STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505387	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Mother Joseph Care	3333 Ensign Road Northeast Olympia, WA 98506

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40914 Based on interview and record review, the facility failed to ensure possible allegations of abuse were thoroughly investigated for 1 of 3 residents (Resident 1), reviewed for abuse/neglect investigations. This failure placed residents at risk for unidentified abuse and a diminished quality of life. Findings included . The facility policy, Abuse Prohibition and Prevention, dated 01/2024, documented a thorough investigation would be completed in response to a suspected or allegation of abuse, neglect, exploitation and/or mistreatment. An investigation would include an assessment of the interactions and relationships between caregivers and the alleged victim (AV) and interviews with the AV, witnesses, and provider. A record review would be completed related to the alleged violation. Resident 1 was admitted to the facility on [DATE] with diagnoses including stroke-like symptoms, bipolar disorder, and post-traumatic stress disorder (PTSD). The admission Minimum Data Set (MDS)/an assessment tool, documented Resident 1 had moderate cognitive impairment and required supervision from staff with activities of daily living (ADLs). The facility investigation, undated, showed Resident 1 was evaluated for their needs while at home by collateral contact (CC) A, a nurse. CC A reported to the facility on [DATE], Resident 1 had told them, during the evaluation, they were in a relationship with Staff D, Physical Therapy Assistant. CC A said Resident 1 had reported to them that they had to wait until the resident was discharged before the resident and Staff D came out with their relationship. CC A reported Resident 1's statements to the facility. On 07/24/2024, Staff D was interviewed by the facility and denied an inappropriate relationship with Resident 1. Staff D admitted to going on walks with the resident, bringing them groceries and pizza, and driving the resident to the store. The investigation showed an unnamed witness on an unknown date and unknown time, had reported seeing the resident and Staff D holding hands in the parking lot of the facility. Staff D said they had only been supporting the resident due to a balance issue. Staff D admitted to being named Resident 1's emergency contact. On 09/19/2024, Resident 1 called the facility and spoke in an accusatory and threatening manner towards staff. Resident 1 said Staff D and Resident 1 were sharing an apartment and they were legally and financially bound together. Resident 1 requested a call back to further discuss concerns. No documented return call was provided. On 09/30/2024, Staff B was terminated due to violation of facility policy. The investigation lacked an interview from Resident 1 (AV) or a sample of residents who received care from Staff B or with Staff B's peers. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505387	A. Building B. Wing	11/08/2024

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/08/2024 at 2:26 PM, Staff B, Registered Nurse and Director of Nursing, said she could not find further interviews related to the investigation. Staff B said she had not participated in the investigation. Staff B said she would have expected peer and sample resident interviews to be a part of the investigation. Staff B said the investigation was not thorough. Reference WAC 388-97-0640 (6)(a)(b)