

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505387	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER Providence Mother Joseph Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40914</p> <p>Based on interview and record review, the facility failed to ensure residents hearing needs were addressed and they had access to bariatric (treatment of obesity) equipment for 1 of 1 sampled resident (Resident 1) reviewed for accommodation of needs. These failures placed resident at risk of diminished independent functioning and a loss of comfort.</p> <p>Findings included .</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus, heart failure, and kidney failure. The Minimum Data Set (MDS, an assessment tool), dated 10/08/2024, documented Resident 1 had no cognitive impairment, weighed 475 pounds, and was not on a physician-prescribed weight loss regimen.</p> <p><Hearing></p> <p>On 12/03/2024 at 3:31 PM, Resident 1 said several complaints had been made about their hearing and there had been no resolution. The resident said he was told the facility could not send him out to an appointment.</p> <p>On 02/05/2025 at 3:06 PM, Resident 1 said they continued to have ear and hearing issues and could not get to an appointment. Resident 1 said there was one local transport service, but they could not tolerate sitting for thr time needed to use it safely. Resident 1 said no other options had been provided.</p> <p>Physician Orders, dated 05/15/2024, showed an order for debrox ear drops (drops to soften ear wax) ordered for ear discomfort.</p> <p>Physician Orders, dated 06/18/2024, showed an order for debrox ear drops for ear discomfort.</p> <p>Physician Orders, dated 11/29/2024, showed an Ears, Nose, and Throat (ENT) referral for hearing loss and potential ear wax build up.</p> <p>On 02/06/2025 at 2:45 PM, Staff F, Nursing Assistant (NA), said Resident 1 was hard of hearing and would ask her to speak up so the resident could hear her.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 4:40 PM, Staff B, Registered Nurse and Director of Nursing Services, said Resident 1 had a referral for an ENT appointment. Staff B said due to the resident's size, there was only one way to transport Resident 1 to appointments. The ride service attempted to do an assessment to determine the resident's ability to ride the van safely. The resident failed one attempt and cancelled the other. No other attempts to transport to a hearing appointment had been made.</p> <p>At 5:30 PM, Staff A, Administrator, said there were no other options to send a resident to an appointment for Resident 1's ongoing hearing concern.</p> <p><Bariatrics></p> <p>Resident 1's comprehensive care plan, dated 01/03/2024, documented Resident 1's BMI (Body Mass Index, calculates weight relative to height) was elevated, indicating morbid obesity. The resident declined a dietician consult as they were not interested in losing weight.</p> <p>Progress notes, dated 09/30/2024, documented the resident weighed 482 pounds and the mechanical lift could only accommodate 500 pounds. [Resident 1] was notified if his weight exceeded 500 pounds, the resident will need to be transferred to another facility. The provider offered Ozempic (a drug for weight loss) and the resident agreed.</p> <p>Progress notes, dated 10/28/2024, documented Resident 1 was not interested in and was not trying to lose weight.</p> <p>On 12/03/2024 at 3:31 PM, Resident 1 said Staff G, Case Manager had come in and told the resident they did not have equipment at the facility to support residents who weighed greater than 500 pounds. Resident 1 said Staff G had told them they would have to transfer to another facility if they gained any more weight. Resident 1 was told the Hoyer (a mechanical lift to get residents in and out of bed) was one of the pieces of equipment they would not be able to use. The resident said they did not use the Hoyer lift. Resident 1 said the transfer pole he liked having to help reposition or get into a wheelchair had been removed. Resident 1 said he had been using the pole for quite some time. The resident said the whole situation made them angry and hurt. Resident 1 did not want to transfer to another facility.</p> <p>Progress notes, dated 01/30/2025, documented mechanical lifts had a weight limit of 500-pounds, transfer poles had a weight limit of 300-pounds if installed via tension or 450-pounds if bolted to the ceiling. The facility ceiling tiles prevented use of the ceiling to bolt the pole. The beds had 650-pound weight limit. The width of Resident 1's bed measured 50 inches and doorway was 48 inches.</p> <p>On 02/05/2025 at 3:06 PM, Resident 1 said he went to the hospital for a brief illness and when he returned, he overheard an unknown staff member say the hospital should have called prior to the resident returning because they would have declined to accept the resident due to their weight. Resident 1 took this as the facility attempting to reject the resident because they did not have the equipment they need to care for the resident.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/06/2025 at 2:05 PM, Staff C, Licensed Practical Nurse, said Resident 1 required one person assistance to pivot into the wheelchair. Staff C said he did not use a Hoyer. Staff C said Resident 1 was really frustrated about their weight gain and feels like nothing is working but then staff would go into the resident's room and find them binge eating. Staff C said it has been frustrating for both the resident and the provider, who is trying to help with weight loss. Staff C said the resident does not want to go to another facility, that they want to go home.</p> <p>At 2:45 PM, Staff F, NA, said Resident 1 normally did not get out of bed but when they did, they required one person assist to pivot into the wheelchair.</p> <p>At 2:55 PM, Staff E, Dietary Technician, said Resident 1 did not voice a desire to lose weight. Staff E said the resident would eat a healthy main meal and would want their desserts. Staff E was aware the resident was told they needed to discharge if they gained more than 500 pounds. Staff E said they had tried to support the resident and accommodate the resident's health eating choices.</p> <p>At 3:20 PM, Staff D, Social Services, said the facility Hoyer could not be used on a resident who weighed over 500 pounds and that Resident 1 required the use of the Hoyer for transfers. Staff D said Resident 1 will say they want to get healthier but Resident 1 does not specifically voice the desire to lose weight. Staff D said if the resident were to gain more weight, they would need to be transferred to a facility that accepted bariatric residents.</p> <p>At 4:40 PM, Staff B said Resident 1 was told if their weight exceeded 500 pounds, they would have to be discharged to a facility who accepted bariatric residents. Staff B said they have never had a resident over 500 pounds admitted to the facility. Staff B said they have tried to help the resident with his diet and losing weight. Staff B said Resident 1 did not have a goal to lose weight, agreeing the facility's goal to have the resident lose weight was not in alignment with the resident's wishes. Staff B said the facility was looking at equipment but there have been no plans to purchase bariatric equipment.</p> <p>At 5:30 PM, Staff A, Administrator, said Resident 1 was eager to lose weight and he was hopeful they would not need to discharge the resident. Staff A said they had to talked to their senior leadership about lifts but they were very expensive and there were no plans in place to purchase bariatric equipment. When asked if their was a plan in place if the resident declined to transfer to another facility, Staff A said there was not.</p> <p>Reference WAC 388-97-0860 (2)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40914</p> <p>Based on interview and record review, the facility failed to develop a comprehensive plan of care for urinary care and urinary tract infection (UTI, an infection of the urine) for 1 of 4 sampled residents (Residents 1) reviewed for care plans. The failure to establish individualized care plans, that accurately reflected assessed care needs and provided direction to staff, placed residents at risk to receive inappropriate and inadequate care to meet their individualized needs.</p> <p>Findings included .</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus, heart failure, and kidney failure. The Minimum Data Set (MDS, an assessment tool), dated 10/08/2024, documented Resident 1 had no cognitive impairment and required maximal assistance from staff with toileting.</p> <p>The Care plan, dated 01/02/2024, documented Resident 1 needed assistance with activities of daily living (ADLs) due to deconditioning and poor activity intolerance.</p> <p>The Urine Analysis (a test to check for organisms in the urine) tests results, dated 08/13/2024, 10/02/2024, 10/29/2024, 12/28/2024, and 01/31/2025, showed Resident 1 had ongoing UTIs with the organism klebsiella pneumoniae (a bacteria normally found in human stool and are often identified as healthcare-associated infection).</p> <p>On 12/03/2024 at 3:31 PM, Resident 1 said due to their anatomy, it was difficult to use a standard urinal. The resident said they had a special, large urinal they used for urinating. Resident 1 required staff to assist with placement of the urinal then staff leave the resident for privacy. Resident 1 said they often wait lengthy periods before staff return to remove the urinal. In the meantime, their genitals sit in urine. Resident 1 believed this increased their risk of UTIs. The resident said they had many UTIs, and they did not believe the facility was acting to prevent occurrences.</p> <p>On 02/05/2025 at 3:06 PM, Resident 1 said staff, particularly inexperienced staff, did not know how to use the urinal due to the larger size and their unique anatomy. Resident 1 said they directed staff on how to assist the urinal correctly or else they would not know what to do. Resident 1 said they recently had another UTI.</p> <p>On 02/06/2025 at 2:45 PM, Staff F, Nursing Assistant, said she did not know how to prevent UTIs. Staff F said Resident 1 just showed her how to use the urinal.</p> <p>At 4:40 PM, Staff B, Registered Nurse and Director of Nursing Services, said Resident 1 did not have a care plan for UTIs or for assistance with the urinal. Staff B said these care areas should be care planned.</p> <p>Reference WAC 388-97-1020 (1), (2)(a)(b)</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>40914</p> <p>Based on interview and record review, the facility failed to ensure the facility assessment (document describing resident population and needs to determine staff and other resources necessary to competently care for residents) was updated to accurately determine and identify the resources needed for the facility residents who needed bariatric (treatment of residents' who experience morbid obesity) care. This failure placed the residents at risk for unmet care needs and a diminished quality of life.</p> <p>Findings included .</p> <p>The Facility Assessment, dated March 2024, documented the facility assessed all resident needs, developing an action plan to train and support nursing staff to care for the resident. The analysis categories included bariatrics and how it impacted over all staffing, training, and services were noted as evaluated. The assessment lacked any detail on how the facility would support residents who were considered bariatric. The assessment was not revised when concerns arose related to residents who were bariatric.</p> <p>On 12/03/2024 at 3:31 PM, Resident 1 said staff told the resident they did not have equipment at the facility to support residents who weighed greater than 500 pounds. Staff G told the resident they would have to transfer to another facility if they gained anymore weight. Resident 1 was told the Hoyer (a mechanical lift to get residents in and out of bed) was one of the pieces of equipment they would not be able to use. A transfer pole was removed from use. The resident really liked having the transfer pole to help reposition or get into the wheelchair. The resident said he had been using the same equipment for some time.</p> <p>Progress notes, dated 09/30/2024, documented the resident weighed 482 pounds and the mechanical lift could only accommodate 500 pounds. Resident 1 was notified if their weight exceeds 500 pounds, the resident would need to be transferred to another facility. The provider offered Ozempic (a drug for weight loss) and the resident agreed.</p> <p>Progress notes, dated 01/30/2025, documented mechanical lifts had a weight limit of 500-pounds, transfer poles had a weight limit of 300-pounds if installed via tension or 450-pounds if bolted to the ceiling. The facility ceiling tiles prevented use of the ceiling to bolt the pole. The beds had 650-pound weight limit. The width of Resident 1's bed measured 50 inches and doorway was 48 inches.</p> <p>At 5:30 PM, Staff A, Administrator, said Resident 1's weight was close to 500 pounds and the facility determined they did not have equipment to support residents who were bariatric. The facility did not review or update the Facility Assessment to address bariatric support.</p> <p>There was no reference WAC associated with this F-tag</p>		