Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/28/2025 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Providence Marianwood | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>44295<br><br>Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from verbal abuse and mistreatment for 1 of 2 (Residents 1) residents reviewed for resident-to-resident incidents. Resident 1 experienced psychological harm when they had a change in their speaking pattern and tone, flat affect, crying, expressions of re-triggering of prior traumas, and feeling distressed after repeated verbal abuse by their roommate that escalated when not addressed timely by staff. This failed practice placed all residents at risk for the potential of verbal abuse, psychological harm, and diminished quality of life.<br><br>Findings included .<br><br>Review of the facility policy, titled, Abuse Prohibition and Prevention, dated 01/2024, showed all residents receiving care or services had the right to be free from abuse by anyone. The facility would have processes and measures in place to prevent, investigate, and act on all allegations of abuse. The policy showed the prevention of further abuse would occur by taking measures to protect the alleged victim, as well as other residents during the investigation. The alleged victim would be monitored, evaluated to determine if the resident felt safe, and if not immediate steps would be taken to alleviate fear. The policy showed residents would be protected from psychological harm during and after the investigation.<br><br><Resident 1><br><br>Review of the quarterly Minimum Data Set (MDS, an assessment tool), dated 01/13/2025, showed Resident 1 was able to make needs known, own decisions, and had no behaviors. The MDS showed Resident 1 had diagnoses including depression, inability to use legs, diabetes, and had a colostomy (an opening in the abdominal wall to divert waste from the colon). The MDS showed Resident 1 used a wheelchair, required two staff extensive assistance with transfers and lower body dressing.<br><br>Review of a Nursing Progress Notes (NPN), dated 01/19/2025, showed Staff D (Resident Care Manager/Registered Nurse, RN) documented they observed Resident 1 and their roommate, Resident 2 yelling at each other, and that Resident 1 requested a room move. An additional NPN, dated 01/19/2025, showed Staff E (RN), documented the same content as Staff D's note. Both NPN's showed no documentation to support staff took any action to protect and prevent further abuse to Resident 1.<br><br>(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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of NPN's, dated 01/21/2025, showed Staff D documented that Resident 2 continued to yell at Resident 1, there were no options available for a room move, and the resident had a reinforced adjustment reaction and expressed response to new environment. An additional note on 01/21/2025, showed Staff E documented that Resident 1 reported that Resident 2 had used foul language at them and Staff E validated Resident 1's frustrations.<br><br>Review of an electronic mail (e-mail) communication, dated Monday 01/20/2025 at 2:57 PM, showed Resident 1 emailed Staff C (Social Services (SS) Assistant) about their roommate having a fit and screaming it smells like a whore house in here. Resident 1 stated their roommate accused them constantly of smelling and when Resident 1 tried to reply to Resident 2's accusations was told to, shut up, shut, shut up. Resident 1 stated, it has been awful and I was told I will be moved rooms when a spot is available and requested a window side because of the air conditioner. Resident 1 documented they felt truly disrespected.<br><br>Review of an e-mail communication, dated Tuesday 01/21/2025 at 8:42 PM, showed Resident 1 emailed Staff C again, the email showed, I am shaking as I write this email. I went to a doctor's appointment today, when I came back, my roommate started harassing me, I am unable to cope with the name calling, yelling, swearing, and telling me to go to hell. Just this evening they called me a bi**h, stupid, and I don't know anything. Telling me to go to hell and they can't wait to get my stinking a** out of here. I tried to tell them I do not appreciate them lying to others about me. Obviously, I must stay completely quiet and allow them to constantly degrade me and shout insults at me. They tell me and the staff several times a day that I stink, they have ramped up their accusations, absolutely nasty name calling, and swearing at me. I am done. I'm crying. I rarely cry, but I cannot take the verbal abuse. I am in a crisis mode emotionally. I want to call the state to report this abuse. I'm on the verge of calling 911. I was in a verbally abusive marriage, my reaction is that of PTSD (Post Traumatic Stress Disorder), and I am reliving all the physical and emotional trauma. Resident 1 emailed, If something isn't done immediately, I will be forced to find a solution myself. I am broken and need help immediately.<br><br>Review of a facility investigation, completed and dated 01/25/2025, showed on 01/21/2025, Staff B (Director of Nursing Services) was informed that Resident 1 sent an email to Staff C (Social Services Assistant) and reported that Resident 2, their roommate was harassing them by stating stupid bi**h, you stink, telling anyone who entered the room that Resident 1 stunk, and reported feeling distressed. The investigation showed on 01/22/2025 Resident 1 was interviewed, expressed feeling worse than an abusive relationship, was observed with a flat face, whispering, and not speaking in a normal tone.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | In an observation and interview on 02/28/2025 at 1:58 PM, Resident 1 was observed in bed brushing their hair. Resident 1 stated Resident 2 would call them a bitch, liar, make statements saying you don't belong here, and if Resident 1 responded or tried to stand up for themselves Resident 2 would tell them to shut up. When asked what staff told them on 01/19/2025 after requesting a room move, Resident 1 stated Staff D told them they need to learn how to get along. Resident 1 stated they were filled with anger, it was bad how they (Resident 2) told everyone they (Resident 1) smelled, and Resident 1 started asking staff if they (Resident 1) smelled. Resident 1 stated after being called a bi**h on 01/21/2025 they were done, it was an emergency at that point because I had not felt those feelings in a long time, and referenced a history of verbal abuse in the past and feeling re-triggered by Resident 2's verbal abuse. Resident 1 stated by the time they asked about a room move they would have put up with a door bed even though they preferred a window bed just to be out of the room away from Resident 2. Resident 1 stated Resident 2 was given a behavior contract and was heard boasting to staff about it all proud. When asked if the verbal abuse stopped, Resident 1 replied it became more passive, as they could hear Resident 2 making comments but not as loudly as before. Resident 1 stated they moved rooms at the beginning of February 2025.<br><br>In an interview on 02/28/2025 at 1:27 PM, Staff I (LPN) stated verbal abuse was saying anything towards a resident that made them feel uncomfortable, such as raising your voice, yelling, saying something hurtful or rude. Staff I stated it was not okay for residents to yell at each other and if they witnessed a resident yelling at another resident, the residents would need to be separated, identify the situation, and report to their supervisor.<br><br>In an interview on 02/20/2025 at 1:46 PM, Staff H (Licensed Practical Nurse, LPN) stated it was not okay for a resident to yell at another resident as that would be abuse. Staff H stated if they observed two residents yelling they would separate both residents, determine what happened, start an incident report, and report to management and the state hotline. Staff H stated they have observed Resident 1 and Resident 2 yelling at each other and saw the nurse go into the room, and was not sure what happened after that.<br><br>During an interview on 02/28/2025 at 2:52 PM Staff B (Director of Nursing) stated they would expect staff to separate and protect the resident from further abuse. Staff B stated they should have moved Resident 1 after staff witnessed Resident 1 and Resident 2 yelling at each other on 01/19/2025. Staff B stated a grievance was initiated after Resident 1's email was received on 01/20/2025 and Resident 2 received a behavior contract on 01/22/2025. Staff B acknowledged staff did not follow the facility abuse policy, if they would have the abuse would not have escalated, and staff did not protect Resident 1 from further verbal abuse from Resident 2 until Resident 1 had expressed emotional distress and retraumatization.<br><br>REFER to F-607<br><br>REFERENCE: WAC 388-97-0640(1)(6)(b). |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44295<br><br>Based on observation, interview, and record review the facility failed to implement their abuse policies and procedures regarding identification of verbal abuse, thorough investigation, protection, preventing further abuse, and timely reporting of abuse and neglect incidents for 4 of 4 residents (Residents 1, 2, 3, & 4) reviewed for resident to resident incidents. These failures placed all residents at risk for unidentified abuse, on-going abuse, and diminished quality of life.<br><br>Findings included .<br><br>Review of the facility policy titled, Abuse Prohibition and Prevention, dated 01/2024, showed verbal abuse included the use of oral, written, or gestured communication or sounds, to residents within hearing distance, regardless of age, ability to comprehend or disability. The policy showed all employees received training to identify abuse and neglect, and an investigation would be conducted in response to suspected abuse, neglect, or mistreatment. The investigation would be thorough, documentation of the observed or alleged abuse in the resident's medical record, and immediate interventions would be put in place to protect the affected resident. Prevention of further abuse, neglect, and mistreatment would include monitoring the alleged victim, notification to the provider, measures taken to protect the victim when the perpetrator was a resident, such as increased monitoring and supervision or room relocation. The facility policy showed residents would be protected from physical and/or psychological harm, staff would respond immediately, room changes if necessary to protect the victim, and an examination of the alleged victim including a psychosocial assessment. All suspected and alleged violations would be reported to the administrator and required state agencies within a specified timeframe.<br><br>According to the Purple Book, Nursing Home Guidelines, dated 10/2015, showed a resident to resident incident was required to be reported to the state agency when mental abuse with psychological harm was identified. When mental abuse with no psychological harm was identified, the facility was required to put the incident on their abuse/incident log. The reporting guidelines showed there was a presumption that abuse occurred whenever there was some type of offensive or unwanted contact with a resident.<br><br><Resident 1><br><br>Review of the quarterly Minimum Data Set (MDS, an assessment tool), dated 01/13/2025, showed Resident 1 was able to make needs known, own decisions, and had no behaviors. The MDS showed Resident 1 had diagnoses including depression, inability to use legs, diabetes, and had a colostomy (an opening in the abdominal wall to divert waste from the colon). The MDS showed Resident 1 used a wheelchair, required two staff extensive assistance with transfers and lower body dressing.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of a Nursing Progress Note (NPN) on 01/19/2025, two days after moving into the room with Resident 2, Staff D (Resident Care Manager/Registered Nurse, RN) documented at 11:28 AM on 01/19/2025 they observed Resident 1 and Resident 2 yelling at each other. The NPN showed Resident 1 told Staff D they wanted to move rooms because their roommate was telling them they stink. The NPN did not indicate what Staff D did in response to Resident 1's request to move rooms, the allegation of verbal abuse, and if anyone such as the provider, administrator or DNS was notified of the incident. An additional note on 01/19/2025 at 11:26 PM by Staff E (RN), showed the exact NPN with no indication action was taken or who was notified.<br><br>Review of a NPN, dated 01/21/2025 at 1:51 PM, showed Staff D documented that Resident 1's roommate continues to be disrespectful, complain about the odor, currently no options for room change, reinforced adjustment reaction and expected response to the new environment. A NPN, dated 01/21/2025 at 11:06 PM, showed Staff E documented that Resident 1 reported at 8:40 PM their roommate used foul language towards them. Staff E documented they validated Resident 1's frustrations. Both NPN's showed no indication action was taken in response to Resident 1's continued concerns of verbal abuse from Resident 2.<br><br>Review of the facility census for 01/19/2025, 01/20/2025, 01/21/2025, and 01/22/2025, showed a minimum of seven female beds, two being window side as preferred by Resident 1 available.<br><br>Review of a facility investigation, completed and dated 01/25/2025, showed on 01/21/2025, Staff B (Director of Nursing Services) was informed that Resident 1 sent an email to Staff C (Social Services Assistant) and reported that Resident 2, their roommate was harassing them by stating stupid bitch, you stink, telling anyone who entered the room that Resident 1 stunk, and reported feeling distressed. The investigation showed Resident 1's chart was reviewed, during initial days of being new roommates there was a verbal exchange with no distress reported, and staff acted accordingly for a new room adjustment. Staff B documented that Resident 2 continued to complain of Resident 1's odor and Resident 2 was redirected. The investigation showed on 01/22/2025 Resident 1 was interviewed, expressed feeling worse than an abusive relationship, was observed with a flat face, whispering, and not speaking in a normal tone. The investigation showed interventions put in place to prevent reoccurrence included; monitoring Resident 1 for distress, encouraged to express concerns promptly, provided with options for another room, move as soon as a preferred bed with a window is available, and reported to the state agency on 01/22/2025 for resident to resident verbal abuse, four days after the staff was aware of the verbal abuse.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation and interview on 02/28/2024 at 1:58 PM, Resident 1 was observed in bed, stated Resident 2 began yelling at them the first day they moved in, appeared that Resident 2 was very upset with all of my belongings, and was going to make me as miserable as possible. Resident 1 stated Resident 2 would call them a bitch, liar, and made statements that you don't belong here. Resident 1 stated they tried to talk to Resident 2 but was told shut up, shut up, shut up! Resident 1 stated they were filled with anger, it got bad, and Resident 2 constantly told everyone I stunk. I started asking staff if I smelled. When asked about their request to move rooms on 01/19/2024, Resident 1 stated Staff D told them they need to learn how to get along. Resident 1 said on 01/21/2025 after Resident 2 called her a bitch and whore, they were done, stating it was an emergency at the point, I haven't felt those feelings in a long time, and referenced a history of verbal abuse in the past and feeling re-triggered by Resident 2's verbal abuse. Resident 1 stated by the time they asked about a room move they would have put up with a door bed even though they preferred a window bed just to be out of the room away from Resident 2. Resident 1 stated Resident 2 was given a behavior contract and was heard boasting to staff about it all proud. When asked if the verbal abuse stopped, Resident 1 replied it became more passive, as they could hear Resident 2 making comments but not as loudly as before.<br><br><Resident 2><br><br>Review of the annual MDS, dated [DATE], showed Resident 2 was able to make their needs known, own decisions, and no behaviors. The MDS showed Resident 2 had diagnoses including abnormal heart rhythm, high blood pressure, and anxiety. The MDS showed Resident 2 required two staff extensive assistance with toileting, bathing, dressing, bed mobility, and transfers.<br><br>Review of a NPN, dated 01/19/2025 at 11:23 AM, showed Staff D documented Resident 2 was angry and yells at the new roommate (Resident 1), when odors were present. Staff D documented there were concerns about the new environment as both Resident 1 and Resident 2 were yelling at each other. The NPN showed no indication what action Staff D took in response to Resident 1 and Resident 2 observed yelling at each other, and if anyone was notified about the incident. A NPN, dated 01/19/2025 at 11:32 PM, showed Staff E documented the exact same NPN with no indication action was taken or who was notified. Review of a NPN, dated 01/20/2025 at 1:36 PM, showed Staff F (Licensed Practical Nurse) documented Resident 2 was upset about the new roommate situation and refused to eat lunch.<br><br>Review of a Social Services (SS) progress note, dated 01/20/2025, showed Staff G (SS Director) documented they were well aware of the situation with Resident 2 and Resident 1 and this was not a new behavior or reaction when Resident 2 got a new roommate. Staff G documented that Resident 2 would demand they move out of the room, reminded Resident 2 it was mean of them to tell Resident 1 they smelled due to a colostomy bag, it must be embarrassing for Resident 1, and if they were unhappy they could find them a new room. A SS progress note, dated 01/22/2025, showed Staff G documented that Resident 2's behaviors have caused difficulties for their roommate (Resident 1) and a behavior contract was presented to Resident 2. The behavior contract included all residents have equal rights, have the right to be free from belittling and bullying, and Resident 2 was verbally abusive to their roommate, and by signing the contract Resident 2 would agree to stop their behavior, move to another room, or to another facility. The note showed Resident 2 signed the contract and admitted they had done all of those things.<br><br>(continued on next page) |

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F 0607

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During an observation and interview on 02/20/2025 at 2:05 PM, Resident 2 was observed in bed and stated they felt so much better after Resident 1 moved rooms. Resident 2 stated, it was my fault, it caused me to lose my temper, and I put up with so much. Resident 2 admitted to calling Resident 1 names, and making comments about the odor.

In an interview on 02/20/2025 at 1:46 PM, Staff H (Licensed Practical Nurse, LPN) stated it was not okay for a resident to yell at another resident as that would be abuse. Staff H stated if they observed two residents yelling they would separate both residents, determine what happened, start an incident report, and report to management and the state hotline. Staff H stated they have observed Resident 1 and Resident 2 yelling at each other and saw the nurse go into the room, and was not sure what happened after that.

In an interview on 02/28/2025 at 1:27 PM, Staff I (LPN) stated verbal abuse was saying anything towards a resident that made them feel uncomfortable, such as raising your voice, yelling, saying something hurtful or rude. Staff I stated it was not okay for residents to yell at each other and if they witnessed a resident yelling at another resident, the residents would need to be separated, identify the situation, and report to their supervisor.

During an interview on 02/28/2025 at 2:52 PM, when asked what staff did when Resident 1 and Resident 2 were observed yelling at each other on 01/19/2025, Staff B replied there was an adjustment period between both residents, staff addressed the smell issue, and Staff B acknowledged the incident on 01/19/2025 should have but was not included in the investigation When asked what staff did when Resident 1 requested a room move, Staff B stated there was no documentation to show what staff did in response to the request for a room move. Staff B stated verbal abuse was yelling, shouting, or screaming at a resident, and would expect staff to separate both residents, notify management, report, and start an investigation, When asked why Resident 1 was not moved rooms and Staff D stating no rooms were available, Staff B stated they thought staff only looked at rooms on the long term care side and did not look at the short term side for room availability. When asked why the incident was reported on 01/22/2025, four days after staff observed the verbal abuse, and after Resident 1 wrote emails expressing their emergency for something to be done, Staff B replied they reported on 01/22/2025 due to Resident 1 being distressed. When asked how psychological harm was ruled out after the 01/19/2025 incident, Staff B stated there was no documentation to show Resident 1 was monitored for psychological harm and would expect staff to follow the facility policy by monitoring residents after an incident. When asked how Resident 1 was protected from further abuse by Resident 2, Staff B stated the residents should have been separated and acknowledged that Resident 2 continued to verbal abuse Resident

<Resident 3>

Review of the annual MDS, dated [DATE], showed Resident 3 was able to make needs known, own decisions, and had no behaviors. The MDS showed Resident 3 had diagnoses including heart failure, arthritis, and depression. The MDS showed Resident 3 used a wheelchair, required two staff extensive assistance with toileting, bathing, dressing, bed mobility, and transfers.

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of a SS progress note, dated 01/03/2025, showed Staff G documented that Resident 3 came to their office very upset due to an issue with Resident 4, who was very impulsive and volatile. Staff G documented it was Resident 4's birthday, Resident 3 had a surprise of flowers and a card for Resident 4 but they did not see the surprise, became upset, yelled, cussed, and threw an item in the dining room all directed towards Resident 3 who appeared clearly rattled by the incident. The SS progress note showed, Resident 3 thought they would change their table in the dining room to have space from Resident 4.<br><br>Review of Resident 3's NPN's showed no progress notes for 01/04/2025 and 01/05/2025 and no indication Resident 3 was monitored for psychological harm related to the resident to resident incident. A late entry NPN for 01/06/2025, showed Staff B documented Resident 3 came by their office requesting to speak with them and Staff A (Administrator) about the incident that occurred on Friday with Resident 4. Staff B stated Resident 3 stated it was not urgent and they set up a meeting to talk on 01/07/2025, four days after the incident occurred.<br><br>Review of a SS progress note, dated 01/07/2025, showed Staff G and Staff B met with Resident 3 who requested the meeting to discuss the events of last Friday. Resident 3 stated they planned to move tables in the dining room but changed their mind and preferred Resident 4 move. Staff G told Resident 3 that Resident 4 was adamant about not moving, reinforced that the right thing for Resident 3 would be for them to move, and Resident 3 stated they would not be moving tables. Staff G documented that Resident 3 did not seem overly distressed about the situation but did state they were scared to death of Resident 4 and it was clear Resident 3 wanted something done to prevent Resident 4's behaviors from continuing.<br><br>Review of a late entry NPN, dated 01/07/2025 showed Staff J (RN), documented Resident 3 was being monitored for witnessed behavior of another resident in the dining room and Resident 3 made comments of it not being fair that they would have to move tables and not Resident 4. Review of a NPN, dated 01/11/2025, showed Staff J documented Resident 3 was on alert charting for emotional and mental distress due to reported yelling behavior by another resident in the dining room. Staff J documented they were called to the dining room to talk to Resident 4 about moving different tables away from Resident 3, Resident 4 refused, and staff moved Resident 3 to another table, and Resident 3 responded by stating Resident 4 always got their way.<br><br>During an observation and interview on 02/28/2025 at 1:35 PM, Resident 3 was observed sitting in their wheelchair and stated Resident 4 had yelled, cussed, and knocked over everything on the table, including a bowl of soup because they were upset and thought Resident 3 forget their birthday. Resident 3 stated they could not take the yelling anymore and gave up their table in the dining room to Resident 4. Resident 3 stated Staff A talked with them the next day (01/04/2025) and Resident 3 told them they were shocked, the incident was terrible, and they were scared. Resident 3 stated the dining room was full of other residents during the incident and they would never talk to Resident 4 again.<br><br><Resident 4><br><br>(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) |
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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the quarterly MDS, dated [DATE], showed Resident 4 was able to make needs known, needed assistance with decisions, and had no behaviors. The MDS showed Resident 4 had medically complex conditions including a nervous system disease, insomnia, and depression. The MDS showed Resident 4 used a wheelchair, required moderate assistance from staff for toileting, dressing, bed mobility, and transfers.<br><br>Review of a SS progress note, dated 01/03/2025, showed Staff G documented Resident 4 lashed out at Resident 3, yelling, cursing, and swept a cup of soup of the dining room table. Staff G documented Resident 4 was asked to move tables, refused, and stated they wanted to sit where Resident 3 was sitting. Staff G documented all residents had a right to sit where they choose, and the facility team was directed to monitor Resident 4 closely, intervene if they became volatile, and redirected if they threw any items and cued to use appropriate language.<br><br>Review of Resident 4's record showed no NPN's from 01/04/2025, 01/05/2025, 01/06/2025, 01/07/2025, and 01/08/2025 to indicate Resident 4 was being monitored for behaviors or psychological harm related to the resident to resident incident.<br><br>Review of the facility investigation, dated and completed 01/12/2025, nine days after the incident occurred, showed Staff B documented on 01/06/2025 Resident 3 asked to speak with management about the incident on 01/03/2025, that they were all aware of and did not appear to be urgent. Staff B documented during their conversation on 01/07/2025, Resident 3 expressed distress and scared from the incident with Resident 4, and therefore Staff B reported to the state hotline.<br><br>Review of the January 2025 facility abuse/incident reporting log showed Staff B documented the incident occurred on 01/03/2025, the nature of the occurrence was behaviorand findings showed the origin was established. The incident log did not include Resident 3 and did not identify the incident as a resident to resident altercation.<br><br>During an interview on 02/28/2025 at 3:15 PM, with Staff A and Staff B, Staff A stated they did not follow up with Resident 3 after the incident and was not aware they were scared from the incident with Resident 4. Staff B stated they would expect psychological harm monitoring to be completed after an incident and stated there was no psychological harm monitoring for Resident 3 in the record. When asked why the incident was not reported until Resident 3 expressed fear, Staff B stated the incident should have but was not reported timely, especially since there was no documentation to prove no psychological harm for Resident 3.<br><br>REFER to F-600<br><br>REFERENCE: WAC 388-97-0640(1)(2)(a)(b)(5)(6)(a)(b) |