STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505313	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmark Manor	32300 First Avenue South Federal Way, WA 98003

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 - Few	Respond appropriately to all alleged violations. 29644 Based on interview and record review, the facility failed to respond to abuse allegations in a timely manner, for 2 of 3 sampled residents (Resident 1 & 8). In addition, the facility failed to ensure residents were protected to prevent further potential abuse or mistreatment when they allowed Staff E, Certified Nursing Assistant (CNA), to continue to work with residents after an allegation of abuse. Failure to recognize possible abuse, suspend the alleged perpetrator pending investigation, and immediately investigate allegations, placed the resident at risk for diminished quality of life, and continued possible abuse. Findings included . Review of the facility policy, Abuse - Protection of Residents, dated 07/18/2023 showed the facility would ensure that all residents were protected from physical and psychosocial harm during and after investigations. The methods to ensure the protection of residents during investigation, may included, but were not limited to responding immediately to protect the alleged victim and integrity of the investigation, examining the alleged victim for any signs of injury, including a psychosocial assessment if needed, immediate notification of the alleged victim's practitioner and the family or responsible party, removal of access by the alleged perpetrator to the alleged victim and assurance that ongoing safety and protection is provided for the alleged victim and, as appropriate, other residents, evaluation of whether the alleged victim feels safe and if they do not feel safe, taking immediate steps to alleviate the fear and monitor the alleged victim and other residents at risk. <RESIDENT 1> Review of the 02/28/2024 Quarterly Minimum Data Set (MDS - an assessment tool), showed Resident 1's communication ability was limited to making concrete requests, and was able to respond adequately to simple, direct communication only. According to this MDS, Resident 1 was continent of bowel and bladder and requested staff assistance with toilet transfers and hygiene. Review of Resident 1's 01/29/2024 communication Care Plan (CP) indicated Resident 1 was able to understand simple English and directed staff to allow adequate time to respond. Resident 1's 03/12/2024 Self-Care performance CP showed Resident 1 was able to walk with extensive assist from bed to bathroom with the use of a gait belt and front wheeled walker, and used wheelchair when tired. A skin prevention intervention was added on 04/19/2024 that showed Resident 1 was unsteady on their feet, and may require increased supervision/assistance in the restroom when tired, to prevent fall and injury related to stumbling. (continued on next page)

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	Review of a 04/25/2024 witness statement written by Staff D, (Certified Nursing Assistant - CNA), showed while on a one-on-one shift, Staff D was sitting in the hall monitoring a resident. Around 4:35 AM on 04/21/2024 Resident 1 turned on the restroom call light and around 4:37 AM Staff E (CNA) entered the room. Staff E moved Resident 1's walker and brought Resident 1's wheelchair, Staff D heard Staff E say, Are you f*cking kidding me. You can't take 5 f*cking steps back to your bed? At this point Staff D was listening in and then approached the room, asked if everything was okay. After this, Staff D cared for their assigned resident. At 6:00 AM, after Staff D finished their shift they reported the verbal abuse to the float nurse. Review of a 04/25/2024 witness statement written by Staff F (Registered Nurse - RN), showed the incident was reported to them, by Staff D after the close of work, which I forgot to look into. During an interview on 05/06/2024 at 10:46 AM, Staff B (Director of Nursing), stated that the shift ended at 6:00 AM, and Staff D reported the incident to the nurse, Staff F, at their car in the parking lot. Staff B stated neither Staff D or Staff F followed up or reported the allegation to facility administrative staff until 04/25/2024, when Staff D reported the incident to the Resident Care Manager. Review of a 04/25/2024 7:18 PM Event Note showed after receiving the report, Resident 1 was assessed for injury, and their family and physician were notified of the allegation. The resident was then placed on alert to monitor for psychosocial harm, four days after the alleged incident. Review of daily staffing sheets with Staff B on 05/06/2024 at 10:46 AM, showed Staff E returned to work to provide care to residents the night shifts of 04/21/2024 and 04/24/2024. Review of the Suspension Pending Investigation Form showed Staff E was suspended on 04/25/2024 and terminated on 04/26/2024. <RESIDENT 8> During an interview on 05/06/2024 at 12:48 Resident 8 stated staff were gentle when providing care, no staff touched them in a manner that made them feel uncomfortable and they felt safe at the facility. Review of Resident 8's records showed a behavior note dated 05/07/2024 at 7:00 AM that Resident 8 was tearful and appeared distressed. Resident 8 stated that yesterday a man came and grabbed them from behind and placed them on the ground. Resident 8 stated there was a group of people surrounding them and the man pulled Resident 8's shorts down. The staff documented reorienting Resident 8 and offering them a cup of coffee and a quiet space. Review of the May 2024 Incident Reporting log on 05/10/2024 showed no report of the allegation made by Resident 8. During an interview on 05/10/2024 at 10:19 AM Staff B stated they were not made aware of any allegations involving Resident 8. After reading the above progress note, Staff B stated they expected staff to follow the process, including notifications and initiating an investigation after ensuring the resident's safety. Staff B stated additional education of staff was required. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	REFERENCE: WAC 388-97-0640(2)(b)(5)(6)(b)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29644 Based on interview and record review, the facility failed to obtain laboratory services according to professional standards of practice for 8 of 10 Residents (Residents 1, 2, 3, 4, 5, 6, 7 & 8) reviewed for COVID-19 testing. The facility failed to obtain Physician Orders (PO) to conduct COVID-19 testing for 6 of 10 residents (Residents 1, 2, 3, 4, 5 & 6), and failed to document the results of the testing for 3 of 10 residents (Resident 6, 7 & 8). This failure increased the likelihood for the delayed identification/diagnosis of COVID-19. Findings included . COVID-19 is an infectious virus which causes respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death. During an interview on 05/06/2024 at 10:20 AM, Staff B (Director of Nursing), stated the facility was in a COVID-19 outbreak, since 04/20/2024. The facility was conducting COVID-19 testing twice a week, and the last positive test result was on 05/02/2024. During an interview on 05/10/2024 at 11:16 AM, Staff B stated physician orders (POs) for COVID-19 testing were part of the facility's admission order sets. New admissions were tested on day 1, day 3, and day 5 after admission. There were also standing orders for COVID-19 testing as needed if symptoms or surveillance during an outbreak. <RESIDENT 1> Review of Resident 1's POs for April 2024 showed no PO and/or standing order (a PO in place permanently or until changed or canceled) for COVID-19 testing. Further review of Resident 1's record showed a COVID-19 test was performed on 04/27/2024 due to a positive result of other resident(s). The test result was negative. COVID-19 testing was documented as performed on 04/29/2024 and 04/30/2024 with negative results. <RESIDENT 2> Review of Resident 2's POs for April 2024 showed no PO and/or standing order for COVID-19 testing. Review of Resident 2's record showed a COVID-19 test was performed on 04/27/2024 and 04/29/2024 due to a positive result of another resident. Both test results were negative. COVID-19 testing was documented as performed on 04/28/2024 as Resident 2 was exhibiting one of more symptoms of COVID-19 with negative results. COVID-19 testing was documented as performed on 04/30/2024 with positive results and Resident 2 was placed on transmission-based precautions. <RESIDENT 3> (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 3's POs for April 2024 and May 2024 showed no PO and/or standing order for COVID-19 testing. Review of Resident 3's record showed a COVID-19 test was performed on 04/27/2024 due to a positive result of other residents. The test results were positive. Another COVID-19 test was performed on 05/02/2024 and the results were negative. <RESIDENT 4> Review of Resident 4's POs for April 2024 showed no PO and/or standing order for COVID-19 testing. Review of Resident 4's record showed a COVID-19 test was performed on 04/20/2024 due to a positive result of other residents. The test results were positive. Another COVID-19 test was performed on 04/27/2024 and the results were negative. <RESIDENT 5> Review of Resident 5's POs for April 2024 showed no current PO and/or standing order for COVID-19 testing. Review of progress notes dated 04/20/2024 showed Resident 5 had a change of condition and was transported to the emergency room at 9:25 AM. Resident 5 returned at 4:00 PM with a diagnosis of COVID-19. The facility nurse performed a COVID-19 test to confirm. The results of the test were not documented. Review of Resident 5's record showed an additional COVID-19 test was performed on 04/27/2024 due to a positive result of other residents. The test results were negative. <RESIDENT 6> Resident 6 admitted to the facility 04/15/2024. Review of Resident 6's orders showed a 04/15/2024 PO for a POC (Point of Care) COVID Test one time only until 04/16/2024, which was scheduled for 04/15 or 04/16/2024. The test was documented as performed on 04/15/2024. The results of the test were not documented. A 04/15/2024 PO directed staff to give a POC COVID Test one time only 3 days after admission, which was scheduled for 04/18 or 04/19/2024. This test was not documented as done as ordered. Another COVID-19 test was performed on 04/27/2024 and the results were negative. There was no associated PO for this COVID-19 test. <RESIDENT 7> Resident 7 admitted to the facility on [DATE]. Review of Resident 7's POs showed a 05/03/2024 PO for a POC COVID Test upon admission. The test was documented as performed on 05/04/2024. The results of the test were not documented. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 05/03/2024 PO directed staff to give a POC COVID Test one time only, on day 3 after admission. The test was documented as performed on 05/07/2024. The results of the test were not documented. <RESIDENT 8> Resident 8 admitted to the facility on [DATE]. Review of Resident 8's orders showed a 05/03/2024 PO for a POC COVID Test one time only on day 1 of admission. The test was documented as performed on 05/04/2024. The results of the test were not documented. During an interview on 05/10/2024 at 11:23 AM, Staff B stated staff should have, but did not document the results of the test. During an interview on 05/10/2024 at 11:39 AM, Staff C, (Licensed Practical Nurse, Infection Preventionist) stated they thought the facility implemented standing orders for COVID-19 testing as needed per State and Federal Guidelines. REFERENCE: WAC 388-97-1340 (1)(2)(3)