STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505453	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kin on Health Care Center	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)
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. 46912 Based on interview and record review, the facility failed to report significant injury of unknown origin for 1 of 5 residents (Resident 3) reviewed for abuse investigations. The facility's failure to report large bruises of unknown origin on the resident's chest and torso, placed the residents at risk for repeated incidents and unidentified abuse and/or neglect. Findings included . Review of the Nursing Home Guidelines, The Purple Book, dated October 2015 (sixth edition) showed, The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source .are reported to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). It showed that Injuries of unknown source means any injury sustained by a resident where the source of the injury was . not observed by a staff person .the resident is not able to report/inform how the injury occurred. It further showed that substantial injuries (including bruises occurring in areas not generally vulnerable to trauma such as the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area) even if they do not appear to be due to abuse or neglect, must be reported to the Department. Review of the facility's policy titled, Abuse, Neglect and Exploitation, dated 09/07/2023, showed, Possible indicators of abuse include, but are not limited to .physical marks such as bruises .physical injury of a resident, of unknown source. It showed that The facility will have written procedures that include .reporting of alleged violations to the Administrator, state agency . within specified timeframes. Review of the investigation report dated 03/05/2025, showed that a Certified Nursing Assistant reported to the Registered Nurse (RN) that Resident 3 had bruising on her upper torso. The RN noted one large green-yellow color bruising on resident chest between two breast[s] . and RN noted another purple color bruising on Resident 3's left side torso next to the left breast. It further showed, Resident did not know what happened, resident [sic] showed signs of discomfort and c/o [complained of] pain during movement and touch. Review of the facility's March 2025 incident log showed that an incident for Resident 3 was logged on 03/03/2025 and had not been reported to the state agency. (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	In an interview and joint record review on 04/04/2025 at 2:56 PM, Staff B, Interim Director of Nursing, stated that the process for investigating an injury of unknown origin was the same process as investigating abuse and neglect and would report and investigate. Joint record review of the investigation report dated 03/05/2025, showed that Resident 3 was found to have two bruises on their chest between two breast [s] and their left side torso. Staff B stated that yes the incident was reportable to the state agency, and it was not reported. In an interview on 04/04/2025 at 3:55 PM, Staff A, Interim Administrator, stated that according to the purple book it should have been reported to the state agency, when Resident 3 was found to have injuries of unknown source. Reference: (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 - Some	Respond appropriately to all alleged violations. 46912 Based on interview and record review, the facility failed to ensure injuries of unknown source and abuse allegations were thoroughly investigated for 4 of 5 residents (Residents 1, 2, 3 & 4), reviewed for abuse investigations. This failure placed the residents at risk for repeated incidents, unidentified abuse, and a diminished quality of life. Findings included . Review of the Nursing Home Guidelines, The Purple Book, Sixth Edition, dated October 2015, showed that injuries of unknown source meant any injury sustained by a resident where the source of the injury was Not observed directly by a staff person . The resident is not able to report/inform how the injury occurred .Injuries of unknown source may be either superficial or substantial in nature. It showed, Substantial injuries require more than first aid and may require close assessment and monitoring by nursing or medical staff. They also include injuries occurring in areas not generally vulnerable to trauma .Substantial injuries of unknown source, even if they do not appear to be due to abuse or neglect, must be reported to the Department, because the injuries may have resulted from the failure to take preventative measures. ALL substantial injuries of unknown source must be thoroughly investigated. ALL injuries (regardless of the extent) occurring in nonvulnerable areas of the body will be considered substantial injuries. The abuse guidelines further showed, EXAMPLES of SUBSTANTIAL INJURIES may include, but are not limited to the following: Abrasions, burns, deep lacerations, bruises of deep color and depth, or those occurring in areas not generally vulnerable to trauma, such as the back, face, head, neck chest, breasts . It further showed that 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. Review of the facility's policy titled, Abuse, Neglect and Exploitation, dated 09/07/2023, showed physical marks such as bruises or physical injury of a resident of unknown source were possible indicators of abuse. The policy also showed that an immediate investigation would be warranted when suspicion of abuse occurred. The policy further showed an investigation would be completed and have thorough documentation. RESIDENT 1 Review of the facility's March 2025 incident log showed an incident logged for Resident 1 on 03/14/2025. Review of the complaint hotline form dated 03/11/2025, showed Staff I, Social Worker, submitted to the state agency that Resident 1 reported that a staff member was rougher than usual and stated, she hurt me. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 04/03/2025 at 1:15 PM, Staff A, Interim Administrator, provided a folder of what was done for Resident 1's incident and did not include an investigation report for Resident 1's allegation on 03/11/2025. When asked if there was written documentation that an investigation was conducted, Staff A stated they would look and see if there's any documentation about the investigation. In a follow-up interview at 2:21 PM, Staff A provided a written report of the investigation and stated, I just wrote what we did. When asked if this was completed today, Staff A stated, yes. In another interview on 04/04/2025 at 2:56 PM, Staff A stated they stated they had five days to complete an abuse investigation. Staff A further stated there should be written documentation of investigations conducted for abuse. When asked if the investigation for Resident 2's allegation was completed within five days, Staff A stated that there was no documentation that it had been completed in five days. RESIDENT 2 Review of the complaint hotline form dated 03/10/2025, showed Staff B, Interim Director of Nursing, submitted to the state agency that a Certified Nursing Assistant (CNA) noticed that Resident 2 had bruising on their left ankle with tenderness when touched. Review of Resident 2's incident investigation dated 03/10/2025, showed a Xray was completed, and that Resident 2 had a fracture [broken ankle-the joint that connects the bones in the lower leg to the foot bones]. It further showed the facility did not thoroughly collect evidence related to other possible witnesses or other residents related to the investigation. The investigation did not show the conclusion of the investigation to rule out abuse was documented. In an interview and joint record review on 04/04/2025 at 3:45 PM, Staff B stated that the process for investigating an injury of unknown origin included, reporting, investigating, asking questions, and interviews with staff and residents in the area. Joint record review of Resident 2's incident investigation dated 03/10/2025, showed Resident 2 had discoloration and swelling of their ankle and Staff B stated, it was reported because it was an injury of unknown origin. When asked if the investigation included other resident interviews, Staff B stated no. Staff B further stated that they didn't put in the conclusion that [abuse] was ruled out. In an interview on 04/04/2025 at 3:45 PM, Staff A stated that when investigating an injury of unknown origin, the goal is to rule out abuse. Staff A stated that the conclusion will say unfounded if abuse was ruled out. When asked if it was a thorough investigation if they did not interview other residents, Staff A stated it was a case by case basis for when they interviewed other residents. When the example was provided that interviewing a roommate might show if they heard or saw anything related to the investigation, Staff A stated, yes, it could be helpful. When asked if abuse was ruled out for Resident 2, Staff A stated, it was not written. RESIDENT 3 Review of the facility's March 2025 incident log showed that an incident for Resident 3 was logged on 03/03/2025 and had not been reported to the state agency. (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 - Some	Review of the investigation report dated 03/05/2025, showed that a Certified Nursing Assistant reported to the Registered Nurse (RN) that Resident 3 had bruising on her upper torso. The RN noted one large green-yellow color bruising on resident chest between two breast[s] .and RN noted another purple color bruising on Resident 3's left side torso next to the left breast. It further showed, Resident did not know what happened, resident [sic] showed signs of discomfort and c/o [complained of] pain during movement and touch. Additionally, it showed, Investigation started, writer tried to talk to resident, resident doesn't know where it comes from. The investigation report did not show that minimum staff and resident interviews were conducted and/or the conclusion of the investigation to rule out abuse was documented. In an interview and joint record review on 04/04/2025 at 2:56 PM, Staff B stated that the process for investigating an injury of unknown origin would be the same process as investigating abuse and neglect and would be to report and investigate. A joint record review of the investigation report dated 03/05/2025, showed that Resident 4 was found to have two bruises on their upper torso and left side torso. When asked if there were any resident interviews conducted, Staff B stated, none noted. Staff B further stated it was inconclusive if there was a thorough investigation done for Resident 3's injury of unknown origin. In an interview on 04/04/2025 at 3:55 PM, Staff A stated that according to the purple book it should have been reported to the state agency when Resident 3 was found to have bruising on their torso. When asked if abuse had been ruled out, Staff A stated it was undetermined by the evidence presented. RESIDENT 4 Review of the complaint hotline form dated 03/14/2025, showed Staff A submitted to the state agency that Resident 4 was found to have discoloration to the right upper arm with swelling and pain to touch. Review of the undated investigation report showed Resident 4 had cognitive deficits and that on 03/10/2025, Resident 4 was found to have pain in their arm. During an assessment, it was found that Resident 4 had some discoloration and swelling to her forearm and it was painful and warm to touch. The investigation did not show that minimum resident interviews were conducted and/or the conclusion of the investigation to rule out abuse was documented. Review of the Radiology Results Report, dated 03/14/2025, showed that Resident 4 had a dislocated shoulder and a fracture [broken and/or dislocated arm bone]. In an interview on 04/04/2025 at 2:56 PM, Staff B stated that the facility reported Resident 4's incident because it was an injury of unknown origin. Staff B further stated they were looking at possible abuse. In an interview and joint record review on 04/04/2025 at 3:05 PM, Staff A stated that we didn't interview any other residents, no documentation that I did. Reference: (WAC) 388-97-0640 (6)(a)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 46912 Based on interview and record review, the facility failed to ensure the attending physician reviewed the total program of care including treatment and medications and completed progress notes timely for 38 of 38 residents (Residents 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41 & 42), reviewed for physician progress notes. This failure had the potential to place the residents at risk for a delay in treatment, unmet medical care needs, and lack of physician oversight. Findings included . Review of the complaint hotline form dated 03/05/2025, showed the facility submitted to the state agency that there are concerns in regard to the Medical Director [Staff D] and his medical duties. Review of the incident investigation dated 03/04/2025, showed that Staff D saw around 40 residents [Residents 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41 & 42] here at the facility and was also the Medical Director. In an interview on 04/04/2025 at 1:01 PM, Staff E, Registered Nurse/Resident Care Manager, stated that Staff D came to the facility on ce a week at least to see residents. Staff E further stated that Staff D was not putting progress notes in right away after seeing residents. In an interview on 04/04/2025 at 1:10 PM, Staff F, Physician Assistant, stated that it was their process that every time they saw residents they review medications, treatments, and program of care and will write a progress note that reflected those things within 48 hours. In an interview on 04/04/2025 at 9:58 AM, Staff G, Medical Records, stated that Staff D doesn't tell anyone which residents he visits, he just comes every Monday. Staff D stated that other providers will upload their progress notes within 24 hours, he [Staff D] doesn't do that. When asked to provide any progress notes uploaded from 02/26/2025 until 04/04/2025, Staff G provided undated blank documentation [and printed their Electronic Health Record] that no progress notes written by Staff D had been uploaded during those dates. In a follow-up interview at 10:03 AM, Staff G stated that no progress notes were uploaded from [02/26/2025] until now from [Staff D]. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 04/04/2025 at 1:45 PM, Staff C, Chief Executive Officer, stated that they expected physicians to see residents usually once a week. Staff C stated that they expected physicians to document clinical metrics, treatment plans, observations and they should document any changes, treatment changes, medications. Staff C stated that they expected physicians progress notes to be completed within days and I would think the progress notes should be in the system [electronic health records], it's important, so we know if something happened or if a doctor on call needs to look at it. Staff C stated that Staff D was slow in putting in progress notes. Staff C stated that they would expect progress notes from Staff D from 02/26/2025 until now and by now yes there should be. Joint record review of the documentation showing no progress notes written by Staff D uploaded from 02/26/2025 until 04/04/2025. Staff C stated, he has not uploaded anything, that's not good. In an interview on 04/04/2025 at 2:03 PM, Staff D stated the last day they saw a resident was on 03/05/2025 and usually saw residents every Monday and sometimes every day. Staff D stated it was their process to provide handwritten documentation after seeing the patient [resident] and would upload a progress note every four to six weeks. When asked if the handwritten documentation included documentation of the resident's care program, a review of medications and treatments, Staff D stated, no that's impossible. In an interview and joint record review on 04/04/2025 at 4:12 PM, Staff B, Interim Director of Nursing, stated that they expected physician progress notes to be written for all residents and all visits. Staff B stated that if it had been longer than seven days, they would expect medical records to reach out to the physician. Staff B further stated that they expected the physician progress notes to include a summary of what's going on with the resident, medications and any complaints. Joint record review of the documentation showing no progress notes written by Staff D uploaded from 02/26/2025 until 04/04/2025, Staff B stated, I would expect there to be progress notes for the residents he saw. In an interview on 04/04/2025 at 4:17 PM, Staff A, Interim Administrator stated, I expect there to be progress notes for the residents he [Staff D] saw. Reference: (WAC) 388-97-1260 (4)(a)