STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505379	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Park Health & Rehabilitation Center	7411 North Nevada Spokane, WA 99208

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 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. 27590 Based on observations, interview, and record review, the facility failed to ensure a resident was free from sexual abuse by a staff member for 1 of 3 sampled residents (Resident 1), reviewed for abuse. Resident 1 experienced harm when they reported a staff member had sexual intercourse with them and the sexual assault exam showed abrasions consistent with penile penetration. This failure placed the resident at risk for further abuse and psychosocial harm. Findings included . Review of the facility's policy titled Abuse, Neglect and Misappropriation of Resident Property Prohibition Policy, updated 10/2022, showed each resident has the right to be free from abuse, including verbal, mental, sexual, or physical abuse . Sexual Abuse was defined as non-consensual sexual contact of any type with a resident. Review of the facility assessment, dated 07/02/2024, showed Resident 1 was admitted with diagnoses to include respiratory disease and Diabetes. The resident was alert and oriented and able to make their needs known. Resident 1 required moderate assistance with Activities of Daily living (ADL's). Progress notes from 05/03/2024 through 07/01/2024 were reviewed. There was one entry on 05/03/2024 which showed Resident 1 made inappropriate sexual statements to staff. The resident was diagnosed with a urinary tract infection (UTI) and treated with antibiotics. There was no further documentation of the resident's sexual behaviors. Resident 1's care plan, revised 07/01/2024, showed the resident had a history of sexually inappropriate comments about sex when there was medical changes such as a UTI. Staff were to attempt non-medical interventions, ensure safety, and allow the resident to express experience. Social Services and Licensed Nurses were to be alerted for follow up. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility investigation, dated 07/01/2024, showed Staff B, Restorative Aide (RA) went to Staff A's, Administrator, office with Staff C, Director of Nursing (DNS), to report Resident 1 had reported engaging in sexual activity with a staff member. Review of the statement by Staff B showed the resident reported there was an inappropriate man that worked the graveyard shift. When asked what the resident meant about inappropriate, the resident sated the staff member had engaged in sexual activity with them. The resident stated they feared retaliation which was why they hadn't reported it prior. Resident 1 explained it had been going on for a while and when asked the last time if occurred, the resident couldn't remember a day but within the last week. Review of the interview between the resident and Staff C and D, Social Services Director (SSD), showed the resident explained they had been sleeping with a man. The resident stated it had been going on for about 4 months on graveyard shift. The resident stated it started out touching and gradually into intercourse. The resident was asked the last time this occurred and the resident responded a couple of days ago. The resident was not able to give a name but described the staff member. Review of hospital records, dated 07/02/2024, showed Collateral Contact 2 (CC2), SANE (Sexual Assault Nurse Examiner) nurse conducted a physical exam with Resident 1. The exam revealed a red linear rectangle like abrasion, on the posterior opening of the vaginal canal, at the 8 o'clock position, and measured 6 millimeters (MM) by 2 mm. There was an additional abrasion in the 5 o'clock position, which measured 1 mm by .25 mm. The resident complained of being tender at both areas of injury. During an interview on 07/03/2024 at 12:20 PM, Staff A and Staff C, stated Staff B immediately reported to them Resident 1 had reported sexual abuse. Staff C and Staff D went and interviewed Resident 1. Three staff members met the description the resident had given and were suspended. Staff A stated they notified the resident's family of the allegation and the family wanted to talk with the resident before they sent the resident to the hospital for a sexual assault exam. The following day, July 2nd, the resident was sent out to the hospital and later that day, Staff A received a call from the hospital and was told trauma had been found on the exam. On 07/03/2024 at 3:04 PM, Collateral Contact 1 (CC1) was interviewed. CC1 stated they were informed by Staff A Resident 1 had made an allegation of sexual abuse. Staff A had explained the process of going to the emergency room for an exam and CC1 wanted to talk with the resident first. The CC1 explained Resident 1 had not made an actual allegation before but a couple of months prior, Resident 1 had commented they wanted to be sexual. CC1 stated Resident 1 was diagnosed with a UTI at that time and after the UTI had been treated, the sexual behavior stopped. CC1 stated when they asked Resident 1 about the sexual abuse, the resident had specific, detailed information about the encounter and CC1 was confident sexual abuse had occurred. After the conversation with the resident, CC1 requested the resident be sent to the hospital for an exam. CC1 accompanied the resident for the exam which showed vaginal abrasions and was told the injuries had happened 2 days or less prior to the exam. On 07/03/2024 at 3:30 PM, Resident 1 was observed lying in bed in their room. Resident 1 stated the encounter had occurred at night. Resident 1 stated they thought the staff member had come into the room to provide care. Resident 1 could not provide a name but described the staff member, which was the description they had provided to the facility. Resident 1 stated the staff member pulled down their brief, touched them, and proceeded to have sex with them. Afterwards, the staff member gave the resident a wash cloth to clean themselves up. Resident 1 went on to say they reported it to Staff B but didn't realize everyone was going to be told. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/30/2024 at 2:40 PM, CC2 stated they examined Resident 1. CC2 had a urinalysis done and it was negative for a UTI. CC2 said they collected evidence and did a physical exam. Resident 1 had two external abrasions on the genitalia. CC2 stated the posterior abrasion was consistent with penile penetration. Reference: WAC 388-97-0640 (1)

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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 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. 27590 Based on interview and record review, the facility failed to prevent the development of a pressure ulcer for 1 of 3 sampled residents (Resident 3), reviewed for pressure ulcers. Resident 3 was at an increased risk for skin breakdown and developed an unstageable pressure ulcer that was not identified while at the facility. This failure placed the resident at risk for worsening pressure ulcer and a diminished quality of life. Findings included . Review of the facility admission assessment, dated 06/16/2024, showed Resident 3 was admitted with diagnoses which included Diabetes and paraplegia (paralysis of the legs and lower body). The resident was moderately impaired with decision making. Resident 3 required maximum assistance with bed mobility. The assessment showed the resident was at risk for pressure ulcers, did not currently have a pressure ulcer but had MASD (Moisture Associated Skin Damage which is inflammation of the skin caused by prolonged exposure of moisture which includes urine or stool). Review of the resident's care plan, dated 06/10/2024, showed Resident 3 was at risk for pressure ulcer development related to immobility, Diabetes, and paraplegia. Staff were to float the resident's heels, frequently reposition the resident, and inspect the skin when providing care. Review of nursing notes from 06/10/2024 - 06/23/2024 showed there was no documentation related to the resident's skin, which included the MASD that was identified on the facility admission assessment. Review of hospital records, dated 06/23/2024, showed the resident was admitted from the facility due to a change in condition. The resident was identified with an unstageable (base of the wound is covered by a layer of dead tissue that may be yellow, grey, green, brown, or black) pressure ulcer. During an interview on 08/02/2024 at 1:27 PM, Staff E, Resident Care Manager (RCM), stated when a resident was admitted , two different nurses evaluate the resident's skin, on admission and then the next day. The nurses also do weekly skin checks. The shower aides have skin sheets they document on as to whether a resident has skin impairments. If there is a skin issue, the shower aide will give one copy to the floor nurse and one copy to the RCM. The nurse or RCM will then go in and evaluate the area. This is a newer process started after the facility was made aware Resident 3 had a pressure ulcer when sent to the hospital. Reference: WAC 388-97-1060 (3)(b)

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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** 47309 Based on interview and record review, the facility failed to ensure supervision was provided as planned 1 of 3 sampled residents (Resident 2) reviewed for falls. Resident 2 experienced harm when they fell out of their bed and sustained a head laceration and skull fracture. This failure placed residents at risk for similar falls, injuries, and adverse outcomes. Findings included . The 02/2000 facility policy titled Fall Evaluation (Morse Scale) and Management documented the licensed nurse completes the Morse Scale, (an assessment tool that helps determine if a resident is at high risk for falls), then implements the appropriate care plan interventions for fall risk management based on the resident's medical history and evaluation. <Resident 2> A review of the record showed Resident 2 had diagnoses including dementia, failure to thrive, and osteoporosis (weak or brittle bones). The 05/01/2024 annual comprehensive assessment documented Resident 2 was severely cognitively impaired, was not understood when speaking, and was totally dependent on staff for activities of daily living (ADLs) including transfers from their bed. The Care Plan revised on 05/15/2024 showed Resident 2 was at risk for falls related to weakness, unaware of safety needs, impaired mobility, and dementia. Staff were instructed to anticipate and meet the resident's needs, attempt to keep the call light in reach and encourage them to use, keep the left side of the bed against the wall, ensure it is snug, and keep the brakes locked, ensure appropriate footwear when out of bed, fall mat at the right side of the bed when the resident is in bed, high/low bed in low position when the resident is in bed, and keep the room free of clutter. Resident 2 was dependent on two staff and a mechanical lift (hoyer) when transferring from their bed to their wheelchair. A review of the 07/15/2024 at 5:00 AM nursing progress notes documented a nursing assistant (NAC) went to the nurse's station and stated Resident 2 had rolled out of bed and was bleeding from their head. When assessed, Resident 2 had a laceration on their scalp at the hairline but had no deformities in their extremities and no change in their level of consciousness. The resident was sent to the emergency room for possible stitches. The progress notes further documented the resident's bed was halfway up, not in the lowest position, and their fall mat was not in use when the NAC went to grab the mechanical lift to get the resident out of bed and the resident rolled out of bed at that time. A review of the 07/15/2024 emergency room visit documented Resident 2 had a ground level fall and struck their head on the floor with no loss of consciousness. The resident was nonverbal at baseline and had dementia. Imaging of the resident's head and spine showed a fracture of their skull. The provider sutured an 8-centimeter scalp laceration and did not attempt to remove a piece of bone that was seated firmly in the area of the laceration. The provider noted that the resident slept throughout the examination. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A 07/15/2024 Facility Neurological Evaluation document showed that at 5:00 AM (post-fall), Resident 2 was alert, their pupil response was brisk, they were moving all extremities, and their vital signs were within normal limits. The document further showed that the resident was at the hospital from 5:45 AM until the next entry at 10:45 AM. At this time, Resident 2's level of consciousness was listed as stupor, their pupils reacted sluggishly, they were unable to follow commands, and there was no response to painful stimuli. The 07/15/2024 at 4:17 PM Nurse Practitioner progress note documented that Resident 2 returned to the facility after an evaluation at the emergency room where they were treated for their head laceration. The note documented that upon Resident 2's return to their room, they were pale, unarousable, and had breathing that indicated death was imminent. The NAC had positioned the resident for comfort and exited to retrieve pain medication for the resident. At this time Resident 2 passed away around 12:39 PM. The 07/15/2024 Fall Incident Investigation documented two NACs were assisting Resident 2 in getting ready for the morning and was prepared to be transferred by a mechanical lift, a system that uses a sling under a resident that is attached to a lift that when cranked up raised a resident off their bed. This procedure required two staff to complete. The investigation noted Resident 2 was care-planned to have the bed against the wall with a mat by the bedside because they had unpredictable movements and rolled. Staff G, NAC, positioned Resident 2 on the sling in the center of the bed. The floor mat was moved from the side of the bed to make room for the mechanical lift to fit under the bedframe. The investigation noted that the bed was elevated approximately two feet in the air. Staff G left the bedside, retrieved the mechanical lift from the alcove at the room's entryway and then backed the lift into the room and heard the resident fall on the ground behind them. The investigation concluded that facility protocols were followed at the time of the fall, and abuse was ruled out. During an interview on 07/16/2024 at 4:02 PM, Staff H, NAC, stated they had just started their shift on 07/15/2024 close to 5:00 AM, and was asked to help lift Resident 2 out of bed to their chair. As they approached Resident 2's room, Staff G told them they had turned to get the mechanical lift and heard Resident 2 fall. Staff H stated when the emergency medical services team arrived, Resident 2 was awake and talking. When the resident returned from the emergency room , they assisted Resident 2 into a clean shirt, and positioned them for comfort, but the resident did not make any responses and passed away shortly after this. During an interview on 07/16/2024 at 4:31 PM, Staff F stated they spoke with Staff G and H after the fall. Staff F confirmed that the use of a mechanical lift required two staff and once a resident was in bed with the bed elevated, staff were not to leave the resident and Staff G left Resident 2 only for a few seconds when they went to retrieve the mechanical lift from the entryway. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/16/2024 at 5:03 PM, Staff G, NAC, stated they provided care for Resident 2 often and it was the normal routine to get Resident 2 up first thing in the morning. Staff G stated they had provided care to Resident 2 and positioned them in the middle of the bed with the sling under [NAME] them. They stated they had raised the bed, moved the floor mat and positioned the resident's wheelchair at the head of the bed to get it ready for the resident when they noticed the oxygen tank on the back of the wheelchair was empty. Staff G stated they left the room to tell the nurse that the resident needed another oxygen tank and to ask Staff H to help them transfer Resident 2 with the mechanical lift. Staff G stated they were unsure how long they were away from Resident 2's room, but it might have been 1 or 2 minutes. Staff G returned to the room and was backing into the room with the mechanical lift when they heard the resident fall. Staff G stated the saw that Resident 2's head was bleeding, so they immediately called for help. Staff G stated the looking back, they would not have left the resident's bed elevated but they never thought Resident 2 would be able to roll out of bed and it was an accident. During a follow-up interview on 07/24/2024 at 2:02 PM, Staff F stated they had further discussed the fall with Staff G, and stated they educated Staff G regarding safe transfers and that they were not to leave a resident unattended with their bed elevated. Staff F stated after Resident 2's fall, all staff that helped transfer residents were assigned mandatory education regarding safe transferring techniques. Reference: WAC 388-97-1060(3)(g)