Printed: 12/04/2024
Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505296 | A. Building<br>B. Wing | 09/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Francis of Bellingham | 3121 Squalicum Parkway<br>Bellingham, WA 98225 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890<br><br>Based on interview and record review, the facility failed to ensure a resident's right to privacy, security, and confidentiality when a staff member relayed confidential information to a visiting family member for 1 of 1 resident (Resident 1) reviewed for personal privacy/confidentiality of records. This failed practice placed residents at risk for the loss of confidentiality and privacy and the right to have their preferences honored.<br><br>Findings included .<br><br>Review of the facility policy titled, Resident Rights- Privacy and Confidentiality dated 07/2024 showed the facility will respect the residents' right to personal privacy and the right to secure and confidential personal and medical records.<br><br>Resident 1 admitted to the facility on [DATE] and according to the Admission Minimum Data Set (MDS- an assessment tool) assessment dated [DATE], the resident was alert and oriented.<br><br>In an interview on 08/16/2024 at 11:50 AM, Collateral Contact 1 (CC1- Resident 1's Power of Attorney [POA]) stated a person (CC2) that was visiting the facility on or about 08/14/2024, was given a copy of Resident 1's care plan and CC2 was not on Resident 1's release of information and should not have been given any of Resident 1's private/confidential information. CC1 stated Staff C handed the care plan to CC2 and was told to give it to them (CC1).<br><br>Review of Resident 1's clinical record on 08/21/2024 showed CC1 was the resident's POA for Healthcare and Financial matters. Review of the facility face sheet for Resident 1 showed CC1 was listed as the POA and the primary emergency contact. CC2 was not listed in Resident 1's record as any type of authorized representative or contact.<br><br>In an interview on 08/22/2024 at 12:20 PM, Staff C, Licensed Practical Nurse, Unit Manager, stated they had given the care plan to CC2 who was supposed to give it to CC1. Staff C stated they believed it was ok to share information with CC2 relating to Resident 1.<br><br>Refererence (WAC) 388-97-0360 |

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 - Few

Respond appropriately to all alleged violations.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890

Based on interview and record review, the facility failed to conduct a thorough investigation for 2 of 3 residents (Resident 1 and 2) reviewed for complete and thorough investigations. The facility failed to thoroughly investigate a fall with significant injury and hospitalization for Resident 1, and to thoroughly investigate an incident of elopement for Resident 2. This failure placed residents at risk for continued or uninvestigated potential abuse or neglect.

<RESIDENT 1>

Resident 1 admitted to the facility on [DATE] with diagnoses that included a history of a stroke with left sided hemiparesis (weakness or partial paralysis affecting one side of the body) and generalized weakness.

Review of Resident 1's clinical record showed the resident had a fall out of bed on 08/13/2024.

Review of a facility investigation report showed that Staff D, Certified Nursing Assistant (CNA) was assisting Resident 1 with incontinent care and bedding change without a second CNA assisting per the care plan. Staff D's witness statement dated 08/14/2024 stated they had rolled the resident onto their left side and turned their back (leaving the resident unsupported) to retrieve supplies, turned back around and witnessed Resident 1's weight shift to the left, their right shoulder came forward and they rolled off of the left side of the bed, onto the floor, striking the back of their head.

Review of Resident 1's care plan showed an intervention dated 07/30/2024, instructing staff that Resident 1 required staff assistance to turn and position in bed, 2 person assist, with a further clarification that the resident was able to turn right to left with one person extensive assistance. An intervention dated 07/10/2024 instructed staff that resident 1 required 2-person extensive assistance for incontinent care or bed pan.

Review of the facility incident investigation dated 08/13/2024 showed the investigation ruled out abuse and neglect stating that Staff D had followed the care plan for Resident 1. The investigation summary stated Staff D had rolled Resident 1 to the left according to the care plan. The investigation failed to identify that Resident 1's plan of care instructed staff to provide bed mobility and incontinent care with 2-person extensive assistance, or Staff D leaving Resident 1 unsupported on their side to retrieve items. The outcome of the investigation provided a skills review of Staff D but failed to include re-instruction regarding care plans. Staff D's statement referenced being aware of Resident 1's care plan yet did not address the reason Staff D did not have a second staff assisting with the incontinent care and the bed change per the care plan.

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 09/03/2024 at 12:47 PM, Staff B, Director of Nursing Services (DNS) stated Resident 1 had weakness due to a stroke and their left side was weaker than their right side. Staff B stated when they had interviewed Staff D following the fall, Staff D knew Resident 1's care plan very well and knew that they only needed 1 person to roll them to the left so that was why they had rolled Resident 1 in that direction. Staff B confirmed Staff D did not have a second staff member assisting them with Resident 1 but did not review that further with Staff D or include those factors in the incident investigation or conclusion of root cause. Staff B stated they had Staff D, walk them through the care and Staff D was very specific about Resident 1 being able to roll to their left and that Staff D felt they were following the care plan at the time of the fall.<br><br>43954<br><br><RESIDENT 2><br><br>Resident 2 was admitted to the facility on [DATE], with diagnoses to include hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) of left side, muscle weakness, and difficulty in walking.<br><br>Review of Resident 2's care plan showed the resident required supervision with 1 person assist for transfers and required supervision with 1 person assist for hallway ambulation with a wheelchair to follow, initiated on 07/24/2024.<br><br>Review of a progress note dated 08/18/2024 at 3:57 PM showed Resident 2 was found outside the facility in the community by the police at the hospital emergency room entrance and they had called the facility to alert them.<br><br>Review of Resident 2's elopement investigation provided by the facility, completed by Staff B, dated 08/18/2024 showed the care plan was not assessed for transfer or ambulation status.<br><br>In a joint interview/record review on 9/3/2024 at 12:50 PM, Staff B, DNS stated when they complete facility investigations, they review the care plan. Staff B stated their expectation is that staff follow residents' care plans. Staff B stated Resident 2's care plan showed they required supervision and 1 person assist with transfers and ambulation with a wheelchair to follow.<br><br>Reference (WAC) 388-97-0640 (6)(a) |

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F 0689

Level of Harm - 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** 37890

Based on observation, interview and record review, the facility failed to provide supervision to ensure residents were free from avoidable accidents for 2 of 3 residents (Resident 1 and 2) reviewed for accident hazards. Resident 1 experienced harm when they fell from bed and sustained a head injury that required sutures and hospitalization when facility staff did not follow the resident's individualized care plan (CP) that required two staff assistance/supervision for incontinence care. This failed practice placed Resident 2 at risk for injury when they wandered outside the facility without staff supervision.

Findings included

Review of the policy titled Quality of Care- Accident Hazards, supervision, devices dated 07/2018 showed resident specific interventions will be reflected in the residents person-centered, individualized care plan.

<RESIDENT 1>

Resident 1 admitted to the facility on [DATE] with diagnoses that included history of a stroke with left sided hemiparesis (weakness or partial paralysis affecting one side of the body) and generalized weakness.

Review of the 07/02/2024 quarterly Minimum Data Set (MDS-an assessment tool) showed Resident 1 had intact cognition, no behaviors, no rejections of care and required extensive assistance with bed mobility and was dependent on staff assistance for toileting hygiene and rolling side to side in bed. Resident 1 had no recent history of falls.

Review of Resident 1's current care plan showed an intervention dated 07/30/2024, that instructed staff that Resident 1 required staff participation to turn and position in bed, two person assist with a further clarification that the resident was able to turn right to left with one person extensive assistance. An intervention dated 07/10/2024 instructed staff that resident 1 required two person extensive assistance for incontinence care or bed pan.

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the resident record on 08/16/2024 showed Resident 1 had a witnessed fall out of bed on 08/13/2024. Review of the facility investigation showed that Staff D, Certified Nursing Assistant (CNA) was assisting Resident 1 with incontinence care and bedding change without a second CNA assisting per the care plan. Review of a signed written statement provided by Staff D dated 08/14/2024 stated they had rolled the resident on their left side and turned their back (leaving the resident unsupported) to retrieve supplies, turned back around and witnessed Resident 1's weight shift to the left, their right shoulder came forward and they rolled off of the left side of the bed and onto the floor, striking the back of their head on the floor. The statement stated there was blood seen on the back of Resident 1's head and Staff D called on their walkie talkie for other staff to assist. Resident 1 was transferred to the Emergency Department (ED) on 08/13/2024, where they were found to have a scalp laceration requiring sutures. Imaging reports were obtained at the ED and showed a subdural hematoma (a head injury where blood collects between the skull and the surface of the brain). The resident was admitted to the Intensive Care Unit and required a total of seven days of hospitalization .<br><br>In an interview on 08/22/2024 at 12:13 PM, Staff F, Licensed Practical Nurse (LPN) stated Resident 1 required 2 staff assistance for care, stating Resident 1 was weak and could barely move their body.<br><br>In an interview on 09/03/2024 at 12:47 PM, Staff B, Director of Nursing Services stated Resident 1 had weakness due to a stroke and their left side was weaker than their right side. Staff B stated when they had interviewed Staff D following the fall, Staff D knew Resident 1's care plan very well and knew that they only needed one person to roll them to the left so that was why they had rolled Resident 1 in that direction. Staff B stated Staff D did not have a second staff member assisting them with Resident 1 but did not review that further with Staff D or include those factors in the incident investigation or conclusion of root cause. Staff B stated they had Staff D walk them through the care provided and Staff D was very specific about Resident 1 being able to roll to their left and that Staff D felt they were following the care plan.<br><br>43954<br><br><RESIDENT 2 ><br><br>Resident 2 admitted to the facility on [DATE], with diagnoses to include hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) of left side, muscle weakness, and difficulty in walking.<br><br>Review of Resident 2's current care plan showed the resident required supervision with one person assistance for transfers and required supervision with one person assistance for hallway ambulation with a wheelchair to follow, initiated on 07/24/2024.<br><br>Review of a progress note dated 08/18/2024 at 3:57 PM showed Resident 2 was found outside of the facility, in the community by the police at the hospital emergency room entrance and they had called the facility to alert them.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Resident 2's elopement investigation, dated 08/18/2024, signed by Staff B, showed no staff witnessed the resident leave the facility. Staff E's, Licensed Practical Nurse (LPN), statement dated 08/20/2024 at 12:51 PM showed they observed Resident 2 at approximately 1:00 PM leaving the dining room and assisted them part way down the hall and then directed Resident 2 to B wing. Staff E was notified by reception around 2:00PM that Resident 2 was found at the hospital emergency room entrance two blocks away.<br><br>In an interview on 09/03/24 at 12:05 PM, Staff E stated they observed Resident 2 on 08/18/2024 after 1:00 PM. Staff E stated they ambulated with Resident 2 part of the way and then directed them to B wing, which was down the hallway. Staff E stated that Resident 2 did not require supervision or assistance with ambulation and use of a walker.<br><br>In a joint interview/record review on 9/3/2024 at 12:50 PM, Staff B, DNS stated when they complete facility investigations, they review the care plan. Staff B stated their expectation is that staff follow residents' care plans. Staff B stated Resident 2's care plan showed they required supervision and one person assist with transfers and ambulation with a wheelchair to follow.<br><br>Reference WAC 388-97-1060(3)(g) |