

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505453	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2024
NAME OF PROVIDER OR SUPPLIER Kin on Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4416 South Brandon Street Seattle, WA 98118	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>45146</p> <p>Based on interview and record review the facility failed to ensure allegations of financial exploitation was thoroughly investigated for 1 of 1 resident (Resident 1), reviewed for abuse investigations. This failure placed the resident at risk for repeated incidents, unidentified financial exploitation, and inappropriate corrective actions.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Abuse, Neglect and Exploitation, date implemented on 09/07/2023 showed, An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.</p> <p>Review of the Nursing Home Guidelines, The Purple Book, revised in 2015, showed that all alleged incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown source, personal and/or financial exploitation, or misappropriation of resident property must be thoroughly investigated.</p> <p>Review of the significant change in status Minimum Data Set (an assessment tool) dated 11/26/2024 showed Resident 1 had intact cognition.</p> <p>In an interview on 12/12/2024 at 11:23 AM, Resident 1 stated they learned from their Collateral Contact (CC1) that a family member was taking their money without their knowledge.</p> <p>In an interview on 12/12/2024 at 12:41 PM, Staff E, Social Worker, stated that about two weeks ago, the resident's CC reported that the resident's money had been taken without the resident's knowledge. Staff E further stated they reported the incident to Adult Protective Services (APS-a state agency that investigate reports about abuse, abandonment, neglect, exploitation and self-neglect of vulnerable adults), and to Staff A, Administrator.</p> <p>In a phone interview on 12/13/2024 at 1:38 PM, CC1 stated that they learned from Resident 1's November 2024 bank statement that over three thousand dollars were missing from the resident's account. CC1 further stated the resident's bank ATM card was also missing while the resident was at the facility, and they reported the incident to the police and the facility.</p> <p>Review of the facility's incident reporting log for November 2024 and December 2024, showed no investigation was done about Resident 1's allegation of financial exploitation.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/23/2024 at 1:59 PM, Staff A stated that they were aware of Resident 1's allegation of financial exploitation. Staff A further stated there was a miscommunication about the allegation and the allegation was not investigated. Staff A further stated that Resident 1's allegation of financial exploitation should have been investigated.</p> <p>Reference: (WAC) 388-97-0640 (6)(a)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>45146</p> <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review, the facility failed to provide care and services consistent with professional standards of practice related to managing signs and symptoms and/or treatment of urinary tract infection (UTI-bladder infection) for 1 of 1 resident (Resident 2), reviewed for quality of care. This failure placed the resident at risk of unmet care needs, medical complications, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Antibiotic Stewardship Program, implemented on 05/23/2023, showed, The facility uses the (CDC's [Centers for Disease Control and Prevention] NHSN [National Healthcare Safety Network] Surveillance Definitions, updated McGeer criteria, or other surveillance tool) to define infections.</p> <p>Review of the facility's undated document titled, Revised McGeer Criteria [used for retrospectively counting true infections] for Infection Surveillance Checklist, showed that a new or marked increase in urine frequency and a laboratory result of an organism equal or more than 100,000 colony forming units (cfu-a unit that is used to estimate the number of viable bacteria in a sample) /milliliter (ml) in a voided urine sample will indicate a UTI.</p> <p>Review the significant change in status Minimum Data Set (an assessment tool) dated 11/20/2024 showed Resident 2 had severe impairment with cognition.</p> <p>Review of the facility's fall investigation dated 11/08/2024 showed Resident 2 had an unwitnessed non-injury fall when they tried to use another resident's bathroom on 11/08/2024.</p> <p>Review of the nursing progress note dated 11/22/2024 showed Resident 2 had a laboratory order for Urine Analysis (UA-a test that checks urine for signs of UTI) with Culture and Sensitivity (C&S - a test to find germs [or bacteria] in the urine that can cause an infection) if indicated due to urinary frequency.</p> <p>Review of the nursing progress note dated 11/24/2024 showed Resident 2 was assisted to the toilet five times during that shift.</p> <p>Review of the nursing progress note dated 11/25/2024 showed Staff C, Resident 2's Physician, reviewed the resident's UA laboratory result and stated, [Staff C] wrote down Monitor, no UTI.</p> <p>Review of the laboratory results reported on 11/26/2024 showed that Resident 2's urine sample tested positive for nitrates (possible indicator of UTI, which means that bacteria are present in the urine). Further review of the urinary C&S laboratory test result showed a greater than 100,000 cfu/ml of Escherichia coli (E. coli - a type of bacteria that is the most common causative agents of UTIs, requiring the physician to ask or confirm the results).</p> <p>Review of the nursing progress note dated 11/26/2024 showed, The final UA & culture report showed E. coli. The culture & susceptibility report was emailed to [Staff C].</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the psychiatry consultation progress note dated 12/09/2024, showed, I found [Resident 2] sitting at the lunch table, finished 75% of [Resident 2's] meals, but looked distressed, 'no, I'm not doing well.' [Resident 2] requested to use the bathroom, 'I cannot hold it anymore.' The NAC [Nursing Assistant Certified] took [Resident 2] to the bathroom, and [Resident 2] did void.</p> <p>Review of the nursing progress note dated 12/09/2024 showed that Resident 2's second UA laboratory order was carried out.</p> <p>Review of the physician progress note dated 12/11/2024 for the date of service on 11/21/2024 showed, The CNA [Certified Nursing Assistant] told me that she goes to BR [bathroom] almost every 10 minutes.</p> <p>Review of the physician progress note dated 12/11/2024 for the date of service on 11/25/2024 showed, The CNA [Certified Nursing Assistant] told me that [Resident 2] goes to BR [bathroom] almost every 10 minutes. Further review of the progress note showed Resident 2's UA laboratory result dated 11/23/2024 was reviewed and the frequency of urine was added to the resident's diagnosis list. There was no documentation regarding Resident 2's UTI management or treatment.</p> <p>Review of the laboratory results reported on 12/13/2024 showed Resident 2's urine sample tested positive with nitrates and the urine C&S result showed a greater than 100,000 cfu/ml of E. coli.</p> <p>Review of the nursing progress note dated 12/14/2024 revealed that Staff C was notified about Resident 2's UA C&S laboratory result, which showed positive for E-coli. The progress notes further showed, Per MD, No UTI and no order at this time.</p> <p>Review of Resident 2's nursing progress notes from 12/14/2024 to 12/23/2024 revealed no provider notes or documentation explaining why the resident's positive UTI was not being managed or treated.</p> <p>Review of the nursing progress note dated 12/16/2024 revealed Resident 2 had their third UA order that showed, Repeat UA, culture & sensitivity if indicated for abnormal UA. Order carried out.</p> <p>Review of the laboratory results reported on 12/20/2024 revealed that Resident 2's third urine sample tested positive for nitrates with C&S result showed a greater than 100,000 cfu/ml of E. coli.</p> <p>Review of the December 2024 medication admiration record showed Resident 2 started a treatment for UTI on 12/18/2024 (three weeks after their first positive UA and C&S results for UTI).</p> <p>In an interview on 12/23/2024 at 9:32 AM, Staff F, CNA, stated that Resident 2 was asking to go to the bathroom frequently six to eight times a shift.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview and joint record review on 12/23/2024 at 12:26 PM, Staff C stated that they follow the CDC guidelines to diagnose and treat UTI. Staff C stated that they were not diagnosing UTI based on the McGeer criteria for infection surveillance. Staff C stated, I do not trust the UA lab [laboratory] result, I only treat if the resident has a fever, dysuria [pain or discomfort when you urinate], and the urine PH [a measure of how acidic or basic a substance or solution is] should be acidic. Staff C stated if they decided not to treat a possible UTI with positive UA result, they would write their rationale. Joint record review of Resident 2's laboratory results showed Resident 2 had a positive UA result for UTI on 11/26/2024, 12/13/2024, and 12/18/2024. Joint record review of the physician note dated 12/11/2024 for the date of service on 11/25/2024 did not show why the provider decided not to treat the UTI with positive E-coli. Further review of Resident 2' progress notes from 12/14/2024 to 12/23/2024 revealed no provider note to show the rationale why the resident's multiple positive UTI result was not treated. Staff C stated they did not have time to write a note right after their visit, It is impossible to document right after a visit. Staff C further stated that it would take them at least two weeks to write and upload their progress note in the resident's medical record.</p> <p>In an interview on 12/24/2024 at 1:21 PM, Staff D, Infection Preventionist, stated that the facility uses the McGeer criteria for infection surveillance. Staff D further stated that Resident 2's new increased frequency of urination, and a positive UA laboratory result met the McGeer criteria for UTI and should have been treated.</p> <p>On 12/23/2024 at 1:36 PM, Staff B, Director of Nursing, stated they would expect from the physician to document the rationale why Resident 2's new increased frequency in urination and a positive laboratory result for UTI was not treated.</p> <p>On 12/23/2024 at 1:59 PM, Staff A, Administrator, stated that they would expect the provider to document the rationale in the resident's progress note within 24 hours if a possible infection would not be treated.</p> <p>Reference: (WAC) 388-97-1060 (1)</p>