STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Care	209 North Ahtanum Avenue Wapato, WA 98951

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review, the facility failed to conduct a complete and thorough investigation into resident-to-resident altercations including protecting the residents involved from further physical or psychological harm for 4 of 6 residents (Residents 4, 5, 6, and 7) reviewed for abuse. This failed practice placed the residents at risk for continued exposure to unidentified physical and verbal abuse, unidentified injuries, and unmet emotional needs. Findings included . <Resident 4> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include kidney failure. The 08/29/2024 comprehensive assessment showed Resident 4's cognition was intact and independent with the use of their wheelchair (w/c). <Resident 5> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include kidney failure. The 06/11/2024 comprehensive assessment showed Resident 5's cognition was intact and independent with the use of their w/c. Review of the August 2024 Incident Reporting Log, showed on 08/03/2024 there was an incident involving Resident 4 and 5. Review of the 08/03/2024 incident investigation report, showed Resident 4 and Resident 5 had a verbal altercation that turned physical. The report showed an activities staff member reported to Staff I, Registered Nurse, that Resident 5 had called Resident 4 a m**********r so Resident 4 told Resident 5 to f **k off. Then, as the staff were separating the residents, they were .about to come to blows (fight) ., Resident 4 swung and hit Resident 5 on their shoulder. The report showed Staff I was pushing Resident 5 away in their w/c when Resident 4 swung but did not make full contact with Resident 5. The investigation showed no root/cause/analysis summary, witness statements, interventions that were initiated or changed, care plan changes, injuries, or education provided to staff or residents to protect both residents from further altercations. Additionally, the investigation did not show a complete description of the incident, who the activity staff was that reported it, which shoulder was hit, or which resident was name calling. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/09/2024 at 4:15 PM, Staff H, Resident Care Manager (RCM), stated they were not aware of the incident that took place between Residents 4 and 5 and that it would have been the responsibility of the Social Services department to follow up with the behaviors for resident-to-resident altercations. During an interview on 09/10/2024 at 1:56 PM, Resident 4 stated their room was located directly across the hall from the entrance to the dining room. Resident 5 was going to the kitchen, through the dining room, when Resident 4 informed them the kitchen staff were not in the kitchen. Resident 5 then turned to Resident 4 and called them a name which angered Resident 4 so they continued to call Resident 5 names and told them to f **k off and threatened Resident 5 that they would get them on the way back (out of the dining room). Resident 4 stated Resident 5 continued talking crap and coming towards them like they wanted to fight, so they felt they needed to defend themselves and swung at Resident 5. Resident 4 stated the staff intervened and took Resident 5 away just as they swung. Resident 4 then stated the next day, when they went to the restorative room for their exercises, Resident 5 was also in there at the same time. Resident 4 stated they were ready to hit Resident 5 if they had said anything to them, but they ignored each other. Resident 4 stated this would be the second time they have had an issue with Resident 5, and stated, if you talk to [Resident 5], they get angry and if you don't say anything to them, they are nice. During attempted interviews on 09/09/2024 at 12:30 PM, and again on 09/10/2024 at 1:51 PM, Resident 5 refused to talk about the incident and stated they did not have anything further to discuss about it. Review of Resident 4's care plan focus for behavior monitoring, last revised on 04/13/2021, showed the resident would use foul language towards residents and staff and make false statements towards other residents when they were upset. The care plan showed no focus for a physical/verbal resident-to-resident altercation and no additional interventions had been implemented or changed since the 08/03/2024 incident. Review of Resident 5's care plan focus for behavior monitoring, last revised on 05/10/2024, showed no focus for a physical/verbal resident-to-resident altercation and no additional interventions had been implemented or changed since last revised on 08/30/2022 or since the 08/03/2024 incident. <Resident 6> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include schizophrenia (a serious mental health condition that affects how people think, feel and behave). The 07/16/2024 comprehensive assessment showed Resident 6's cognition was intact and was independent with the use of their w/c. <Resident 7> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include severe vascular dementia with behaviors (caused by lack of blood/oxygen to the brain and causes changes in personality, behavior, and mood). The 07/23/2024 comprehensive assessment showed Resident 7's cognition was severely impaired, demonstrated verbal and physical behaviors that were directed towards others, and was independent with the use of their w/c. (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 09/01/2024 through 09/09/2024 Incident Reporting Log, showed on 09/01/2024 there was an incident involving Residents 6 and 7. Review of the 09/01/2024 incident investigation report, completed by Staff I, showed staff reported to Staff I that Residents 6 and 7 had a physical altercation during lunch time in the dining room. The report showed that Resident 6 had hit Resident 7 after they had been hit by that resident. The report showed Resident 6 tried helping Resident 7 with their butter when Resident 7 threw the butter at Resident 6 and then hit them, so Resident 7 hit Resident 6 back. The report showed Resident 7 was agitated earlier in the shift and had slapped the nurse when they attempted to administer their medications. The report showed no root/cause/analysis summary, what had been done about Resident 7's agitation earlier in the shift, where either resident had been hit/slapped, a skin check for Resident 7, monitoring for latent injuries, and no interventions or care plan changes were implemented. Review of Resident 6's care plan focus for behavior monitoring, last revised on 04/24/2023, showed no focus for a physical/verbal resident-to-resident altercation and no additional interventions had been implemented or changed since the 09/01/2024 incident. Review of Resident 7's care plan focus for behavior monitoring, last revised on 05/13/2022, showed the resident would strike out at staff with interventions to redirect the resident, offer them their baby doll, or a snack/drink of their choice. The care plan showed no focus for a resident-to-resident altercation and no additional interventions had been implemented or changed since the 09/01/2024 incident. During an interview on 09/10/2024 at 9:32 AM, Staff K, Nursing Assistant (NA), stated they were not made aware of any altercations that had taken place between Residents 4 and 5. Staff K stated Resident 4 got along with everybody and as far as they knew displayed no behaviors. Staff K additionally stated Resident 7 would consistently hit staff but was not aware of any altercations that took place with other residents. During an interview on 09/10/2024 at 12:17 PM, Staff G, RCM, stated they were not aware of the altercation between Residents 6 and 7 and that it must have happened on a weekend, and they didn't hear about it. Staff G further stated it was the responsibility of the Social Services department to update the care plans for behaviors. During an interview on 09/10/2024 at 1:46 PM, Resident 6 stated they had gone over to Resident 7's table to assist them with their butter. Then Resident 7 threw their butter at Resident 6, so Resident 6 threw it back. Resident 6 stated Resident 7 then slapped them in their forearm which then Resident 6 then slapped Resident 6 back on their forearm, which I think I hit their elbow, not their forearm. Resident 6 then stated the next day they approached Resident 7, and they acted as if nothing ever happened. Additionally, Resident 6 stated Resident 7 had memory issues and had observed the same interactions with other residents and staff. During an interview on 09/11/2024 at 9:26 AM, Staff E, Social Services Director, stated they would monitor and follow-up with residents involved in resident-to-resident altercations to ensure they are doing alright afterwards. Staff E stated it would be the responsibility of the nursing department to follow up on outcome, appropriate interventions, and investigation summaries. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/11/2024 at 12:07 PM, Staff L, NA, stated Resident 7 would hit staff and other residents and needed to be watched . Staff L stated if they see the resident coming close to another resident, they would move them away from the situation and give Resident 7 coffee or candy as a distraction. Staff L stated staff were not always there to monitor Resident 7 and they were not one on one care During an interview on 09/11/2024 at 12:21 PM, Staff I stated their normal practice for resident-to-resident altercations would be to interview residents, obtain witness statements, and ensure the residents were safe. Staff I stated they did not witness the incident with Residents 4 and 5 and was called to the dining room by staff. Staff I stated they did not assess either resident for injuries and verified it was Resident 5 that got hit by Resident 4. Staff I stated they did not do any education with staff regarding the incident or put any interventions into place because Residents 4 and 5 have had issues before so staff were already aware they needed to be kept apart. Also, Staff I stated they did not witness the altercation between Residents 6 and 7 and were called to the dining room where both residents had already been separated by staff. Staff I stated they assessed Resident 6 for injuries but did not assess Resident 7. Staff I stated when they initiated alert charting for both residents they would normally also monitor for latent injuries did I not do that? Additionally, Staff I stated their incident reports had not been very thorough as of late and admitted they needed to do better. During an interview on 09/11/2024 at 1:15 PM, Staff C, Director of Nursing Services (DNS), with Staff D, Assistant DNS, present, stated they would expect thorough and complete investigations to be completed along with interventions and staff education on the interventions. Staff C stated the residents not only needed to be protected at that moment of the incident but on-going as well. Staff C further stated there should have been a summary of the findings of the investigation, skin checks and monitoring, and witness statements obtained. Staff C further stated it should have been a collaborative effort of the Social Services department and the Resident Care Managers to implement appropriate interventions for resident-to-resident altercations and that did not happen. WAC Reference: 388-97-0640 (6)(a)(b)(c)