STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505280	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renton Health & Rehabilitation	80 Southwest Second Street Renton, WA 98057

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44295 Based on observation, interview and record review, the facility failed to provide the level of supervision necessary to prevent accidents for resident-to-resident altercations for 2 (Residents 1, 2) of 5 residents reviewed for supervision and accidents. The facility failed to provide supervision and placed residents at risk for potential verbal and physical abuse, serious injury, pain, and diminished quality of life. Findings included . Review of the facility policy titled, Safety and Supervision of Residents, revised 07/2017, showed the facility would strive to make the environment as free from accident hazards as possible and resident safety, supervision, and assistance to prevent accidents were facility wide priorities. The policy showed resident supervision was a core component of the systems approach to safety, the type and frequency of supervision was determined by the individual resident's assessed needs. The policy showed interventions would be developed to reduce the individuals risks related to hazards in the environment, including adequate supervision and the interventions would be communicated to staff, with a system to ensure interventions were implemented, documented, and monitored for effectiveness. Review of the facility policy titled, Wandering and Elopement, revised 03/2019, showed the facility would identify residents who were at risk for wandering and when identified as a wandering risk, or other safety issues, the resident's care plan (CP) would include strategies and interventions to maintain the resident's safety. <Resident 1> Review of an admission Minimum Data Set (MDS, an assessment tool), dated 05/27/2024, showed Resident 1 was able to make their needs known, make their own decisions, and had no behaviors of rejecting care or wandering. The MDS showed Resident 1 had diagnoses including a right hip fracture with surgical repair, anxiety, and insomnia. Review of the MDS showed Resident 1 required staff assistance to transfer and used a walker to ambulate. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 07/16/2023 at 2:50 PM, Resident 1 was observed sitting on their bed and stated Resident 2 came into the room during the evening on 06/27/2024. On 06/28/2024 Resident 1 stated they returned to their room and some of their snacks and protein bars were opened, consumed, and the wrappers and crumbs were left in the drawer. Resident 1 stated later that night they returned to their room to find Resident 2 wearing their shirt, sitting on their bed and left feces on their bed sheets. Resident 1 stated Resident 2 would often talk to themselves, scream, yell, and remove their brief, throw it on the floor, and walk around the room without any pants on. Resident 1 stated they informed staff of Resident 2 taking their belongings and staff replied, we're looking into it. Resident 1 stated on 07/01/2024 they were sleeping when they felt weight on their right leg, instinctively pulled their right leg back, screamed for Resident 2 to get off their leg. Resident 1 stated Resident 2 was trying to get up but facility staff came in and assisted Resident 2 off of Resident 1. Resident 1 stated they had a bad right knee that needed to be replaced but they experienced a fall and broke their hip before being able to have the knee replaced. Resident 1 stated their right knee and right hip were inflamed and had some pain. Resident 1 stated they were upset due to the smells in the room, and Resident 1's behavior. Review of Nursing Progress Note (NPN), dated 06/27/2024-06/29/2024, showed no documentation that Resident 1 had any incidents with Resident 2, or staff's response to Resident 2 sitting on Resident 1's leg that was recently surgically repaired. A NPN, date 07/02/2024, showed Staff D (Social Services Director) documented Resident 1 agreed to have Resident 2 moved to another room because they startled Resident 1 and they felt safe now after Resident 2 moved to another room. Staff D documented that the nurse would do an evaluation. Review of a NPN, dated 07/02/204, showed Staff E (Licensed Practical Nurse) documented Resident 1 would have an x-ray of their leg the next morning, no additional information was documented. Review of a Provider Progress Note (PPN), dated 07/03/2024, showed the provider reviewed Resident 1's x-rays and no injuries were found. The provider documented Resident 1 had increased pain to their right knee, and the knee was observed red and swollen. <Resident 2> Review of a pre-admission hospital palliative medicine consult, dated 06/15/2024, showed Resident 2 was recently moved from a nursing home to a memory care unit (provides specialized care for people with all forms of dementia), after two hours of being on the memory unit Resident 2 was assaulted by another patient and was brought to the hospital where they experienced a fall with hip fracture. The consult showed Resident 2 was agitated and delirious, likely due to their dementia and current medical conditions. Resident 2's Collateral Contact (CC) was present for the consult and told the physician that Resident 2 was extremely confused, combative, resistive, and wandered around with feces. Review of an admission MDS, dated [DATE], showed Resident 2 admitted to the facility on [DATE] into the same room as Resident 1, was not able to make their own decisions, required a surrogate decision maker, had delusions (misconceptions contrary to reality) but no behaviors of rejecting care or wandering. The MDS showed Resident 2 had diagnoses including a left femur fracture, dementia, psychotic disorder (a disconnection from reality), and insomnia. Review of the MDS showed Resident 2 required staff assistance for incontinence care and transfers. Review of an admission assessment, dated 06/27/2024, did not show an assessment completed to determine Resident 2's wandering risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a CP titled, impaired cognitive function related to dementia, dated 06/27/2024, directed staff to cue, reorient, and supervise Resident 2 as needed. Review of Resident 2's CP's showed no CP or interventions developed for Resident 2's wandering behaviors or how staff should manage those behaviors. Review of a NPN, dated 06/27/2024, showed Staff C (Licensed Practical Nurse, LPN) documented Resident 2 admitted to the facility, was actively trying to get out of bed, anxious, removing their brief, and displaying symptoms of sun downing (increasing behaviors in the evening with people with dementia). Staff C later documented that Resident 2 was using fecal matter to paste their face, hair, and bed. The documentation did not show what actions staff took to remedy the situation. Review of a PPN dated 06/28/2024, showed a facility provider saw Resident 2 and documented Resident 2 told the provider to leave them alone and was confused and agitated. The provider documented conversations with Resident 1's CC who thought insomnia could be contributing to worsening psychosis and Resident 2 took an anti-psychotic medication to manage their behaviors. Review of a Social Services (SS) progress note, dated 07/02/2024, showed Staff D documented that Resident 2 was moved to memory care unit prior to admission to the facility due to Resident 2 wandering naked in the middle of the night. An additional SS note, dated 07/02/2024, showed Resident 2 was moved to a different room. During an observation and interview on 07/16/2024 at 3:10 PM, Resident 2 was observed sitting on their bed fully dressed and stated I have diarrhea, it just pours out of me. Resident 2 was not able to recall details on the incident with Resident 1. Resident 2 was observed a few minutes later at 3:14 PM walking around their room and peeking their head out of their doorway. Review of a facility investigation for Resident 1 and Resident 2's resident to resident incident, dated 07/02/2024, showed on 07/02/2024, Resident 1's CC reported that on 07/01/2024 Resident 2 walked to Resident 1's bed around 4:30 AM and sat on their leg, causing discomfort. The CC voiced concerns that Resident 2 was stealing Resident 1's clothing, food, and sat on Resident 1's bed leaving feces on the bed sheets. Review of the investigation showed Staff F (Resident Care Manager) interviewed multiple staff who were aware of Resident 2's behaviors on multiple occasions to include Resident 2's date of admission on 06/27/2024, when Staff E told Staff F, the first night Resident 2 admitted they were found walking around the room, on Resident 1's side of the room, had moved their belongings around, and Resident 1 seemed frustrated by Resident 2's behaviors. The investigation showed on 06/28/2024 or 06/29/2024 Staff G (Certified Nursing Assistant, CNA) stated they brought Resident 1 back to their room. Feces was observed smeared on their bed sheets. Additional interviews showed staff found Resident 2 walking around their room in only a brief on their second day of admission, found Resident 2 sitting on Resident 1's bed on multiple occasions, sitting in Resident 1's wheelchair, and believed Resident 2 was getting out of bed by themselves. The investigation showed Staff F asked Resident 1 if they informed staff of these incidents, and they replied yes they told staff but anytime it was discussed Resident 2 was in the room and Resident 1 did not feel comfortable making complaints in front of Resident 2. The investigation showed on the morning of 07/01/2024, Staff A (Administrator) was informed by two staff members that Resident 1 and Resident 2 were not getting along. Review of the investigation showed Resident 2 was not moved to another room until 07/02/2024, after Resident 1's CC voiced their concerns and an x-ray was obtained on 07/03/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/05/2024 at 1:30 PM, Staff A (Administrator) stated they visited Resident 1 and Resident 2's room daily, Resident 2 was not observed wearing Resident 1's clothes but would look through their belongings. Staff A stated Resident 2 was moved to another room because the residents were not a compatible match. During an interview on 08/08/2024 at 9:30 AM, Staff I (Registered Nurse/Resource Nurse) stated admission referrals are reviewed and if a potential new resident was a wander or elopement risk the Director of Nursing Services (DNS) would review the referral before admission. Residents should be assessed upon admission and quarterly for wandering and elopement risk. Staff I stated the staff anticipated Resident 2 to be more bedbound after having a hip replacement and didn't look at these multiple incidents as a whole rather as an isolated incident. Staff I would expect staff to inform SS of Resident 2's behaviors and SS to follow up with both residents. In an interview on 08/08/2024 at 11:00 AM Staff B (DNS) stated they don't recall reviewing Resident 2's admission referral, and a resident assessed as an elopement or wander risks should have a CP in place to include a safety plan. Staff B confirmed Resident 2 did not have a wandering risk CP in place with interventions to maintain the resident's safety. Staff B stated they would expect documentation to support what actions staff took to maintain both Resident 1 and Resident 2's safety, and acknowledged there was no documentation to support actions taken by staff. REFERENCE: WAC 388-97-1060(3)(g)