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 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on observation, interview, and record review the facility failed to provide care and services in a manner that maintained and promoted resident rights and dignity for 10 (Residents 56, 170, 69, 18, 15, 92, 85, 22, 164, & 70) of 35 sample residents. The failure to provide dignity during dining services including administration of medications in the dining room (Residents 56, 170, 69, 18, 15, 92 & 300 South Dining Room), provide privacy (Residents 85 & 22), and provide care in a dignified manner (Resident 70 & 164) placed residents at risk for a diminished sense of self-worth and well-being. Findings included . <Facility Policy> Review of the 08/2017 Facility Admission Agreement showed residents had the right to be treated with respect and dignity. According to the 11/2023 revised . Standards of Care facility policy, staff would close a resident's door or curtain for privacy when providing care. <Dining Services> <Resident 56> Observations of meal services in the dining room on 01/07/2025 at 8:36 AM showed staff deliver a breakfast tray to Resident 56. There was plastic wrap covering the resident's coffee and water. Staff asked Resident 56 if they would like the plastic wrap removed from their coffee cup, Resident 56 stated, yes, from everything. Staff only removed the plastic wrap from the coffee cup, left the water cup, and walked away without saying anything further. In an interview on 01/09/2025 at 12:55 PM, Staff GG (Supervisor Food Services) stated they were surprised to hear the residents were being served their food and/or drinks with plastic wrap in the dining room and stated staff should have assisted to remove the wrap for the residents. <Resident 170> (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations of meal services on 01/03/2025 at 8:46 AM showed staff delivering a breakfast tray to Resident 170's room. Staff placed the tray on the bedside table, picked up straws, and punched them through the plastic wrap that covered the cups during tray delivery. The staff did not offer to remove the plastic coverings from the cups prior to exiting the room. In an interview at this time, Resident 170 stated they preferred to drink fluids without a straw and were unsure why staff always put straws through the plastic wrap when serving. In an interview on 01/09/2025 at 12:55 PM, Staff GG stated it was their expectation staff provided assistance to remove the plastic wrap when the food was served. <300 South Dining Room> Observation on 01/02/2025 at 12:10 PM showed dietary staff distributing lunch to residents. Each resident on the unit and in the dining room was provided a glass of ice water. Each glass was covered in clear plastic wrap and was punctured with a drinking straw. In an interview on 01/09/2025 at 12:55 PM Staff GG stated it was necessary to cover drinks as they moved through the hallway. Staff GG stated it was not necessary to leave the plastic wrap on for residents taking their meal in the dining room. <Resident 69> Observations of meal services on 01/02/2025 at 12:28 PM, showed Resident 69 eating lunch in the dining room. Staff J (Licensed Practical Nurse - LPN) brought medications in a cup into the dining room and handed the medications to Resident 69. Staff J stood by the table until Resident 69 took their medications. Six other residents were eating their lunch nearby. In an interview on 01/10/2025 at 12:25 PM, Staff K (Manager Long Term Care - Registered Nurse) stated medications should not be administered in the dining room during meal service as it was a dignity concern. <Resident 18> According to the 10/31/2024 Comprehensive Minimum Data Set (MDS - an assessment tool), Resident 18 had severely impaired memory and decision-making ability. Observation on 01/02/2025 at 12:04 PM showed Resident 18 in the dining room waiting for lunch. Staff V (LPN) approached Resident 18 and attempted to give them their medication. Resident 18 shook their head, declining to take their medications at that time. Staff V loudly stated; Ok how about we make a deal, I'll come back. Resident 70 was sitting at the next table over and observed the interaction with Staff V and Resident 18 and was engaging with Staff V about Resident 18 declining their medications. In an interview on 01/10/2025 at 12:44 PM, Staff B (Director of Nursing) confirmed administering medications in the dining room was a dignity concern for Resident 18. <Resident 15> (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 12/07/2024 Discharge MDS, Resident 15 had (diabetic) unstable blood sugars and required the use of insulin (injectable diabetic medication) during the assessment period. Review of a 12/29/2024 physician order showed Resident 15 was to receive two insulin injections and have a finger stick blood sugar check before each meal for diabetes. Observations of the dining room lunch service on 01/02/2025 at 12:05 PM showed Staff J performing a finger stick blood sugar test at the dining room table for Resident 15. Staff J placed the blood sugar meter down on the dining room table and gave Resident 15 the insulin injection where other residents were also eating their lunch. In an interview on 01/10/2025 at 10:43 AM, Staff K stated the nursing staff should not give insulin injections or conduct blood sugar finger stick testing while residents were in the dining room. Staff K stated this was important for privacy and for infection control purposes. In an interview on 01/10/2025 at 12:54 PM, Staff B stated staff should not give medications while residents were in the dining room because of dignity reasons. <Resident 92> An observation on 01/02/2025 at 12:34 PM showed Staff L (Certified Nursing Assistant) feeding Resident 92 in the dining room on unit 5 North. At this time, Staff L was standing over Resident 92 while assisting them with feeding. Staff L was observed to bend over, getting six inches face to face with Resident 92, to check if they were done chewing the last bite they had in their mouth only seconds after giving them each bite of food. Staff L informed Resident 92 their appointment transportation arrived to pick them up, so they had to stop eating with half of their lunch tray remaining. In an interview on 01/02/2025 at 12:52 PM Staff L stated they were not allowed to sit while feeding residents per management instructions. In an interview on 01/09/2025 Staff B stated they expected staff to assist feeding residents with dignity, pausing between bites, not feeding them fast, and sitting at eye level. Staff B stated it was important to assist residents in this manner for their dignity. 45941 <Privacy> <Resident 85> According to the 11/07/2024 Admission MDS, Resident 85 was readmitted to the facility on [DATE] and required extensive assistance of one staff for eating and had greater than 51% of their intake through Tube Feeding (TF- a tube inserted into the stomach which liquid nutrition was instilled). Observation on 01/07/2025 at 10:16 AM showed Resident 85 lying in bed in their room. Staff V was providing nutritional formula via TF to Resident 85. The observation showed the resident's door was open and the privacy curtain was not pulled. Resident 85 was visible from the hallway. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/09/2025 at 12:20 PM, Staff B stated they expected staff to provide privacy to residents during care. <Resident 22> Observation on 01/07/2025 at 1:31 PM and 01/08/2025 at 8:40 AM showed Resident 22 lying in bed with a catheter bag hanging from the bottom of the bed frame with no privacy cover. This bag had urine in it and was visible from the hallway. Review of a 12/24/2024 catheter care plan directed staff to keep Resident 22's catheter drainage bag covered to promote dignity. In an interview on 01/10/2025 at 12:25 PM, Staff K stated it was their expectation catheter bags be covered to promote a resident's dignity. 46479 <Providing Care in a Dignified Manner> <Resident 70> Review of Resident 70's 10/11/2024 Quarterly MDS showed the resident did not have problems with their memory or cognition. The MDS showed Resident 70 had diagnoses of a mood disorder. The MDS showed Resident 70 did not refuse care during the assessment period. Observation on 01/02/2025 at 12:20 PM showed a sign posted in the hallway next to Resident 70's room. The sign read Food delivery: Please go back to nurse station and take photo of delivered food on the desk. Then take food to room. This is to ensure that food is noted as delivered. Similar observations on 01/06/2025 at 8:58 AM, 01/07/2025 at 2:09 PM, and 01/08/2025 at 9:44 AM showed the sign posted in the hallway outside of Resident 70's room. In an interview on 01/08/2024 at 12:47 PM, Resident 70 stated they were aware of the sign but did not know why the sign was posted outside of their room. Resident 70 stated the nurses did not seem to know what the sign was about. Resident 70 stated the sign bothers me, I don't know what it means, it's just rude. In an interview on 01/10/2025 at 12:20 PM, Staff B stated Resident 70 ordered outside food to be delivered to them on occasion. Staff B stated the sign was protection for facility staff. When asked about the resident's right to dignity and privacy, Staff B stated they were doing the best they could. 47836 <Resident 164> In an interview on 01/03/2025 at 10:31 AM Resident 164 stated they had appealed their declination of rehabilitation services through their insurance prior to Christmas and were still waiting to hear the results. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/07/2025 at 9:05 AM Resident 164 stated they still had not heard anything regarding their appeal. Resident 164 stated they were very frustrated since all they had been doing was lying in bed since their last therapy session on 12/20/2025. Resident 164 expressed concerns about declining in their mobility status. In an interview and record review on 01/08/2025 at 8:58 AM Resident 164 stated Staff M (Social Worker) brought them a copy of an appeal denial yesterday afternoon. Review of the appeal denial paperwork showed a date of 12/23/2024. Resident 164 stated Staff M reported they received the denial 12/23/2024 but did not realize the insurance company mailed it to the resident's home address and not directly to the resident at the facility. In an interview on 01/08/2025 at 12:13 PM Staff M stated they informed Resident 164 of the appeal denial yesterday. Staff M stated they had received the appeal results 12/23/2024 but let the insurance notify the resident. Staff M stated the insurance company mailed the results of the appeal to Resident 164's home address. Staff M stated they should have notified the resident of the results of their appeal immediately upon receiving 12/23/2024 as that was good process but did not. In an interview on 01/10/2025 at 12:35 PM Staff A (Administrator) stated they expected staff to notify residents immediately of their appeal results. Staff A stated it was important to inform the resident because it impacted their stay and finances. REFERENCE: WAC 388-97-0180(1-4). 50511 42203 51791

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 43642 Based on observation, interview, and record review the facility failed to allow 3 (Resident 22, 142, & 170) of 4 residents reviewed for choices, the right to make choices regarding important daily routines and health care, including accommodating preferences for the frequency and/or type of bathing, and 1 supplementary resident (Resident 100). The facility's failure to accommodate resident choice placed these residents at risk for a diminished quality of life. Findings included . <Resident 22> According to a 12/12/2024 Quarterly MDS, Resident 22 had multiple medically complex diagnoses including stroke, had clear speech, was able to understand, and be understood by others. This MDS showed it was very important to Resident 22 to choose between a tub bath, shower, bed bath, or sponge bath, was dependent on staff for bathing, and had no rejection of care. In an interview on 01/06/2025 at 10:03 AM, Resident 22 indicated they could not remember the last time they had a shower and stated, bathing is not as often as it used to be. Resident 22 stated they preferred bathing more often. Review of Resident 22's Kardex (directions to staff regarding how to provide care) as of 01/06/2026 showed directions to staff that the resident was to receive a tub bath in the morning on Thursdays. Review of Resident 22's hard chart showed a blank Move-In and change of Neighborhood Checklist. This form had questions which included the resident's daily routines and preferences regarding bathing but these questions were not answered. Review of the December 2024 Activities of Daily Living (ADL) documentation showed Resident 22 only received one shower out of four bathing opportunities in December. Staff documented the resident received a bed bath on three of the four opportunities rather than a tub bath preffered by Resident 22 and as indicated on the Kardex. Review of the January 2025 ADL documentation showed staff documented Resident 22 received a bed bath on 01/01/2025, rather than a tub bath as indicated on the Kardex. <Resident 142> According to a 11/14/2024 Quarterly MDS, Resident 142 had clear speech, was able to understand, and be understood by others, and had intact memory. This MDS showed it was very important to Resident 142 to choose between a tub bath, shower, bed bath, or sponge bath, was dependent on staff for bathing, and had no rejection of care. In an interview on 01/06/2025 at 8:35 AM, Resident 142 stated, it would be nice to do [showers] more than once a week. Resident 142 stated they have talked with staff about their preference for more showers. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 142's Kardex as of 01/06/2026 showed directions to staff the resident was to receive a shower in the morning on Sundays. Review of Resident 142's hard chart showed a blank, Move-In and change of Neighborhood Checklist. This form had questions which included the resident's daily routines and preferences regarding bathing. This form had unanswered questions which included the resident's daily routines and preferences regarding bathing but these questions. Review of the December 2024 ADL documentation showed Resident 142 only received two showers out of four opportunities on Sunday mornings in December, less than scheduled and less than Resident 22's stated prefernce from the 01/06/2025 interview. Review of the January 2025 ADL documentation between the 1st through the 8th showed staff documented Resident 142 only received a tub bath on 01/02/2025, rather than a shower as indicated on the Kardex. <Resident 170> According to a 12/11/2024 Admission MDS, Resident 170 had clear speech with intact memory. This MDS showed it was very important to Resident 170 to choose between a tub bath, shower, bed bath, or sponge bath, was dependent on staff for a bed to chair transfer, and had no rejection of care. In an interview on 01/02/2025 at 9:03 PM, Resident 170 stated they were only receiving bathing once a week, and stated, that is not enough, it is a big problem, I like to be clean. In an interview on 01/03/2025 at 8:34 AM, Resident 170 stated they tried to talk with staff about bathing and stated, I would really love to bath more often. Review of a 12/23/2024 ADL Care Plan (CP) showed an identified a goal for Resident 170 was their ADL needs would be met and gave directions to the staff to assist Resident 170 with all ADLs and to see the Kardex for level of assistance needed. Review of Resident 170's Kardex as of 01/06/2025 showed no directions to staff for bathing type or frequency, only that the resident was dependent on staff for bathing. Review of Resident 170's hard chart showed no preference form was completed in the resident's records. In an interview on 01/08/2025 at 9:17 AM, Staff WW (Certified Nursing Assistant) stated the staff only do one bath a day in their section in the mornings and the residents were scheduled for bathing once a week. Staff WW stated if a resident wanted bathing more often, they would work with the resident, but indicated the CNAs have many duties, including dining services daily, which makes it difficult to get everything done. Review of the unit shower schedule showed all 22 residents on the unit were only scheduled for once a week bathing. In an interview on 01/10/2025 at 12:25 PM, Staff K (Manager Long Term Care - Registered Nurse) stated it was their expectation resident preferences be followed, preference forms were completed, and for staff to document any changes or refusals for bathing. 42203 (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 100> According to the 11/18/2024 Annual Minimum Data Set (MDS - an assessment tool) Resident 100 used a wheelchair and was dependent on staff for transfers and bathing. The MDS showed Resident 100 had medically complex diagnoses including a rash. In an interview on 01/03/2025 at 10:29 AM Resident 100 stated they did not to get a choice about the type of bathing the facility provided them. Resident 100 stated their preference was for a bath but they were only offered a bed bath. Review of the bathing records from 12/01/2024 through 01/06/2025 showed Resident 100 received a bed bath on 12/07/2024, 12/14/2024, 12/22/2024, and 12/28/2024. The records showed Resident 100 refused bathing on 12/12/2024 and 12/27/2024. There was no record showing Resident 100 was offered their preference for bathing. REFERENCE: WAC 388-97-0900(1-4).

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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. 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. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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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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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).

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 01/10/2025
NAME OF PROVIDER OR SUPPLIER Providence Mount St Vincent		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 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.

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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.

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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)

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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).

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 45941 Based on interview and record review, the facility failed to ensure a system by which residents/representatives received required written notices at the time of transfer/discharge, or as soon as practicable for 2 of 7 residents (Residents 14 and 120) reviewed for hospitalization s. Failure to ensure written notification to the resident and/or the resident's representative of the reasons for the discharge in writing and in a language and manner they understood, placed residents at risk for a discharge that was not in alignment with the resident's stated goals for care and preferences. Findings included . <Facility Policy> Review of a 02/2022 facility's Bed Hold and Return to Facility policy, showed for the planned transfers, the facility would provide the transfer/discharge information before or at the time of the transfer. The policy showed for emergency transfers, the facility would contact residents or representatives to offer information within 24 hours. <Resident 14> Review of Resident 14's 11/14/2024 Discharge Return Anticipated Minimum Data Set (MDS - an assessment tool)showed Resident 14 discharged to an acute care hospital on 11/14/2024. Review of Resident 14's health records on 01/02/2025 showed no documentation staff provided the required written transfer notification within 24 hours to Resident 14 and/or their representative regarding their transfer to hospital. In an interview on 01/06/2025 at 12:12 PM, Staff D (Social Services Director) Stated their process was to provide a written notification to residents or their representatives the same day the residents go to the hospital, or the notification is emailed to them the next day. Staff D reviewed Resident 14's record and was unable to locate a written notification copy provided to Resident 14 during transferred to the hospital. In an interview on 01/10/2025 at 12:35 PM, Staff A (Administrator) stated they expected staff to provide written notification to residents/representatives in a timely manner during hospitalization . 47836 <Resident 120> According to a 08/15/2024 Discharge MDS Resident 120 discharged to an acute care hospital on 08/15/2024. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 120's health records on 01/03/2025 showed no documentation staff provided the required written transfer notification to Resident 120 and/or their representative regarding their transfer to the hospital. In an interview on 01/07/2025 at 12:55 PM Staff D reviewed Resident 120's records and stated there was no documentation that showed the written transfer notification was provided as required to Resident 120 or their representative. In an interview on 01/10/2025 at 12:35 PM Staff A stated they expected staff to provided written transfer notifications as soon as possible after the transfer and in a timely manner. REFERENCE: WAC 388-97-0120 (2)(a-d).

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on interview and record review, the facility failed to provide the resident and/or the resident's representative with a written notice of the facility's bed-hold policy, at the time of transfer or within 24 hours, for 2 of 7 sample residents (Resident 14 & 120) reviewed for hospitalization . This failure placed the residents and their representatives at risk of not being informed of their right to, and the cost of, holding the resident's bed while hospitalized that was necessary for decision-making. Findings included . <Facility Policy> Review of a 02/2022 facility's Bed Hold and Return to Facility policy, showed facility would provide residents and their representatives bed hold and return information at admission and before a hospital transfer or therapeutic leave. For the planned transfers, the facility would provide the bed hold information before or at the time of the transfer. The policy showed for emergency transfers, the facility would contact residents or representatives to offer bed hold within 24 hours. <Resident 14> Review of Resident 14's 11/14/2024 Discharge Return Anticipated MDS showed Resident 14 discharged to an acute care hospital on 11/14/2024. Review of Resident 14's health record showed Resident 14 was sent to the hospital on 11/14/2024 and readmitted to the facility on [DATE]. Review of Resident 14's health record showed no documentation that indicated a bed hold notification was provided to Resident 14 when they discharged to the hospital on 11/14/2024 as required. In an interview on 01/06/2025 at 12:12 PM, Staff N (Social Services Assistant) stated facility's bed hold process was to offer bed hold information to residents/representatives' same day when residents were sent out to a hospital. In an interview on 01/10/2025 at 12:35 PM, Staff A (Administrator) they expected staff to offer bed hold to residents/representatives in a timely manner when residents were sent out to a hospital. 47836 <Resident 120> According to a 08/15/2024 Discharge MDS Resident 120 discharged to an acute care hospital on 08/15/2024. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 120's health records showed they were transferred to an acute care hospital on 0815/2024 and returned to the facility on [DATE]. Review of Resident 120's health records showed no documentation that indicated staff provided a bed hold notification to Resident 120 when they discharged [DATE] as required. In an interview on 01/07/2025 at 12:55 PM Staff D (Social Service Director) reviewed Resident 120's records and stated there was no documentation staff provided the bed hold notification to Resident 120, or their representative as required. In an interview on 01/10/2025 at 12:35 PM Staff A stated they expected staff to provide a bed hold notification at time of transfer to the hospital or as soon as possible after the transfer. REFERENCE: WAC 388-97-0120 (4).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 43642 Based on observations, interview, and record review the facility failed to ensure 1 (Resident 170) of 35 residents Minimum Data Set (MDS- an assessment tool) were completed accurately to reflect the resident's condition. This failure placed residents at risk for unidentified and/or unmet needs. Findings included . <Resident 170> According to a 12/11/2024 Admission MDS, Resident 170 had multiple medically complex diagnoses including cancer. This MDS indicated Resident 170 did not have a life expectancy of less than six months and was not on hospice. Review of Resident 170's physician orders showed the resident was receiving an antianxiety medication for anxiety as part of a hospice comfort kit. Observations on 01/07/2025 at 1:35 PM showed Resident 170's hard chart at the nurse's station had stickers on the front indicating the resident was on hospice services. According to a 12/06/2024 hospice election statement form, Resident 170 was started on hospice services on 12/06/2024. In an interview on 01/10/2025 at 2:31 PM, Staff SS (Care Manager - Registered Nurse) stated the completion of an accurate MDS was how they identify resident problems/issues that needed to be addressed. Staff SS reviewed Resident 170's 12/11/2024 Admission MDS and stated it was inaccurate as hospice should have been coded, but was not. Staff SS stated capturing hospice care in the MDS was important because the goal was comfort-focused and they needed to ensure Resident 170's care plan aligned with the resident's wishes. Refer to F849 - Hospice Services. REFERENCE: WAC 388-97-1000(1)(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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47836 Based on observation, interview, and record review the facility failed to develop and/or implement comprehensive Care Plans (CPs) for 2 (Residents 428 & 93) of 35 sample residents whose CPs were reviewed. This failure placed residents at risk for unmet care needs, inappropriate care, and frustration. Findings included . <Resident 428> According to a 12/30/2024 Admission Minimum Data Set (MDS - an assessment tool) Resident 428 admitted to the facility on [DATE]. The MDS showed Resident 428 was frequently incontinent of bowels. Review of Resident 428's 12/30/2024 9:10 AM Infection Prevention & Control progress note Resident 428 admitted on [DATE] and was on enteric precautions (infection control measure designed to prevent transmission of pathogens through the fecal-oral route) at the hospital for diarrhea their entire hospital stay. The note showed the hospital ruled out any infectious origin, but Resident 428 was still experiencing diarrhea since admission to the facility. In an interview on 01/03/2025 at 8:55 AM Resident 428 stated they had frequent diarrhea which required an antidiarrheal medication for management. Resident 428 stated they were normally continent of bowels but were now frequently incontinent of stool since this hospitalization due to the diarrhea coming on quickly and without warning. During this interview Resident 428 pressed the call light to call for toileting assistance but in less than a minute was unable to wait and was incontinent of diarrhea. Review of Resident 428's CP showed no documentation of the unmanaged diarrhea. In an interview on 01/09/2025 at 9:40 AM Staff C (Infection Preventionist) stated Resident 428 was on enteric precautions their entire stay at the hospital but was ruled out as infectious so was removed from the precautions. Staff C stated Resident 428 still had issues with diarrhea but did not have a CP developed directing staff on how to care for this issue but should have. Staff C stated it was important to develop a CP for the frequent diarrhea to ensure Resident 428 stayed hydrated and to avoid skin breakdown. 43642 <Resident 93> According to a 12/26/2024 Annual MDS, Resident 93 was at risk for pressure ulcers and had no rejection of care. This MDS showed staff assessed Resident 93 used a walker for mobility, required supervision for transfers from bed, and was dependent on staff for dressing, putting on/taking off footwear, and personal hygiene. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 01/03/2025 at 9:27 AM and 01/06/2025 at 9:49 AM showed edema to both Resident 93's lower legs. Review of Resident 93's 12/26/2024 progress note showed edema was identified during an assessment and weights were being monitored. Review of Resident 93's comprehensive CP showed no problem was developed regarding the resident's lower leg edema. In an interview on 01/10/2025 at 12:25 PM, Staff K (Manager Long Term Care - Registered Nurse) stated it was their expectation staff address current resident conditions on a CP so staff are aware of interventions that should be in place for a resident. In an interview on 01/10/2025 at 1:43 PM, Staff B (Director of Nursing) stated it was their expectation staff develop a CP, implement interventions to monitor identified edema, and document findings on the weekly skin assessments. REFERENCE: WAC 388-97-1020(1), (2)(a)(b).

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F 0657

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47836

Based on observation, interview, and record review the facility failed to provide care conferences as required for 2 (Residents 427 & 28) of 35 sample residents whose Care Plans (CPs) were reviewed, and failed to ensure CPs were updated as needed to reflect changes in resident's care needs for 4 (Residents 22, 142, 170, & 7) of 35 sample residents whose CPs were reviewed. The failure to provide care conferences and to update CPs with changes in residents' health status placed residents at risk for unmet care needs, unnecessary care, and frustration.

Findings included .

<Facility Policy>

According to a facility policy titled, Resident Care Plan Reviews and Care Conferences, revised 04/2023, showed the facility would hold care conferences in accordance with regulatory requirements and as needed.

<Care Conference>

<Resident 427>

According to 01/01/2025 Admission Minimum data Set (MDS - an assessment tool) Resident 427 admitted to the facility on [DATE] without memory impairment.

In an interview on 01/02/2025 at 12:14 PM Resident 427 stated they did not have a care conference yet. Resident 427 stated staff did not schedule a care conference with them since admitting to the facility but they wanted one so they could understand their plan of care for their stay at the facility and get some questions answered.

In an interview on 01/08/2025 at 12:30 PM Staff M (Social Worker) stated the facility expected care conferences to be scheduled as needed or when the residents requested. Staff M stated Resident 427 did not request a care conference, so they did not schedule one for them.

50511

<Resident 28>

According to the Annual 11/20/2024 MDS, Resident 28 had medically complex conditions. Resident 28 could make themselves self-understood, could understand others, and did not have memory impairment.

According to the 02/19/2021 Communication Risk CP, Resident 28 had a communications deficit due to hearing loss. The CP showed a goal for Resident 28's care needs would be satisfactorily met through effective communication during their long-term care stay. The CP included interventions for staff to provide verbal communication with visual cues and to verify understanding with Resident 28.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review showed a 09/12/2024 Care Conference form. The form had a section showing who participated. This section did not indicate Resident 28 or their family member was invited to the 09/12/2024 care conference. Record review showed a 06/26/2024 Care Conference form for Resident 28. The form had a section showing who participated. This section did not indicate Resident 28 or their family member was invited to the 06/26/2024 care conference. In an interview on 01/03/2025 at 9:50 AM Resident 28 stated staff occasionally included them and talked about their care, but this was rare. In an interview on 01/09/2025 at 2:25 PM Staff K (Manager Long Term Care Registered Nurse) stated the facility offered quarterly and yearly care conferences, or more often if a resident requested one. Staff K stated the facility used the care conference form to invite residents and family members to their care conferences. Staff K stated the form should be used to invite Resident 28 to their care conferences but did not. In an interview on 01/09/2025 at 10:21 AM Staff D (Social Service Director) stated they expected care conferences to be done with the resident and/or representative, and interdisciplinary team including, but not limited to, a social worker, nursing, the provider, and the director of rehabilitation. Staff D stated they expected care conferences to be offered and held within five days of admission, quarterly, and as needed/requested. 43642 <CP Revison> <Resident 22> According to a 12/12/2024 Quarterly MDS, Resident 22 had multiple medically complex diagnoses including stroke, had clear speech, was able to understand, and be understood by others. This MDS showed Resident 22 was assessed with a functional limitation in range of motion to one side of their arms and legs. The MDS showed Resident 22 required set up assistance for eating, was dependent on staff for daily hygiene. According to the 12/29/2022 potential for oral health issues . CP, Resident 22 had no natural teeth and used upper dentures only. The CP directed staff to ensure Resident 22 wore their upper dentures. Review of the Kardex (care instructions for nurse's aides) as of 01/06/2025 showed Resident 22 used their lower dentures, rather the upper dentures identified on the CP. In an interview on 01/10/2025 at 12:25 PM, Staff K (Manager Long Term Care - Registered Nurse) stated the Kardex was inaccurate and needed to be updated to ensure Resident 22 received the assistance they needed with their dentures. <Resident 142> (continued on next page)

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F 0657

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

According to the 11/14/2024 Quarterly MDS, Resident 141 had intact memory. The MDS showed Resident 142 had diagnoses including malnutrition.

In an interview on 01/03/2025 at 8:51 AM Resident 142 stated they recently had all their teeth extracted and now used upper and lower dentures. Observations at this time showed Resident 142 had both upper and lower dentures in their mouth.

According to a 11/06/2024 progress note, Resident 141 had a dental appointment on that date. The note showed this appointment was for an extraction.

According to the 07/15/2024 at risk for nutritional status . CP, Resident 142 was at risk related to poor oral/dental status with broken teeth. Resident 142's goal was to be free of infection, pain, and bleeding in their oral cavity. This CP did not address Resident 142's denture use.

Review of the Kardex as of 01/07/2024 showed Resident 142's denture status was not addressed.

In an interview on 01/10/2025 at 12:25 PM, Staff K stated that Resident 142 required dentures. Staff K stated the resident's CP and Kardex should be updated to address the resident's dentures.

<Resident 170>

According to a 12/11/2024 Admission MDS, Resident 170 had multiple medically complex diagnoses including cancer. This MDS indicated Resident 170 required an indwelling catheter (tubing to assist with bladder drainage).

According to a progress note Resident 170's catheter was removed on 12/27/2024.

According to the 12/17/2024 at risk for complications related to use of an indwelling catheter . CP Resident 170 still required an indwelling catheter. The CP directed staff to provide catheter care as needed. There was no CP to show what, if any, assistance Resident 170 needed to urinate.

Review of the Kardex as of 01/06/2025 showed Resident 170 still needed a catheter.

In an interview on 01/10/2025 at 12:25 PM, Staff K stated that Resident 170 no longer had a catheter. Staff K stated the resident's CP and Kardex should be updated to address their current toileting status.

42203

<Resident 7>

According to the 10/07/2024 Quarterly MDS, Resident 7 had diagnoses including stroke history, and one-sided limitations to their Range of Motion (ROM). The MDS showed Resident 7 received a bed mobility restorative nursing program but no ROM programs.

Record review showed a 02/03/2022 impaired mobility . CP was developed for Resident 7. This CP included an intervention for staff to provide a Passive ROM (PROM) program to Resident 7's left side to prevent contractures (permanent tightening of the tendons and muscles).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/10/2025 at 10:59 AM Staff B stated Resident 7 no longer required a PROM program. Staff B stated the CP was not up to date. REFERENCE: WAC 388-97-1020(2)(c)(d).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on observation, interview, and record review the facility failed to ensure: physician's orders were followed for 2 (Resident 22 & 85) and medications were administered for 1 (Resident 28) of 35 sample residents reviewed. These failures placed residents at risk for medication errors, delayed treatment, and adverse outcomes. Findings included . <Following Orders> <Resident 22> According to a 12/12/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 22 had multiple medically complex diagnoses including neurogenic bladder (a condition where the nerves that control the bladder are damaged) and required the use of an indwelling catheter (a tube inserted into the bladder to collect and drain urine). Observations on 01/06/2025 at 8:55 AM, and 01/07/2025 at 1:31 PM showed Resident 22 with a catheter bag hanging from the bottom of the bed frame. Review of Resident 22's physician orders showed a 12/21/2024 order to remove the indwelling catheter for a trial and to replace with a size 16 FR [French] catheter if the resident was unable to urinate. A second 12/21/2024 order showed staff were to scan the resident's bladder each shift and to place the size 16 FR indwelling catheter if the bladder had greater than 500 cubic centimeters (cc). Review of a 12/23/2024 nursing alert charting progress note showed staff documented Resident 22 had 698 cc of urine and a size 14 FR indwelling catheter was inserted. There was no physician's order directing staff to change the size of the indwelling catheter to a 14 FR or directions to staff on the duration of the newly placed catheter. In an interview on 01/10/2025 at 12:25 PM, Staff K (Manager Long Term Care - Registered Nurse) stated Resident 22 should have routine physician orders in place for the continued use of the indwelling catheter. Staff K stated it was their expectation staff should have, but did not follow the physician orders when the new catheter was implemented on 12/23/2024. 45941 <Resident 85> According to the 11/07/2024 Admission MDS, Resident 85 was readmitted to the facility on [DATE] with weakness on one side of the body and had severe cognitive impairment. This assessment showed Resident 85 was dependent on staff with toileting, feeding, personal hygiene, and repositioning. The assessment showed Resident 85 was at risk for pressure ulcers. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 85's January 2025 physician orders on 01/06/2025 showed a 10/29/2024 order directing staff to apply a dressing to Resident 85's sacral wound and change every three days. Review of Resident 85's January 2025 Treatment Administration Record (TAR) showed the facility nursing staff documented Resident 85 refused treatment on 01/03/2025 and on 01/06/2025 documented they applied the dressing to Resident 85's sacral wound as ordered. Observation on 01/06/2025 at 1:33 PM and on 01/07/2025 at 10:24 AM showed Resident 85 had no dressing on their sacral area. In an interview on 01/07/2025 at 1:00 PM, Staff Q (Certified Nursing Assistant) stated they did not see a dressing to Resident 85's sacral area recently. Observation and interview on 01/08/2025 at 11:34 AM showed Staff S (Licensed Practical Nurse - LPN) assess Resident 85's sacral area and stated Resident 85 did not have a wound on their sacral area and there was no dressing. In an interview on 01/09/2025 at 9:41 AM, Staff E (Director Long Term Care Registered Nurse) stated they expected staff to follow the physician orders. Staff E stated if there was any change, staff should clarify the orders with provider, but they did not. 50511 <Medications> <Resident 28> According to the 11/20/2024 Annual MDS, Resident 28 was assessed to have medically complex conditions including unstable blood sugars, high blood pressure and heart failure. The MDS showed Resident 28 took a diuretic medication (expels excess water fluid from the body to lower blood pressure) and a medication to lower blood sugar levels. Review of the January 2025 Medication Administration Record (MAR) showed Resident 28 had a 11/04/2024 physician's order for a blood sugar lowering medication and to give 1 tablet twice a day. Review of the January 2025 MAR showed Resident 28 had a 01/16/2024 physician's order for a supplemental medication to be given two tablets every other day. In an interview on 01/08/2025 at 9:09 AM Resident 28 stated they were told by the nurse that two of their medications were not given this morning and was told the pharmacy needed to be called. Resident 28 stated they thought the supplemental pill was not given and was not sure of the other one that was missed. Resident 28 stated the nurse was aware of the missing medications and was going to check why it was missing. Resident 28 stated they were very upset about not receiving their medications due to pharmacy issues. Resident 28 stated they called their family to tell them how upset they were with frequently missing medications and they might need to move out because of this. Review of Resident 28's January 2025 MAR showed supplemental medication and blood sugar lowering medication was not given in the AM on 01/08/2025. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/08/2025 at 12:40 PM Staff J (LPN) stated Resident 28's medications were not available when they were passing out medications this morning. Staff J stated they did not have time to call the doctor or pharmacy regarding the missing medications for Resident 28 and could not recall what the medications were that were missing for Resident 28. In an interview on 01/10/2025 at 10:30 AM, Staff K stated the nurse should have notified the provider for further instructions on what to do about Resident 28 missing their medications, but did not. Staff K stated the nurse should have documented in the progress notes that Resident 28 was missing their medications and documented the provider instructions on what to do because of missing their medications, but did not. REFERENCE: WAC 388-97-1620(2)(b)(i)(ii).

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on observation, interview, and record review the facility failed to provide assistance with Activities of Daily Living (ADL), related to cleanliness and grooming for 8 of 35 residents (Resident 14, 22, 170, 93, 112, 120, 126, & 82) reviewed for ADLs. Facility failure to provide residents who were dependent on staff for assistance with nail care, dentures, dressing, shaving, and bathing placed the residents at risk for poor hygiene, long facial hair, embarrassment, and a diminished quality of life. Findings included . <Nail Care> <Resident 14> According to the 12/19/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 14 readmitted to the facility on [DATE] with weakness on the left side of their body. The assessment showed Resident 14 was dependent on staff for personal hygiene, showers, and toileting needs. Observations on 01/03/2025 at 11:31 AM and on 01/06/2025 at 8:23 AM showed Resident 14 was in bed. Resident 14 had long fingernails with black debris under their fingernails. Observation and interview on 01/07/2025 at 10:07 AM showed Resident 14 was up in a wheelchair in their room. Resident 14 had long fingernails with black residue under their nails. Resident 14 stated they needed staff assistance to clip their fingernails. According to the 01/02/2025 ADL self-care performance deficit Care Plan (CP), Resident 14 required one-person extensive assistance with personal hygiene and toileting In an interview on 01/09/2025 at 10:36 AM, Staff E (Director Long Term Care Registered Nurse) stated they expected staff to check the resident's preferences related to ADLs and provide assistance as needed. If the resident refused, staff should document the refusals. In an interview on 01/10/2025 at 11:10 AM, Staff A (Administrator) stated staff should provide ADLs to all residents daily and as needed. 43642 <Dentures> <Resident 22> (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to a 12/12/2024 Quarterly MDS, Resident 22 had multiple medically complex diagnoses including stroke, had clear speech, was able to understand, and be understood by others. This MDS showed Resident 22 was assessed with a functional limitation in range of motion to one side of their arms and legs. The MDS showed Resident 22 required set up assistance for eating, was dependent on staff for upper and lower body dressing and had no rejection of care. Review of a revised 12/29/2022 potential oral health CP showed directions to staff to ensure Resident 22 wears upper dentures. Observations on 01/06/2025 at 9:00 AM showed staff deliver Resident 22's breakfast tray and place it on the resident's overbed table. Staff set up the tray and left the room. Resident 22 was not wearing any dentures. In an interview on 01/06/2025 at 10:03 AM, Resident 22 stated they had dentures and would wear the dentures if they had them. Resident 22 stated, they keep forgetting to bring them to me, it does not look good when I do not wear them. In an observation at this time, Resident 22's dentures were in a denture cup across the room next to the sink. Observations on 01/08/2025 at 8:57 AM showed Resident 22 eating breakfast without wearing dentures. On 01/09/2025 at 12:36 PM, when asked why Resident 22 was not wearing their dentures, the resident indicated the staff had not brought them over yet, and stated, I will remind them. In an interview on 01/10/2025 at 12:25 PM, Staff K (Manager Long Term Care - Registered Nurse) stated it was their expectation for staff to assist residents with their dentures every day during routine morning care and prior to meals to assist with eating. <Dressing> <Resident 170> According to a 12/11/2024 Admission MDS, Resident 170 had intact memory, clear speech, was understood, and able to understand others. This MDS showed staff assessed Resident 170 required substantial assistance to roll from side to side in bed, was dependent on staff for lower body dressing and transfers, and had no rejection of care. Observations on 01/02/2025 at 9:03 AM showed Resident 170 lying in bed wearing a hospital gown. In an interview at this time, Resident 170 stated the staff did not offer to get them up and stated they liked to get up and dressed in clothes. Similar observations of Resident 170 lying in bed with a hospital gown on were observed on 01/03/2025 at 11:00 AM, 01/06/2025 at 8:54 AM, and on 01/07/2025 at 1:31 PM. In an interview on 01/10/2025 at 12:25 PM, Staff K stated it was their expectation staff get residents up and dressed in the morning if they are willing. Staff K stated staff should notify the nurse and document in the records if a resident refuses. <Shaving> <Resident 93> (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to a 12/26/2024 Annual MDS, Resident 93 had multiple medically complex diagnoses including dementia. This MDS showed staff assessed Resident 93 to be dependent on staff for personal hygiene, and had no rejection of care. Review of a 12/31/2024 ADL CP showed staff identified a goal Resident 93 would receive the appropriate level of assistance for their ADLs and mobility and gave directions to staff to see the Kardex (directions to care staff) for ADLs and mobility assistance needs. Review of Resident 93's Kardex on 01/06/2025 showed the resident was dependent on staff for bathing and hygiene. Observations on 01/03/2025 at 9:31 AM showed Resident 93 with long chin hairs and being taken into the shower room by staff. On 01/06/2025 at 9:46 AM, observations showed Resident 93 with the same long chin hairs as previously observed on 01/03/2025, three days later. <Resident 112> According to a 12/01/2024 Quarterly MDS, Resident 112 had multiple medically complex diagnoses including dementia. This MDS showed staff assessed Resident 112 to be dependent on staff for personal hygiene and had no rejection of care. Review of a 12/02/2024 ADL CP showed staff identified a goal Resident 112 would receive the appropriate level of assistance for their ADLs and mobility and gave directions to staff to see the Kardex for ADLs and mobility assistance needs. Review of Resident 112's Kardex on 01/06/2025 showed the resident was dependent on staff for bathing and required supervision with one assist for hygiene. This Kardex gave instructions to staff to shave Resident 112's facial hair as needed after shower per the resident's preference. Observations on 01/02/2025 at 10:01 AM, 01/03/2025 at 9:22 AM, and on 01/06/2025 at 9:54 AM showed Resident 112 with long chin hairs. In an interview and observations on 01/07/2025 at 3:25 PM, Staff W (RN) confirmed the long chin hairs for Resident 93 and Resident 112. Staff W stated it was their expectation staff assist residents to shave on shower days and as needed between shower days. 47836 <Bathing> <Resident 120> According to a 09/25/2024 Quarterly MDS, Resident 120 had no cognitive impairment. The MDS showed Resident 120 required assistance with bathing. Review of Resident 120's ADL CP showed they preferred bed baths and staff would offer and assist them weekly on Thursdays. Review of Resident 120's bathing history report on 01/06/2025 showed no bathing offered on 12/26/2024 and 01/02/2025 per resident bathing schedule. Resident 120's bathing history report showed the last bed bath offered and received was on 12/19/2024. (continued on next page)

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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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/06/2025 at 10:28 AM Resident 120 stated staff had not offered them a bed bath since the Thursday before Christmas 2024, 12/19/2024. Resident 120 was upset and stated the staff often would not offer them bathing. In an interview on 01/07/2025 at 1:12 PM Staff K stated their expectations were staff offer residents bathing weekly per preference and schedule and as requested. Staff K stated Resident 120 preferred bed baths and was to have them every Thursday per their CP. Staff K reviewed Resident 120's health records and stated Resident 120 had not had bathing since 12/19/2024 but should have every Thursday. Staff K stated there were no refusals documented in Resident 120's health records and staff knew they needed to document if a resident refused. In an interview on 01/09/2025 at 10:01 AM Staff B (Director of Nursing) stated they expected staff to offer bathing per the residents' schedule and preferences. Staff B stated it was important to provide bathing to residents for infection prevention and to prevent skin breakdown. 46479 <Resident 126> According to the 10/04/2024 Annual MDS, Resident 126 had clear speech, was able to understand others, and was understood by others in conversation. The assessment showed it was very important for Resident 126 to choose between a tub bath, shower, bed bath, or sponge bath and the resident had no rejection of care during the assessment period. In an interview on 01/02/2025, Resident 126 stated they only received one shower per week and that they would like more showers. Review of Resident 126's Kardex (directions to care staff) on 01/06/2025 showed the resident preferred to be showered in the morning on Tuesdays. The Kardex showed Resident 126 was dependent on staff for bathing. Review of the 2 North unit bath schedule provided by staff, showed Resident 126 was scheduled for showers on Tuesdays during the day shift. Review of Resident 126's November 2024 Certified Nursing Assistant (CNA) documentation showed Resident 126 received a shower on 11/05/2024 and refused a shower on Wednesday, 11/13/2024. There was no documentation that showed Resident 126 was offered a shower on Tuesday 11/12/2024, their preferred shower day. Their next shower was not documented until 11/19/2024, 13 days after the 11/05/2024 shower. There was no documentation that showed the resident was offered a shower the next shift or next day after their declination of the shower on 11/13/2024. Review of Resident 126's December 2024 CNA documentation showed the resident received a shower on 12/03/2024, declined a shower on 12/06/2024, and was not showered again until 12/17/2024, 13 days after the shower on 12/03/2024. There was no documentation showing the resident was offered a shower the next shift or next day after their declination of the shower on 12/06/2024. Resident 126 received a shower on 12/17/2024 and 13 days later, on 12/31/2024. There was no documentation the resident was offered and declined a shower between 12/17/2024 and 12/31/2024. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/10/2025 at 12:34 PM, Staff B stated they expected resident refusals to be documented. Staff B stated if a resident wanted more than one shower per week, the facility could try and accommodate them. Staff B stated they would inform the family of the resident that the family could hire a private care giver for the resident if the facility could not accommodate the resident's request. <Resident 82> According to the 12/23/2024 Significant Change in Status MDS, Resident 82 was sometimes understood and could sometimes understand others in conversation. The MDS showed Resident 82 had severe impairment with their ability to think, remember, and make decisions. Resident 82 did not reject care during the assessment period, and it was very important to them to chose between a tub bath, shower, bed bath, or sponge bath. The MDS showed Resident 82 was not showered/bathed during the assessment period and their ability to perform shower/bathing was not assessed. Review of Resident 82's Kardex on 01/06/2025 showed the resident was dependent on staff for assistance with bathing. The Kardex showed Resident 82 preferred a tub bath on Wednesday mornings. Review of the 2 North unit bath schedule provided by staff, showed Resident 82 was scheduled to be bathed on Tuesdays during the day shift. Observation on 01/08/2024 showed Resident 82 lying in bed. The resident had hair stubble on their chin and their hair appeared stringy and greasy. Review of Resident 82's October 2024 CNA documentation showed the resident received two showers during the month of October. This documentation showed staff did not provide Resident 82 with bathing once per week as the resident was assessed to require. There was no documentation that showed Resident 82 was offered and refused bathing opportunities. Review of Resident 82's November 2024 CNA documentation showed Resident 82 received three showers for the month of November. This documentation showed Resident 82 refused two showers. There was no documentation that showed the resident was offered bathing assistance the next shift or the next day. Review of Resident 82's December 2024 CNA documentation showed Resident 82 received three bathing opportunities during the month of December. There were no bathing opportunities documented from 12/18/2024 to 12/31/2024 showing Resident 82 went 14 days without a shower or bed bath. There were no documented refusals for the month of December. In an interview on 01/10/2025 at 12:39 PM, Staff B stated the facility did not have specific CNAs assigned to bathing residents. Staff B stated the CNA assigned to the resident, was responsible for providing bathing assistance for residents scheduled for bathing on the shift. Staff B stated staff should document refusals for bathing and staff should reattempt later in the shift, the next shift, and next day. Staff B stated they expected staff on the next shift or the next day should document the resident's acceptance of or declined bathing assistance. REFERENCE: WAC 388-97-1060(2)(c).

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review the facility failed to ensure activity programs met the needs of each resident for 3 of 5 sampled residents (Resident 110, 170, & 171) reviewed for activities. Failure to provide meaningful activities left residents at risk for boredom, frustration, and a diminished quality of life. Findings included . <Facility Policy> According to the facility's 07/2024 Activities policy, each resident should be provided the opportunity to participate in activities that reflected their interests and lifestyle. The policy showed the activities offered should help meet residents' physical, mental, and psychosocial wellbeing. <Resident 110> According to the 11/14/2024 Admission Minimum Data Set (MDS - an assessment tool) Resident 110 had intact memory, and sometimes experienced social isolation. The MDS showed it was extremely important to Resident 110 to get outside when the weather was suitable. The MDS showed all activity preferences were extremely important for Resident 110, except participating in group activities, which was not very important to the resident. According to the 11/29/2024 Little or no activity involvement related to mobility status . Care Plan (CP) Resident 110's goal was to participate in activities of their choice per the facility's activities calendar. The CP included interventions to provide and orient Resident 110 to the facility's activity calendar and to refer to Activity assessment . In an interview and observation on 01/03/2025 at 12:46 PM Resident 110 was looking out of their window when a surveyor entered their room. Resident 110 stated they were not bored while a resident at the facility but wanted to go outside. Resident 110 stated facility staff did not offer to take them outside since admitting in November 2024. Review of the November 2024 activities flow sheets showed Resident 110 was not offered to go outside that month. Review of the December 2024 activities flow sheets showed Resident 110 was offered one on one activity on 13 of 29 days when the resident was available, and participated in the book cart and movies/sit com activities on 12/30/2024 only. The flowsheet showed from 12/19/2024 through 12/29/2024, no activities provided. The January 2025 activities flowsheet showed on four of eight days no activity participation was documented and showed no offers to go outside for Resident 110. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/08/2025 at 1:44 PM, Staff NN (Recreation Therapist) stated it was important to provide residents meaningful activities. Staff NN stated all activities provided were documented in the electronic chart and would appear on the activities flow sheets. Staff NN stated they did not offer to take Resident 110 for some fresh air since the resident moved to the unit and if this occurred when Resident 110 was on their prior unit, it would be documented. 43642 <Resident 170> According to a 12/11/2024 Admission MDS, Resident 170 had intact memory, clear speech, was understood, and able to understand others. This MDS showed staff assessed Resident 170 required substantial assistance to roll from side to side in bed, was dependent on staff for transfers, had no rejection of care, and indicated activity preferences were very important to them. In an interview on 01/03/2025 at 8:35 AM, when Resident 170 was asked about activities, the resident stated they would, absolutely go to activities, and stated, I would love that. Resident 170 stated they have not gone to any activities since being admitted to the facility and felt it was because they were unable to walk to get to them. Observations on 01/06/2025 at 8:54 AM and 10:10 AM, and on 01/07/2025 at 1:31 PM showed Resident 170 lying in bed wearing a hospital gown. Activities were observed being set up and occurring in the activity room on 01/06/2025 and 01/07/2025 while Resident 170 was in bed in their room. Review of a 01/02/2025 Activity CP showed directions for staff to encourage activity attendance with Resident 170 and identified the resident was interested in bingo. Review of the December 2024 activities flow sheets showed documentation Resident 170 was only offered: a one to one activity, a movie/sit com activity, and sensory activity on 3 of 26 days; and a book cart and an independent leisure project on 2 of 26 days in December 2024. No refusals were documented on the flow sheets. Review of the January 2025 activities flow sheets showed documentation Resident 170 was offered a one to one activity, book cart, independent leisure project, movies/sit com, and a sensory activity on 1 of 5 days in January on 01/03/2025. No refusals were documented on the flow sheets. In an interview on 01/10/2025 at 1:02 PM, Staff AAA (Recreational Therapist) stated they worked on two units and had about 40 residents to work with for activities. Staff AAA stated if a resident refused an activity or if an activity was provided, it should be documented in the resident records. Staff AAA stated any offers or refusals for Resident 170 should be documented. 45941 <Resident 171> (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 12/08/2024 Admission MDS Resident 171 admitted to the facility on [DATE]. The MDS showed Resident 171 made their own decisions and had no behavior of rejecting care during this assessment period. The MDS showed it was very important to Resident 171 to have things to read, music to listen to, engage with groups of people, participate in their favorite activities, and to join religious services. According to the 12/09/2024 potential for leisure activity deficit due to hard of hearing CP Resident 171's goal was to participate in activities per their preferences and choices. The CP included interventions to provide the weekly activity and movie calendar in Resident 171's room. According to the 12/26/2024 COVID 19 (viral respiratory infection) CP, staff were instructed to provide in room activities of Resident 171's interest and opportunities for the resident to express their feelings related to the situational stressor of their respiratory infection. Observation and interview on 01/03/2025 at 9:43 AM showed Resident 171's door was closed and an Aerosol precaution sign was on the door. Resident 171 was sitting on the edge of their and was looking out of their window. Resident 171 stated they had COVID, and no one came to their room. Similar observations on 01/06/2025 at 8:06 AM and 12:21 PM, and on 01/07/2025 at 9:18 AM and 12:35 PM showed no reading material, no music playing, and no religious services available for Resident 171 in their room. In an interview on 01/07/2025 at 12:50 PM, Staff R (Licensed Practical Nurse) stated Resident 171 tested negative for COVID on 01/04/2025 and was not on isolation precautions anymore. In an interview on 01/07/2025 at 1:16 PM, Staff TT (Recreation Therapist Assistant) stated they had to take care of two floors for activities and had to complete admission activity assessments for the new admissions. Staff TT stated they did not provide in-room activities to Resident 171 because they had COVID, and staff did not want to spread the infection to other residents. In an interview on 01/10/2025 at 11:14 AM, Staff A (Administrator) stated it was important to provide activities to all residents according to their choices. Staff A stated staff should provide in-room activities to Resident 171 with COVID per their preferences, but they did not. REFERENCE: WAC 388-97-0940(1). 51791

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 50511 Based on observation, interview, and record review the facility failed to ensure 1 of 5 residents (Resident 15) reviewed for Pressure Ulcers (PU- injury to the skin and underlying tissue due to prolonged pressure), received necessary care and services, consistent with professional standards of practice, to promote healing, and prevent new ulcers from developing. Failure to implement wound prevention interventions, report on worsening conditions and to use appropriate hand hygiene practices and personal protective equipment (gloves, masks and gowns) when providing wound care and provide proper infection control practices, placed residents at risk for deterioration in skin condition(s) pressure ulcers and a diminished quality of life. <Facility Policy> Review of the revised 01/2023 Pressure Ulcer Prevention and Treatment policy, showed the facility would evaluate the resident's clinical condition and pressure ulcer risk factors and implement interventions that were consistent with resident needs, goals and recognized standards of practice. <Pressure Reducing Device> According to the 11/15/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 15 had impairments to both sides of their lower body and was dependent on staff for activities of daily living, mobility, and used a wheelchair. The MDS showed Resident 15 was at risk for pressure ulcers and needed pressure reducing devices for their chair and bed. Review of the revised 11/19/2024 Impairment to Skin Integrity Care Plan (CP) showed Resident 15 had the potential for impairment to skin integrity due to impaired mobility and a history of pressure ulcers. Interventions on the CP instructed staff to provide a cushion while the resident was in their wheelchair and to wear foot cradles or to elevate their feet while the resident was up in their wheelchair. Review of the physician orders showed an order to float Resident 15's left foot. Physician orders showed staff were to monitor wounds for signs and symptoms of infection and worsening condition during each shift and to document and notify the provider. Review of Kardex (caregiver information sheet) showed staff were to float heels with pressure mat or boots. Observation on 01/08/2025 at 08:53 AM showed Resident 15 sitting in the dining room, with slippers on. The left foot was hanging to the floor while the resident was sitting in the wheelchair. Observation on 01/08/2025 at 12:35 PM showed Resident 15 was sitting in the dining room in a wheelchair. Resident 15 had slipper shoes on and the left foot heel was hanging down. In an interview on 01/09/2025 at 1:42 PM Staff EE (Certified Nursing Aid) stated Resident 15 wore a boot on their foot while in bed but did not use anything while they were sitting up in their wheelchair. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/09/2025 at 2:40 PM Staff K (Manager Long Term Care Registered Nurse) stated staff should always float Resident 15's heel and needed to check with Staff B on what this meant for Resident 15's care. In an interview on 01/10/2025 at 10:34 AM, Staff K stated after checking with Staff B, Resident 15 should be using boots but was not. <Reporting of wound of condition> Review of Treatment Records for December 2024 showed staff were to monitor wounds from a left lateral diabetic foot ulcer for signs or symptoms of infection or worsening during each shift, to write in the progress notes the appearance of the wound and to notify the provider. Observation on 01/07/2025 at 1:43 PM, while Staff Z (Licensed Nurse) was applying a dressing cover to Resident 15's lower back area, another dressing on Resident 15's left foot was observed to be saturated with blood and the bandage had come off from the left side of the foot. Staff Z stated the contracted wound care service provided wound care the day before and stated they were not told by any other staff that the wound was bleeding. Review of progress notes showed a progress note dated 01/07/2025 by Staff Z showing that Resident 15 had drainage to right heel and had a non-open diabetic ulcer to left foot. Staff Z noted that they notified the provider and was waiting for a response. No other progress notes located in the medical record showed that a wound was bleeding on the left foot. In an interview on 01/09/2025 at 2:43 PM, Staff K stated they were not made aware Resident 15 had a bleeding wound. Staff K stated it was not uncommon for bandages to fall off as they have as needed orders to replace bandages. Staff K stated the care staff should have reported the bed sheets being bloody and should have notified the nurse so the nurse could address why Resident 15 was bleeding. Staff K stated there should be a new skin assessment report made by the nurse and the nurse should notify the provider of the issue. If a skin assessment report was completed by the nurse the unit manager would be notified about Resident 15's wound issue. In an interview on 01/10/2025 at 12:49 PM Staff B stated their expectation was for nurses to follow physician orders. Staff K stated if there was a change in appearance of Resident 15's skin, this should be documented on the skin assessment form and reported to the unit manager and the provider. Refer to F880 Infection Prevention and Control REFERENCE: WAC 388-97-1060 (3)(b).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46479 Based on observation, interview, and record review the facility failed to ensure the environment was free of accident hazards for 4 of 9 (2 North, 4 South, St Joseph's Residence (SJR), & 5 North) units reviewed. The failure to ensure sharps (syringe needles, razors etc.) and chemicals were stored safely placed residents at risk for injury, unsafe chemicals, and accident hazards. Findings included . <Facility Policy> According to the revised 01/2025 Cleaning and Disinfection of Environment Surfaces policy, all chemicals would remain out of reach of residents and stored behind locked doors to ensure safety. <2 North Unit> Observation on 01/02/2025 at 8:43 AM showed the clean utility room on the 2 North unit was unlocked. Eight blood collection kits with needles were observed uncontained on a shelf at waist height. A towel warmer device was present and in use in the utility room. The towel warmer was easily opened and not secured/locked. In an interview on 01/02/2025 at 9:44 AM, Staff V (Licensed Practical Nurse - LPN) confirmed the eight blood collection kits in the unlocked utility room and stated they should be secured from residents. Staff V observed the utility room door and confirmed there was no locking mechanism on the utility room door. Staff V stated they did not have a key to lock the utility room. In an interview on 01/10/2025 at 12:42 PM, Staff B (Director of Nursing) stated it was their expectation that needles/sharps be secured and out of resident reach. 50511 <4 South Unit> Observation on 01/02/2025 at 9:39 AM showed the door to clean utility room was unlocked on the 4 South unit. The door opened freely and allowed access to bottles of shaving cream, body wash, and barrier incontinent creams stocked in utility room. Observation on 01/02/2025 at 9:43 AM showed the spa room door was propped open on the 4 South unit. One bottle of disinfectant cleaner deodorant with warning label on bottle of disinfectant to keep out of reach of children and a caution warning to avoid contact with eyes and skin was observed in the spa. In an interview on 01/10/2025 at 10:42 AM Staff K (Manager, Long Term Care Registered Nurse) stated the spa/tub room should be locked for safety reasons but was not. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43642 <Unsecured chemicals> <SJR Unit> Observations 01/02/2025 at 10:03 AM on the SJR unit showed a laundry door open with a sign on the door that said, please keep door closed. There were no staff nearby the room. Inside the room was an unlocked cabinet that contained a bottle of disinfectant. On the bottle was a label that said, Danger, keep out of the reach of children. A bottle of laundry detergent was also in the unlocked cabinet. On top of the counter, in a basket with other items, was an aerosol spray can of a disinfectant and sanitizer. This can had a label which said, keep out of the reach of children. Observations on 01/02/2025 at 10:34 AM showed the door was closed but remained unlocked, there was no lockable mechanism on the door. The chemicals were still inside the room in an unlocked cabinet and on the counter. In an interview on 01/10/2025 at 1:31 PM, Staff OO (Director of Operations) stated the door to the laundry room should remain closed and the chemicals should be locked and inaccessible to the residents. 47836 <5 North Unit> Observation on 01/02/2025 at 9:23 AM showed the spa room and clean utility room on 5 North unit unlocked. One gallon bottle of a skin disinfectant/antiseptic solution, a spray bottle of a facility disinfectant cleaning solution were observed uncontained on a shelf in an open cabinet at knee height, and razors in an unlocked drawer in the spa room. The unlocked clean utility room on 5 North unit was observed to have razors and resident hygiene supplies uncontained. In an interview on 01/02/2025 at 9:54 AM Staff HH (LPN) stated the spa and clean utility room were always left unlocked. Staff HH stated it could be dangerous for residents to leave the spa and clean utility room unlocked. In an interview on 01/02/2025 at 9:54 AM Staff E (Resident Care Manager) stated both doors should remain locked, and staff should have keys, but the spa room lock was broken. Staff E acknowledged the chemicals and razors should be behind locked doors. In an interview on 01/10/2025 at 12:35 PM Staff A (Administrator) stated their expectations were for chemicals to be behind locked containment and out of reach from residents. Staff A stated it was important to properly store chemicals and razors to ensure resident safety. REFERENCE: WAC 388-97-1060(3)(g).

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on observation, interview, and record review the facility failed to ensure residents weights were accurately monitored for 1 of 7 residents (Resident 14) reviewed for nutrition. The failure to ensure resident weights were rechecked when appropriate and the physician notified as required placed residents at risk for weight loss, weight gain, and other negative health outcomes. Findings included . <Facility Policy> According to the facility's 10/2023 Weight and Nutrition Monitoring Policy, the facility would strive to prevent significant weight loss in residents. The policy showed changes in the residents' nutritional status and weight would be discussed routinely by clinical staff and the Registered Dietician (RD). <Resident 14> According to the 12/19/2024 Admission Minimum Data Set (MDS - an assessment tool) Resident 14 readmitted to the facility on [DATE] and had diagnoses including anemia and malnutrition. The MDS showed Resident 14 was dependent on staff for transfers, personal hygiene, showers, toileting needs, and needed one-person set-up assistance for meals. The MDS showed Resident 14 weighed 151 pounds (lbs.) and had no significant weight loss during the assessment period. Review of Resident 14's nutritional assessment completed on 12/19/2024 by Staff II showed Resident 14 was at risk for weight loss due to poor appetite. Staff II's assessment of Resident 14 instructed staff to notify them of any significant change in Resident 14's weight. Review of Resident 14's weight record showed Resident 14's weight on 11/10/2024 was 155 lbs., on 12/13/2024 was 151.2 lbs., and on 01/03/2025 was 119.8 lbs. Review of Resident 14's health record on 01/08/2025 showed no documentation staff reweighed Resident 14 to verify if the 01/03/2025 weight of 119.8 lbs. was accurate. There was no documentation showing nurses notified the physician or Staff II about Resident 14's potential 30 lbs. weight loss in three weeks. In an interview on 01/09/2025 at 9:26 AM, Staff E (Director - Long Term Care, Registered Nurse) stated Resident 14's health record showed the resident lost over 30 lbs. weight since 12/13/2024. Staff E stated the facility process was to weigh residents weekly unless there was specific order by the provider. Staff E stated staff should have reweighed Resident 14 on 01/03/2025 as it was improbable they lost that much weight. Staff E stated the facility should have notified the provider but did not. REFERENCE: WAC 388-97-1060 (3)(h).

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 47836 Based on observation, interview, and record review the facility failed to ensure pain management was provided to residents consistent with professional standards of practice including the failure to complete a thorough pain assessment prior to as needed (PRN) pain medication administration and have pain medications readily available for 2 of 7 residents (Resident 120 & 28) reviewed for pain management. These failures placed residents at risk for experiencing untreated pain and a decreased quality of life. Findings included . <Resident 120> According to a 09/25/2024 Annual Minimum Data Set (MDS - an assessment tool) Resident 120 had no cognitive impairment. The MDS showed Resident 120 had a diagnosis of chronic pain and received routine and PRN pain medications without any nonpharmacological pain interventions implemented. The MDS showed Resident 120 experienced pain more than five days during the assessment period and their pain occasionally affected their sleep and day to day activities. Review of a 09/27/2024 Altered Comfort related to Chronic Pain and Muscle Spasm Care Plan (CP) showed staff would assess pain routinely and collaborate with Resident 120 to ensure pain relief. Review of Resident 120's physician orders showed a 11/12/2024 narcotic pain medication to be administered every eight hours PRN. Review of Resident 120's November 2024, December 2024, and January 2025 Medication Administration Records (MAR) showed a PRN narcotic pain medication with pain level, location, interventions, and amount as areas to document as part of the pain assessment prior to administration. These MARs showed inaccurate, and incomplete pain assessments prior to administration of the PRN narcotic pain medication for Resident 120. In an interview on 01/03/2025 at 1:35 PM Resident 120 stated the staff did not administer their pain medications timely and did not assess their pain prior to administration. Resident 120 stated they requested the provider schedule the pain medication routinely to ensure timely administration. In an interview on 01/07/2025 at 1:21 PM Staff K (Manager Long Term Care Registered Nurse) stated they expected staff to complete the pain assessment including documentation of Resident 120's pain level, pain location, dosing amount, and non-pharmacologic interventions prior to PRN pain medication administration. Staff K stated staff did not consistently document Resident 120's pain level, pain location, correct dose administered, or offered nonpharmacological pain interventions prior to administration, but should have. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/09/2025 at 10:01 AM Staff B (Director of Nursing) stated they expected staff to document an accurate and thorough pain assessment prior to all PRN pain medication administration. Staff B stated as part of the pain assessment they expected staff to document the residents pain level per the 1-10 pain scale, the location of the pain, nonpharmacological pain interventions provided, and the effectiveness of the pain medication. Staff B stated it was important to complete pain assessments to ensure good pain management and quality of life for residents. 50511 <Facility Policy> According to the facility's 12/2024 Pain Management policy, a resident who had a major change in pain regimen was put on alert charting and pain was assessed every shift while on alert. The policy showed current pain medications, and their effectiveness were reviewed in collaboration with the provider as indicated and documented in progress notes every shift when on alert for pain-related issues. <Resident 28> According to a 11/20/2024 Annual MDS, Resident 28 had chronic pain and was taking pain medications for their condition without nonpharmacological pain interventions implemented. Review of a 02/19/2021 Altered Comfort CP showed Resident 28 was in constant pain and received pain medication to relieve pain related to chronic wounds. In an interview on 01/03/2025 at 10:03 AM Resident 28 stated they had pain to their right thigh, and they took pain medications several times a day because of their chronic wounds. In an interview on 01/06/2025 at 9:39 AM Resident 28 stated the night nurse informed them the facility did not have their PRN pain medication. The medication did not arrive from the pharmacy. Resident 28 stated staff gave them an over-the-counter pain medication for their breakthrough pain but was frustrated because the facility ran out of their medications before, and they didn't understand how this kept happening. Review of a progress note entry on 01/06/2025 at 10:45 PM showed the nurse called the pharmacy on 01/05/2025 and again on 01/06/2025 to reorder Resident 28's pain medication. The pharmacy responded the pain medication was to be delivered. The progress note showed the nurse was not able to obtain the medication from the emergency medication supply kit because the pain medication was not in the kit. Review of a progress note entry on 01/07/2025 at 1:30 AM showed the nurse wrote that they did not receive a medication delivery for Resident 28's pain medication. Review of the progress notes showed Resident 28 was not on alert charting for pain while the facility was awaiting delivery of the pain medication. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/09/2025 at 2:02 PM Staff K stated the facility switched to another pharmacy recently which may have contributed to the delay. Staff K stated the pharmacy reported they would refill the medication on 01/05/2025, but they did not. Staff K stated the nurses should have pulled the pain medication from the facility emergency supply kit, notify nursing management, notify the provider, and document in the progress notes. Staff K stated the nurses did not follow the facility protocol but should have. REFERENCE: WAC 388-97-1060(1).

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 45941 Based on interview and record review the facility failed to ensure nursing staff had the appropriate competencies and skill sets to provide nursing and related services, to assure resident safety, and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident according to resident assessments and plans of care for 4 of 4 facility staff (Staff Q - Certified Nursing Assistant), Staff W Registered Nurse (RN), Staff X - (RN), and Staff Y - (RN)) randomly selected and reviewed for competency. Additionally, the facility failed to ensure proficiency of nursing staff. The failure of nursing and nurse aide staff, to demonstrate a measurable pattern of knowledge, skills, abilities, behaviors that nurses need to perform work roles successfully, resulted in deficiencies related to the competency of nursing staff. Findings included . The 2024 Facility Assessment review date 10/14/2024 showed training, education and competencies of nurses and nurse aides were necessary to provide support and care to the residents of the facility. The Facility Assessment showed nurses and nursing assistants would complete a skills assessment upon hire and competency-based skills assessments annually. The Facility Assessment showed the facility would provide education and verify competency of nursing staff in the areas of abuse and neglect, resident rights, dementia care, infection control, communication, and specific resident needs based on the person-centered care plans. The Facility Assessment showed the facility would also provide Nurse Assistant training, education, and verify competency in the areas of personal care skills, vital sign monitoring, safety and mobility, communication and empathy, infection control, emergency protocols, and cultural competency. In an interview on 01/08/2025 at 12:20 PM, Staff B (Director of Nursing) stated they were responsible for nursing staff's competency and oversight, completed staff evaluations to assess staff competencies, skills, and knowledge upon hiring and annually. Staff B was asked to provide verification of competency documentation for Staff Q, Staff W, Staff X, and Staff Yand Staff B could not provide competency performance evaluations as requested. In an interview on 01/10/2025 at 9:23 AM, Staff A (Administrator) stated the facility should complete nursing staff evaluation to assess their competencies, skills, and knowledge to provide safe care to residents, but the facility did not assess the nursing staff's competency as required. Refer to F550 Resident Rights Refer to F 600 Free from Abuse and Neglect Refer to F 880 Infection Prevention and Control REFERENCE: WAC 388-97-1080(1).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42203 Based on observation, interview, and record review the facility failed to ensure medications and biologicals were secured for 1 of 7 units (300 S/Resident 89), and expired medications and biologicals were disposed of for 1 of 6 medication carts (5 South Medication Cart 1), and 4 of 4 medication rooms (5 North, 5 South, 4 South, and 3 South) reviewed for medication storage and labeling. These failures to ensure medication rooms and carts were secured and free from expired medications and ensure medications were not left unattended in common areas placed residents at risk for receiving the wrong medications, expired medications, and other negative health outcomes. Findings included . <Facility Policy> According to the 06/2022 revised Medication Storage and Disposal facility policy, facility would provide proper disposal of medications. <300 South/Resident 89> According to the 11/05/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 89 was assessed with severely impaired memory. The MDS showed Resident 89 had a chronic respiratory disease. Observation on 01/02/2025 at 11:24 AM in the 300 South dining room showed three residents seated at a table. One resident pointed at a respiratory inhaler placed on the table, pointed at Resident 89, and stated that's her medicine. The inhaler was not in a box or labeled in anyway. At 11:34 AM a nurse's aide served water to the residents at the table and did not identify the unsecured inhaler On 01/02/2025 at 11:54 AM Staff QQ (License Practical Nurse - LPN) appeared on the unit. Staff QQ stated they were the nurse on duty, and just returned from a break. Staff QQ stated they gave Resident 89 the inhaler. Staff QQ stated they did not know if Resident 89 had intact memory or was assessed to able to administer their own medications prior to giving it to them. Staff QQ stated they should have but did not verify if Resident 89 was able to administer their inhaler before leaving it with the resident unsupervised. Staff QQ stated it was their first day working that unit. 47836 <5 North Medication Room> (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/06/2025 at 1:54 PM showed four urinary catheter kits expired on 09/28/2024, a sputum sample kit expired 10/2024, three wound dressings expired 10/31/2023, a specimen collection kit expired 01/31/2021, an injectable medication expired 12/30/2024, a QFT (brand name) specimen kit expired 09/30/2024, a bottle of hemoccult developer and hemoccult sensa developer with the expiration dates illegible/worn off, and a gallon bottle of antibacterial and antimicrobial skin cleanser solution expired on 07/2023. In an interview on 01/06/2025 at 2:00 PM Staff RR (Registered Nurse - RN) stated the expired medications and supplies should have been disposed of upon expiration. In an interview on 01/09/2025 at 10:01 AM Staff B (Director of Nursing) stated they expected staff to monitor expiration dates, dispose of all expired medications and supplies immediately, and reorder as needed. Staff B stated it was important to dispose of expired medications and supplies to ensure they were viable for the residents. 45941 <5 South Medication Cart 1> Observation on 01/06/2025 at 1:50 PM showed one bottle of over-the-counter medication was expired on 11/2024. <5 South Medication Room> Observation on 01/06/2025 at 1:57 PM showed Intravenous (IV- needle inserted into a vein to give drug or fluid) start kit was expired on 11/06/2024, safety Huber needle (a special needle used to administer medications in ports) set expired on 09/30/2021, suction Yanker (tube to suction fluids from the body) expired on 09/28/2024, and four subcutaneous starter kits expired on 05/01/2023. In an interview on 01/06/2025 at 2:07 PM, Staff R Stated they checked the medication cart periodically but missed the opportunity to remove the expired medication from the medication cart. Staff R stated they should check the IV supply in the medication room and should remove the expired ones, but they did not. In an interview on 01/09/2025 at 12:20 PM, Staff B stated nurses should check the med carts and med rooms and dispose of the expired medications. 50511 <4 South Medication Room> Observation on 01/07/2025 at 08:40 AM observed one immunization vaccine vial labeled with an expiration date of 12/18/2023 and three bottles of ostomy care powder with an expiration date on the bottle of 10/5/2024. In an interview on 01/07/2025 at 8:46 AM Staff Z (LPN) stated the expired vaccine and ostomy supplies should not have been in the medication room as it could cause harm to a resident and would not be as effective. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<3 South Medication Room> Observation on 01/10/2025 at 12:15 PM observed one bag full of unused nebulizer ampules with an expiration date on the bag of 09/05/2024 and one bottle of a liquid laxative with an expiration date of 07/24/2024. In an interview on 01/10/2025 at 12:15 PM Staff ZZ (RN) confirmed expired medications and stated they should not be in the medication room and should be disposed of immediately. In an interview on 01/10/2025 at 10:31 AM Staff K (Manager Long Term Care Registered Nurse) stated all nurses were responsible for checking medication storage for expired medication, this did not happen but should have. REFERENCE: WAC 388-97-1300(2).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review the facility failed to ensure food and drinks served to residents were prepared and distributed under sanitary conditions for 1 of 1 facility kitchens, and 2 of 6 unit kitchenettes. The failure to maintain kitchen equipment in a sanitary manner, complete Hand Hygiene (HH - washing or sanitizing hands) as required, sanitize kitchen thermometers appropriately, and ensure Certified Nursing Assistant's (CNA's) hair was secured when preparing meals in unit kitchenettes placed residents at risk for contaminated/spoiled food, foodborne illness, and other negative health outcomes. Findings included . <Facility Policy> According to the facility's 04/2023 Neighborhood Food Service policy, staff must wash their hands prior to food preparation. The policy showed hair must be restrained. <Facility Main Kitchen - Equipment> Observation on 01/02/2025 of the facility's main kitchen from 8:45 AM through 8:50 AM showed: an uncovered meat slicer with nothing preventing dust or other contaminants from building up on its surfaces; a stand mixer bowl not in use, right side up on a shelf next to the mixer on with nothing preventing dust or other contaminants from building up inside; two food processor bases with a substantial amount of dried-up food splatter of different colors and consistencies; the counter-mounted can opener had a dried buildup of food on the blade. In an interview at that time Staff GG (Dining Service Supervisor) stated they expected kitchen equipment including mixers, meat slicers and grinders, and food processors to be maintained in a manner that prevented unnecessary exposure to dust and contaminants. Staff GG stated the can opener should have been cleaned after use. <Main Kitchen - Lunch Preparation> Observation of lunch preparation in the facility's main kitchen on 01/08/2025 at 10:40 AM showed Staff VV (Cook) frying shrimp in a deep fryer with disposable gloves on. Staff VV removed their gloves to answer the phone. Without washing their hands, Staff VV put on a new pair of gloves and returned to frying shrimp. At 10:48 AM Staff VV emptied the fry basket into three stainless steel pans with aluminum foil wearing the same gloves they put on without HH after answering the phone. At 10:58 AM Staff VV removed the pair of gloves and put on a new pair. Staff VV did not wash their hands before replacing the gloves. At 11:13 AM an unidentified cook was observed to smooth the outside of their surgical mask, then without washing their hands flipped some sauteing chicken, opened the freezer by the handle and retrieving a package of shrimp, handled two fryer baskets, fetched another shrimp package, and placed shrimp in the two fryer baskets, and pressed the empty shrimp containers in the garbage can before washing their hands at 11:16 AM. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<4th Floor North> Observations of meal services on the 4th floor North Unit on 01/02/2025 at 12:10 PM, showed Staff MM (Nutrition Attendant) wearing a hairnet that only covered the top half of their hair, the lower half of their hair was loose and uncovered. Staff MM had uncovered steam table pans containing dishes they were preparing to check the temperatures of prior to meal service. Staff MM placed their thermometer probe into a pan of shrimp and then wiped the probe with a paper towel. Staff MM then put the thermometer probe into a second pan and then wiped the probe with a paper towel. Next, Staff MM put the same probe, without sanitization, into a pan of carrots. Staff MM then checked the temperatures of mashed potatoes, gravy, pureed carrots, ground meat, and pureed chicken stew while only wiping the thermometer probe with a paper towel, rather than sanitizing with an alcohol swab. On 01/08/2025 at 12:29 PM, during meal services, Staff MM was observed using a thermometer to check the food temperatures prior to meal service. Staff MM sanitized the thermometer probe prior to starting, then proceeded to check the couscous (a type of pasta), beets, and cabbage while only using a paper towel to wipe the probe, Staff MM then checked the temperature of the shrimp and wiped the probe with a paper towel. Staff XX (Supervisor - Food Services) approached Staff MM, gave them a sanitizer wipe, and encouraged them to use it between dishes. Staff XX then left the area. Staff MM used the sanitizer wipe once, then proceeded to check the black bean soup, mashed potato, minced, and pureed food product temperatures, using a paper towel to wipe the probe between the bins instead of swabs. In an interview on 01/09/2025 at 12:55 PM Staff GG stated they expected dietary staff to disinfect thermometers with alcohol swabs when taking temperatures of different dishes prior to serving food. <4th Floor South> Observations on 01/02/2025 PM at 12:03 PM showed Staff CC (CNA) and Staff DD (CNA) were serving food onto lunch plates. Staff DD did not have a hairnet or other means to secure their hair. At 12:05 PM Staff CC delivered a tray to a resident's room, then returned to serving food from the steam table without washing their hands or putting on gloves. At 12:06 PM Staff DD served dessert from the steam table without a means to secure their hair. At 12:09 PM Staff CC returned from delivering a tray from a designated Enhanced Barrier Precaution (EBP) room and returned to serving lunches without washing their hands. At 12:13 PM Staff CC delivered a tray to room [ROOM NUMBER]. A housekeeping cart was blocking the doorway and Staff CC moved the housekeeping cart with a bare hand and delivered the tray to the room. Staff CC returned from room [ROOM NUMBER] and did not wash hands before pouring coffee for another resident. In an interview on 01/02/2025 at 12:31 PM Staff GG stated the facility followed the food code for hand hygiene. Staff GG stated staff should wash their hands before, after, during and throughout a meal service. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the 400 South dining room on 01/08/2025 at 12:10 PM showed Staff EE (CNA) serving lunch to residents. With gloved hands, Staff EE touched a table where a resident sat then served a plate without changing gloves or doing HH. Staff EE then brought some cocktail sauce to a resident, and an iced tea to a different resident, all with the same gloves on. At 12:15 PM Staff EE now with bare hands, entered room [ROOM NUMBER] which had a sign outside indicating a resident in the room was on Enhanced Barrier Precautions, which required staff to don gloves and a gown if there was any resident contact. Without donning gown and gloves, Staff EE fully entered the room with the door ajar, discussed food choices with the resident before leaving at 12:18 PM. Upon leaving the room without performing HH, Staff EE touched the door, donned gloves and began preparing more plates. AT 12:19 PM, Staff EE placed straws in three drink and placed two trays on a cart, still with no HH. At 12:21 PM Staff EE with the assistance of a second CNA repositioned a resident and then performed HH. In an interview on 01/09/2025 at 12:55 PM Staff GG stated they expected all staff assisting with meal service in unit dining rooms to perform HH when required, including after answering the phone in the main kitchen. Staff GG stated they expected CNAs to restrain their hair if serving food from a steam table in a unit dining room. REFERENCE WAC 388-97-1100 (3). 43642 50511

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47836 Based on observation and interview the facility failed to keep all protected health information in the residents' records confidential and out of view from unauthorized individuals on 1 of 7 (5 North) units reviewed. This failure placed all former and current residents at risk for a violation of their right to privacy. Findings included . <Facility Policy> Review of the 08/2017 Facility Admission Agreement showed residents had a right to secure and confidential personal and medical records. <5 North> Observation and interview on 01/06/2025 at 8:52 AM showed a paper copy of an interdisciplinary team progress note in the grievance file folder on the wall by the elevator on the fifth floor. Staff E (Resident Care Manager) stated the paper copy of the progress note should not be in the grievance wall folder as anyone had access to that file folder. Staff E stated it was important to maintain resident record confidentiality for resident rights. Observation and interview on 01/06/2025 at 10:41 AM showed a 5 North resident roster/report sheet lying on top of cart 1 in view for anyone to see. Staff UU Licensed Practical Nurse) stated they should have covered the sensitive resident information on the report sheet before walking away from their cart but forgot. Staff UU stated it was important to protect resident information for resident's rights. In an interview on 01/09/2025 at 10:01 AM Staff B (Director of Nursing) stated staff were expected to keep resident information covered and out of site from others. Staff B stated it was important to maintain resident confidentiality for their rights. REFERENCE: WAC 388-97-1720(1)(c).

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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.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 43642 Based on observation, interview, and record review the facility failed to ensure effective coordination of care between the facility and hospice staff, for 1 of 2 residents (Resident 170) reviewed for hospice services. Additionally, the facility failed to update the resident's Care Plan (CP) to show which agency was responsible for the hospice care. These failures prevented implementation of a system by which consistent communication between the facility and hospice staff occurred, and placed residents at risk for not for receiving necessary care and services. Findings included . <Facility Policy> According to facility's revised 04/2023 Hospice Coordination policy, the facility and hospice would: establish a regular communication schedule and determine the appropriate method(s) for communication .; exchange all relevant resident information, including the resident's CP .; would ensure their staff were knowledgeable about the communication protocols and were trained to effectively communicate with each other. <Resident 170> According to a 12/11/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 170 had multiple medically complex diagnoses including cancer. This MDS indicated Resident 170 did not have a life expectancy of less than six months and was not on hospice. Observations on 01/07/2025 at 1:35 PM showed Resident 170's hard chart at the nurse's station had stickers on the front indicating the resident was on hospice services. In the chart was a 12/06/2024 hospice election statement form indicating Resident 170 was started on hospice services on 12/06/2024. Review of the 12/06/2024 Hospice Facility Collaboration Notes form from Resident 170's chart showed this form was used on that occasion to document the resident's admission to hospice. The form showed pain was identified as a concern for Resident 170. There was a section to document interventions/comments/instructions but was left blank with a line across the section diagonally and a signature from the hospice nurse underneath. The second page of the form was left blank, including a Collaboration section, which included a spot to document the date of the next visit, information on who received the provided communication at the facility, to the provider, and the resident and/or representative. Review of Resident 170's physician's orders showed no order for hospice services, only a 12/21/2024 order for an antianxiety medication to be administered as needed for anxiety as part of the hospice comfort kit. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 170's 12/17/2024 Comfort Care CP showed the resident's goal was for comfort care per the hospice plan of care. Only three interventions were listed: pain management per hospice intervention, follow the physician's order form for advance directives, and involve the family with the resident's care with a comfort focused goal. A 12/23/2024 Self-Care deficit CP gave directions to staff to assist Resident 170 with all activities of daily living and to see the Kardex (directions to staff regarding how to provide care) for the level of assistance needed. Review of Resident 170's Kardex as of 01/06/2025 did not show any indication the resident was on hospice or what care was to be provided by the facility or hospice. In an interview on 01/08/2025 at 9:17 AM, Staff WW (Certified Nursing Assistant) stated they were responsible for Resident 170's bathing and they utilized the Kardex for the resident's care need instructions. Staff WW was unsure what care was given by the hospice providers. Review of Resident 170's progress notes showed no hospice visit notes were uploaded into Resident 170's records until 01/03/2025, at which time a late entry note was added from a 12/09/2024 and a 12/17/2024 hospice visit. On 01/06/2025 late entry notes were added from a 12/09/2024 and a 12/11/2024 hospice visit. In an interview on 01/10/2025 at 12:25 PM, Staff K (Manager Long Term Care - Registered Nurse) stated it was their expectation there be adequate collaboration between the facility and hospice, the hospice records would be readily available in the resident records, a hospice order obtained and in place, and a detailed CP developed identifying what care the resident would receive from the facility and from hospice. Staff K stated good collaboration was important so the facility could assure everything was coordinated and the resident was receiving the care required. Staff K reviewed Resident 170's records and stated the records were, unfortunately lacking. In an interview on 01/10/2025 at 4:07 PM, Staff A (Administrator) stated it was their expectation hospice services were coordinated with the facility, including ensuring orders, CPs, and progress/visit notes were readily available in the resident's records. REFERENCE: WAC 388-97-1060(1).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a sanitary environment to help prevent the transmission of communicable diseases. The facility failed to implement and/or follow isolation precautions for 3 of 7 residents (Resident 14, 85, and 15) reviewed for Enhanced Barrier Precautions (EBP) , and failed to follow Transmission Based Precaution (TBP) for 1 of 2 rooms (room [ROOM NUMBER]) reviewed for TBP. These failures placed the residents at risk for facility acquired or healthcare-associated infections and related complications. Findings included . <Facility Policy> The facility's 08/2024 Transmission-Based Precautions (TBP) policy showed the facility used different kinds of precautions to protect residents and staff from different kinds of communicable diseases. The policy showed the appropriate precautions would be implemented when residents were diagnosed with or suspected to have infections or communicable diseases that could be spread by contact or droplets. This policy showed EBP precautions were implemented for residents with open wounds, central line, urinary catheter, feeding tube, and tracheostomy. Facility would place an EBP sign on resident's door to instruct staff and visitors to follow the precautions. The facility's 10/2023 revised Enteral Nutrition policy showed the staff would use clean techniques at all times when opening the feeding system to prevent contamination. <Enhanced Barrier Precaution> <Resident 14> According to the 12/19/2024 Admission Minimum data Set (MDS - an assessment tool), Resident 14 had intravenous (IV- into a vein) access and received an IV medication for an infection. The MDS showed Resident 14 was dependent on staff for transfers and personal hygiene. Observation on 01/03/2025 at 8:26 AM showed Resident 14's door had an EBP sign, and instructed staff to wear a gown and gloves during direct care. Observation showed Staff KK (Certified Nursing Assistant- CNA) providing care to Resident 14, Staff KK was not wearing an isolation gown. In an interview on 01/03/2025 at 9:11 AM, Staff KK stated they should wear isolation gown, but they forgot to put the gown on. <Resident 85> According to the 11/07/2024 Admission MDS, Resident 85 had greater than 51% of their intake through Tube Feeding (TF- a tube into the stomach into which liquid nutrition was instilled). This assessment showed Resident 85 had severely impaired vision. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 01/07/2025 at 9:07 AM showed Resident 85's door had an EBP sign that instructed staff to wear a gown and gloves when providing care to Resident 85. Observation at that time showed Staff V (Licensed Practical Nurse) without a gown while administering nutritional liquid via the TF to Resident 85. Observation on 01/07/2025 at 9:29 AM showed the TF tubing fell on the floor while Staff V administered liquid nutrition to Resident 85. Staff V grabbed the same tubing from the floor and attached the tubing to the resident. Staff V did not obtain clean tubing. In an interview on 01/07/2025 at 10:16 AM, Staff V stated they should wear an isolation gown while providing care to the resident and should not use the tubing from the floor because that tubing was not clean anymore. Staff V stated they were nervous and forgot to grab new tubing. In an interview on 01/08/2025 at 12:20 PM, Staff B (Director of Nursing) stated they expected staff to follow the facility infection control policy but they did not. 50511 <Resident 15> According to a 11/1/2024 Quarterly MDS, Resident 15 had a pressure ulcer and required skin treatments during the assessment period. Review of Resident 15's Treatment Administration Record for December 2024 showed an order for EBP for an open wound and to ensure correct signage, personal protection equipment, and supplies were available and were in use on every shift. Observations on 01/08/2025 at 2:48 PM Staff PP (Licensed Practical Nurse - LPN) provided wound care to Resident 15's left foot. Staff PP was not wearing a gown per EBP sign that was posted on Resident 15's room door. Observation showed Staff PP did not remove their gloves and did not wash hands when leaving the resident's room to get a smaller bandage. After completion of wound care treatment, Staff PP used ungloved hands to pull up prep sheet that had used wound supplies on it and did not sanitize hands before putting on new gloves. In an interview on 01/08/2025 at 3:00 PM Staff PP read the EBP on door and stated the sign read staff should use a gown and sanitize their hands while providing direct care to Resident 15. Staff PP stated they should have used a gown while providing wound care for infection control but did not. Staff PP stated they should have washed hands before, during and after wound care. In an interview on 01/09/2025 at 2:16 PM Staff K (Manager Long Term Care Registered Nurse) stated for rooms with EBP, it would be used for close personal contact. Staff K stated staff should be putting on a gown, washing their hands and washing hands before they go out of a room. In an interview on 01/10/2025 at 12:52 PM Staff B stated they would expect staff to follow EBP protocols and use gowns, use proper hand hygiene and use gloves when providing direct care. Staff B stated their expectation would be for staff to follow EBP protocols but they did not. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	47836 <Transmission Based Precautions> <room [ROOM NUMBER]> Observation and interview on 01/02/2025 at 8:19 AM showed room [ROOM NUMBER] with a contact precaution sign and an EBP sign posted on the door. Staff UU (LPN) stated the resident in room [ROOM NUMBER] bed 1 had a contagious infection in their wounds and was on contact precautions to prevent the spread of the infection and the resident in 501 bed 2 was on EBP to protect them from contracting an infection because they had a chest port, a dialysis access to their left arm, and open wounds. Observation on 01/03/2025 at 8:34 AM showed room [ROOM NUMBER] with the contact precaution and EBP signs posted on the door. In an interview on 01/09/2025 at 9:40 AM Staff C (Infection Preventionist) stated EBP were to protect fragile residents with indwelling medical devices or wounds from contracting an infection. Staff C stated residents on Transmission-Based Precautions (Contact, Droplet, and Airborne Precautions) should not be placed in the same room as residents on EBP for their health and safety. Refer to F686-Treatment to Prevent Pressure Ulcer REFERENCE: WAC 388-97-1320(1)(c), (2)(b). .