STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505418	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Marianwood	3725 Providence Point Drive Southeast Issaquah, WA 98029

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 44295 Based on observation, interview, and record review the facility failed to ensure resident responsible parties were notified when there was a change in condition or when a resident experienced a fall for 1 (Resident 1) of 3 residents reviewed. These failures violated a resident's right to have their representative involved and informed of any changes in condition. Findings included . Review of the facility policy titled, Fall Prevention and Response, revised 08/2023, showed after a resident experienced a fall the licensed nurse was required to notify the provider and the resident's representative. <Resident 1> Review of an admission Minimum Data Set (MDS, an assessment tool), dated 06/06/2024, showed Resident 1 was not able to make their own decisions, was rarely or never understood by others, and was assessed with an altered level of consciousness (a change in the resident's awareness of the environment with reduced alertness). The MDS showed Resident 1 had impairments to one side of their body, affecting one arm and one leg. The MDS showed Resident 1 was dependent on staff for bed mobility, toileting, and transfers. The MDS showed Resident 1 was non-verbal and had diagnoses including a history of a brain bleed (stroke), high blood pressure, and diabetes. Review of Resident 1's face sheet (a summary of the residents personal and demographic information), undated showed Resident 1 had a Collateral Contact (CC) to contact for changes in condition. Review of Resident 1's fall Care Plan (CP), revised 07/23/2024, showed Resident 1 was at risk for falls related to general weakness and current medical conditions. The CP directed staff to ensure the call light was in reach, prompt the resident to call for assistance, and ensure the resident was positioned in the center of the bed. (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
	505418	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Marianwood	3725 Providence Point Drive Southeast Issaquah, WA 98029

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a fall investigation, dated 07/25/2024, showed Resident 1 was found on the floor by their bed lying face down on their stomach. The investigation showed Resident 1 was not able to verbalize what happened and it was believed Resident 1's fall was likely caused by the resident trying to reposition themselves in bed. The investigation showed the provider and the residents representative were informed of the fall, the documentation did not show the date or time when the notifications occurred. Review of a concern form, dated 09/04/2024, showed Resident 1's CC was very concerned they did not receive notification of Resident 1's fall. The concern form showed Resident 1's CC asked several times how this happened and was told it was the facility's policy to notify the representative of a fall. During an interview on 09/11/2024 at 2:00 PM, Staff B (Director of Nursing Services) stated licensed nurse were expected to notify the resident responsible party when a resident experienced a fall. Staff B stated Resident 1's representative notification was not documented therefore it was not done. Staff B stated Resident 1's CC called the facility social worker and was upset they did not receive notification of Resident 1's fall on 07/22/2024. Staff B stated the CC found out about Resident 1's fall during a care conference on 09/04/2024. In an observation on 09/11/2024 at 2:12 PM, Resident 1 was observed sitting in a wheelchair with their eyes closed. Resident 1 did not respond to verbal stimuli or questions about the incident. During an interview on 09/30/2024 at 1:02 PM, Resident 1's CC stated they found out about Resident 1's fall a month and a half later. The CC stated they were frustrated that they did not receive notification on the date of the fall and felt bad that Resident 1 was alone and was not able to say what happened about the fall. REFERENCE: WAC 388-97-0320(1)(a)