Staff B (Director of Nursing) and Staff C (Director of Clinical Operations) made all the decisions for resident readmission from the hospital. Staff E stated Resident 1's belongings were packed and remained in their room for about four or five days after they left. Staff E was told Resident 1 would not be returning and their belongings were moved to another location so another resident could move into Resident 1's old room. Staff E stated Resident 1's room was not occupied by another resident until 01/27/2025, 12 days after Resident 1 went to the ER. In an interview on 02/07/2025 at 4:17 PM with Staff A, Staff B, and Staff C, Staff A stated the facility was committed to providing continued care to the residents they serve as part of their mission. Staff A stated the facility should ensure when a resident was sent to the hospital the resident would be allowed to return, either through a bed hold to the same room or return to another available bed, for continued care. Staff A stated Resident 1 should have returned to the facility when they were medically cleared by the hospital for discharge. REFERENCE: WAC 388-97-0120(4)(b).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44296 Based on observation, interview, and record review the facility failed to provide an environment that was free from hazards for 2 of 4 residents (Resident 2 and 3) reviewed for accidents. The failure of staff to intervene when Resident 2 was using cannabis (an illegal drug that causes an altered mental status) through a vape pen (a device that heats the drug to a consistency to inhale through the lungs) and allowed secondary exposure of cannabis to the roommate, staff, and placed residents at risk of harm from fire, injury, exposure to an illegal drug, and diminished quality of life. Findings included . The 10/18/2024 Admissions Minimum Data Set (MDS, an assessment tool) showed Resident 2 was cognitively intact and rarely needed assistance with health literacy. The MDS showed Resident 2 had multiple medically complex conditions including pain and limited mobility. The MDS showed Resident 2 was assessed to require maximum assistance from staff for personal care and mobility. Review of the 10/11/2024 Admission Agreement - Smoking Policy Acknowledgement showed the facility was a non-smoking campus and smoking was not allowed anywhere in the buildings or on the property of the facility. Resident 2 checked the box next to the statement I am a smoker or have a history of smoking and I understand [the facility] is a non-smoking campus. I agree that I will not possesses cigarettes or smoking materials. I will not smoke any tobacco or cannabis products while residing at [the facility] and understand compliance with this agreement can result in immediate and involuntary discharge from [the facility]. The agreement was verbally acknowledged and signed by a witness on 10/11/2024. Review of the 12/08/2024 3:11 PM nursing progress notes showed Resident 2 was using a can of air freshener to cover up the smell of cannabis in the room. The note showed the nurse intervened and removed cigarettes and vape supplies from the resident's room and reported to the facility management. Review of the 12/08/2024 11:14 PM nurse progress note showed Resident 2's room smelled of cannabis, Resident 2 covered their mouth and face with a teddy bear when the nurse entered the room. The note showed the nurse asked why Resident 2 was vaping after prior warnings. The note showed Resident 2 begged the nurse not to say anything. The note showed Resident 2 gave the nurse one empty vape pen and one full vape pen. The note showed the nurse reported to the on call supervisor. Review of the 12/09/2024 care plan (CP) showed Resident 2 was at risk for injury due to non-compliance with the nonsmoking policy; Resident 2 would not smoke or vape inside or outside of the facility; Resident 2 would understand the smoke/vape free policy. The CP intervention showed staff would discuss with Resident 2 the smoke free policy and alternatives for smoking or vaping. Review of the undated Kardex Summary (care instructions to caregivers) for Resident 2 showed Remind of nonsmoking/vaping policy. Staff to alert nurse / neighborhood coordinator as indicated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a 12/10/2024 10:02 AM social services progress note showed a discussion with Resident 2 about the facility policy of no smoking and if vaping continued a transfer to another facility would be necessary. The progress note showed Resident 2 acknowledged the policy and denied vaping. Review of a 12/18/2024 11:52 AM social services progress note showed Resident 2 was issued a 30-day notice to discharge related to vaping cannabis in their room after prior instructions from staff about the facility policy on no smoking and safety concerns. Review of a 12/20/2024 3:37 PM nurse progress note showed Resident 2 was spraying a can of air freshener and put something under their covers when the nurse entered the room. The progress note showed The smell of cannabis reeking from [Resident 2's] side of the room, nurse did not question or search [Resident 2] . [Resident 2] was not able to stay aroused after shaking and arousing them. Review of a 01/18/2025 2:35 PM nurse progress note showed Resident 2 had visitors, and after they left the room and into the hallway reeked of cannabis, Resident 2 looked intoxicated, eyes were red and small the nurse did not question Resident 2 about this activity and did ask if Resident 2 had possession of any substances. The progress note did not show if substances were present or removed from the resident. Review of a 01/19/2025 3:23 PM progress note showed night shift reported Resident 2 was vaping, the cannabis odor could be smelled in the hallway, the day nurse went into the room and saw Resident 2 was vaping. The note showed Resident 2 saw the nurse and hid the vape pen under their sheets. The note showed the nurse reported to the supervisor and Resident 2 kept the substances in their possession. Review of a 01/25/2025 4:19 PM nurse progress note showed the nurse went into Resident 2's room, the room reeked of cannabis, Resident 2 was giddy and eyes were red. The note showed the nurse did not confront Resident 2 about vaping. Review of a 01/26/2025 3:36 PM nurse progress note showed the nurse went into Resident 2's room, Resident 2 had just completed vaping as the room was cloudy and malodorous of cannabis, the nurse addressed the situation with Resident 2 who did not deny vaping and stated they opened the window. In an observation and interview on 01/28/2025 at 2:55 PM, Resident 2 was in bed, wearing oxygen tubing in their nose connected to a concentrator (a machine that produces oxygen-enriched air) on the floor. Resident 2 had a roommate (Resident 3) who lived on the door side of the room. Resident 2 stated they were given a 30-day notice to discharge because the facility staff reported they were vaping cannabis in their room. Resident 2 stated they in fact were vaping cannabis and was aware that they were breaking the facility non-smoking rules. Resident 2 would not answer when the last time they vaped in the room or if they had vaping supplies in their possession at the time of the interview. In an observation and interview on 01/28/2025 at 2:57 PM, Resident 3 was lying in a low bed, lowered to the floor, covered with the sheets and blanket. Resident 3 opened their eyes when greeted. Resident 3 was asked how they were doing, how they were feeling, and if they had any concerns. Resident 3 did not answer any of the questions and closed their eyes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/29/2025 at 10:52 AM with Staff A (Administrator), Staff B (Director of Nursing), and Staff C (Director of Clinical Operations) Staff A, B and C were asked to review the progress notes from 01/18/2025 through 01/26/2025 regarding Resident 2's vaping cannabis. Staff A, B and C were asked what action the facility took when the nurse discovered Resident 2 continued to vape in their room. Staff A stated the nurse should have removed the vape materials and reported to the supervisor. Staff A was asked if the materials were removed and the supervisor was notified. Staff B was asked if Resident 2 was assessed for safety of vaping. Staff B stated they would look at the records and provide the assessment if it was completed. No assessment was provided. In an interview on 01/29/2025 at 4:40 PM, Staff A stated Resident 2 still had vape supplies in their possession and gave them to the facility management 01/29/2025. REFERENCE: WAC 388-97-1060(3)(g).