STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505406	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Health Care Center	855 Aaron Drive Lynden, WA 98264

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on interview and record review, the facility failed to ensure policies and procedures for timely reporting of fall for 1 of 4 residents (Resident 51) reviewed for abuse. The facility failed to report to the state agency when a resident fell after, during a transfer, in which their care plan was not being followed. This failure by the facility to identify, report, and investigate for an allegation of potential abuse or neglect placed residents at risk of being victims of unidentified and uninvestigated abuse and/or neglect and limited the thoroughness of investigations. Findings included . Review of the facility policy titled, Reporting Abuse to Facility Management dated 10/24/2022 showed: When an alleged or suspected case of serious injuries of unknown source, or abuse is reported, the facility Administrator or designee, will immediately (within two hours of alleged incident) notify the following persons or agencies of such incident as indicated by regulation; if the alleged violation involves neglect, exploitation, mistreatment, or misappropriation of resident property and does not result in serious bodily injury, results will be reported within 24 hours, and results of all investigations of alleged violations will be reported via log within five working days: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The Resident's Representative (Sponsor) of Record; c. Adult Protective Services as appropriate; d. Law Enforcement Officials (when there is suspicion or confirmation of a crime); e. The Resident's Attending Physician (immediately); and f. The Facility Medical Director. Review of the facility policy titled, Abuse Investigations Policy dated 10/24/2022 showed the facility will report allegations of abuse and neglect to state agencies as required per regulation. All reports of resident abuse, neglect and injuries of unknown source shall be thoroughly investigated. Witness reports will be obtained, and the witnesses will be required to sign and date written reports and the resident, and their representative kept informed of the progress of the investigation. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 51 admitted to the facility on [DATE] with diagnoses that included symptomatic epilepsy (seizures that are cause by an underlying brain disease), retinal vein occlusion (blockage in a vein that drains blood from the retina), and Alzheimer's Disease (progressive disease that destroys memory and other important functions). Review of Resident 51's Quarterly Minimum Data Set (MDS-an assessment tool) dated 06/04/2024 showed the resident had severe cognitive impairment. Review of Resident 51's care plan dated 06/03/2024 showed they required moderate assistance of two staff members with transfer from their wheelchair to toilet with use of grab bar and to allow them extra time for feet placement and balance before the commode swap transfer was completed. Resident 51's care plan was updated 8/19/2024 for them to use a bed pan/urinal. In an interview on 08/16/2024 at 8:31 AM Collateral Contact 1 (CC1), Resident 51's representative, stated they were notified, recently, by the facility that Resident 51 had a fall in the bathroom . Review of the state incident reporting log for August 2024 showed no entries related to Resident 51's fall in the bathroom on 08/11/2024. Review of the facilities fall investigation dated 08/11/2024, showed Resident 51 experienced a fall in their bathroom after the staff caring for them lost their footing on a Hoyer (a mobile floor lift system that transfers a person from one surface to another) sling, slipped and fell , which resulted in Resident 51 falling on top of the staff onto their bottom. The incident report showed Resident 51's care plan was reviewed, and no new interventions were implemented. The incident report showed Resident 51, prior to the fall, had been changed from a two person assist with a front wheel walker to a Hoyer lift for transfers in/out of bed as they were unable to transfer safely. In an interview on 08/19/24 at 2:26 PM Staff D, Licensed Practical Nurse (LPN), stated Resident 51 sustained a fall in the bathroom after an aide tripped and fell on the Hoyer sling that was located on the resident's wheelchair during a transfer. Staff D stated the staff had not followed the care plan and was by himself during the transfer/care of Resident 51. Staff D stated abuse and neglect were ruled out as Resident 51 had not been harmed during the fall. Staff D stated they were in the process of educating the staff involved in the fall. In a follow up interview on 08/21/2024 at 9:01 AM Staff D, LPN stated they were alerted to Resident 51's fall on 08/11/2024 and they initiated their investigation on 08/12/2024. Staff D stated the facility's policy was to report any allegations of abuse/neglect to the state if they felt that it was abuse/neglect. Staff D stated they spoke to the staff involved in Resident 51's fall, could not recall the date, and they were aware they did not follow the care plan. Staff D stated the definition of neglect included not caring for a resident or providing for their needs. Staff D stated they felt the fall was an accident as the staff involved was providing care to Resident 51 and had no pattern of not providing care to residents. Staff D stated CC1 had not been notified that the staff involved in the fall was not following the care plan at the time of Resident 51's fall. Staff D stated that not following a resident's care plan could be considered neglect. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a joint interview with Staff A (Administrator) and Staff B (Director of Nurses), Staff A stated Resident 51's fall was determined to be an accident and abuse/neglect was ruled out and did not require any report to the state agency. Staff B stated the staff involved in the fall had a pattern of not following resident's care plan where they were reinstructed in June and had struggled early in the year and required extra support and training. Staff B stated the staff involved had no serious disregard for consequences thus neglect was ruled out, they did not willfully show intent to not follow the care plan and they went based on what they thought. Refer to WAC 388-97-0640(5)(a)

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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	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on observation, interview, and record review the facility failed to ensure possible allegations of abuse/neglect were thoroughly investigated for 1 of 4 residents (Residents 51), reviewed for abuse/neglect investigations. This failure placed the resident at risk for unidentified abuse or neglect and a diminished quality of life. Findings included . Review of the facility policy titled, Abuse Investigations Policy dated 10/24/2022 stated an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source be reported, the Administrator, or their designee, will appoint a member of management to investigate the alleged incident. Witness reports will be obtained and be required to sign and date written reports. The individual conducting the investigation would, as appropriate Interview the person(s) reporting the incident and staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. Resident 51 admitted to the facility on [DATE] with diagnoses that included epilepsy (seizures that are cause by an underlying brain disease), retinal vein occlusion (blockage in a vein that drains blood from the retina), and Alzheimer's Disease (progressive disease that destroys memory and other important functions). Review of Resident 51's Quarterly Minimum Data Set (MDS-an assessment tool) assessment dated [DATE] showed the resident had severe cognitive impairment. Review of Resident 51's care plan dated 06/03/2024 showed the resident required moderate assistance of two staff members with transfer from their wheelchair to toilet with use of grab bar and to allow them extra time for feet placement and balance before the commode swap transfer was completed. Resident 51's care plan was updated on 8/19/2024 for staff to use a bed pan/urinal for toileting needs. Review of the facilities incident report, dated 08/11/2024, showed Resident 51 experienced a fall in their bathroom after the staff caring for them lost their footing on a Hoyer (a mobile floor lift system that transfers a person from one surface to another) sling, slipped and fell , which resulted in Resident 51 falling on top of the staff onto their bottom. The incident report showed Resident 51's care plan was reviewed, and no new interventions were implemented. The incident report showed Resident 51, prior to the fall, had been changed from a two person assist with a front wheel walker to a Hoyer lift for transfers in/out of bed as they were unable to transfer safely. There was no notation of Resident 51's transfers on/off the toilet. The incident report contained a statement from the nurse and the Nursing Assistant Certified (NAC) involved in the body of the incident report. There were no other statements or follow up interviews. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/19/2024 at 2:16 PM Staff E, NAC, stated they were the staff involved in the fall with Resident 51. Staff E stated Resident 51 was a standard two person assist and then they became a Hoyer transfer and staff were to always have two people in the room when transferring them. When asked about the Resident 51's fall, Staff E stated, they were unaware of the sling in the resident's wheelchair and their foot slipped on the sling buckle while holding Resident 51 and they fell , and the resident fell with them. Staff E stated they were the only staff in the bathroom at the time of the fall, the call light to the bathroom was on, and the nurse came in after the fall. Staff E stated they provided care for the resident once a week to once every two weeks. Staff E stated Resident 51 had been able to stand up by themselves and they used the gait belt. Staff E stated they were not aware Resident 51 care had changed to them requiring a Hoyer lift for transfers. Staff E stated they knew how to care for Resident 51 that day by skimming through the care plan, knew that they needed 2-person assistance and a gait belt and faulted themselves by not reading the care plan thoroughly enough. Review of Resident 51's care plan dated 06/03/2024 showed Resident 51 required moderate assistance of two staff members with transfer from their wheelchair to toilet with use of grab bar and to allow them extra time to for feet placement and balance before the commode swap transfer was completed. In an interview on 08/19/2024 at 2:26 PM Staff D, Licensed Practical Nurse (LPN) stated Resident 51 sustained a fall in the bathroom after an aide tripped and fell on the Hoyer sling located on the resident's wheelchair during a transfer. Staff D stated the staff had not followed the care plan and was by themselves during the transfer/care to Resident 51 while in the bathroom. Staff D stated abuse and neglect were ruled out as Resident 51 had not been harmed during the fall. Staff D stated they were in the process of educating the staff involved in the fall. In an interview on 08/21/2024 at 11:14 AM Staff F, Registered Nurse (RN), stated Resident 51 fell during the prior evening. Staff F entered the room and stated that Resident 51's bathroom call light was on. When they entered the bathroom they saw Staff E on the floor and the resident sitting on top of Staff E. When Staff F asked what had happened the NAC told them they finished toileting Resident 51 and they were dressing them for the night, the NAC lost their footing when their foot became tangled in the Hoyer sling. Staff F stated they reviewed Resident 51's care plan after the fall which showed they were a one person assist with use of a grab bar. Staff F stated they reviewed the paper copy of Resident 51's care plan located at the nurse's station in the binder and did not review the care plan located in the electronic health record for Resident 51. Staff F stated they notified Staff D of the incident through email and text message and started an incident report electronically. Staff F stated they were not interviewed by any facility staff regarding the incident. In an interview on 08/19/2024 at 2:36 PM Staff B stated falls require an investigation to include statements and interviews with staff and residents about what occurred. The investigation would also include completing assessments for injuries and necessary notifications. All the information would be taken and reviewed to conduct a root cause analysis. When asked how abuse and neglect were ruled out for Resident 51 and the fall sustained, Staff B stated there was not a pattern of misconduct and there was no intent by the staff to harm the resident. (continued on next page)

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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	In a follow up interview on 08/21/2024 at 9:01 AM Staff D stated they were alerted to Resident 51's fall on 08/11/2024 and they initiated their investigation on 08/12/2024. Staff D stated the facility's policy was to report any allegations of abuse/neglect to the state if they felt that it was abuse or neglect. Staff D stated they spoke to the staff involved in Resident 51's fall, could not recall the date, and they were aware that staff had not followed the care plan during this incident. Staff D stated the definition of neglect included not caring for a resident or providing for their needs. Staff D stated they felt the fall was an accident as the staff involved was providing care to Resident 51 and had no pattern of not providing care to residents. Staff D stated CC1 had not been notified that the staff involved in the fall was not following the care plan at the time of Resident 51's fall. Staff D stated that not following a resident's care plan could be neglect. Review of employee file on 08/21/2024 at 9:30 AM, showed Staff E had been reeducated: -On 08/19/2024 to follow residents individualized are plans. -On 06/14/2024 to follow residents individualized care plans. -On 01/09/2024 to follow care plans, in addition to other identified areas. In a joint interview on 08/21/2024 at 2:08 PM with Staff A (Administrator) and Staff B (Director of Nurses), Staff A stated Resident 51's fall was determined to be an accident and abuse/neglect was ruled out not requiring any report to the state agency. Staff B stated the staff involved in the fall had a pattern of not following resident's care plan where they were reeducated in June and had struggled early in the year and required extra support and training. Staff B stated the staff involved had no serious disregard for consequences thus neglect was ruled out, they did not willfully show intent to not follow the care plan and they went based on what they thought. Refer to WAC 388-97-0640 (6)(a)(b)