

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 08/11/2025
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the plan of care to use a gait belt (a safety device used to assist residents with mobility issues) for 1 of 1 resident (Resident 1), reviewed for accident hazards. Resident 1 experienced harm when they fractured their left clavicle (a break in the bone that connects the breastbone to the shoulder blade) and experienced pain when staff members transferred the resident without the use of a gait belt. The failure to follow plan of care when assisting with transfers placed residents at risk for avoidable injury, unsafe transfers, and a diminished quality of life. Findings included. Review the facility's policy, titled Use of Gait Belt, revised on 05/30/2024 showed it was the facility's policy to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety. The policy showed that each employee would be given a gait belt during orientation, receive education on the proper use of gait belts, and that each employee was expected to always have it available for use when at work. Review of the facility's policy titled, Safe Resident Handling/Transfer, revised on 03/27/2025, showed the facility would ensure that residents were handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. Review of Resident 1's face sheet showed they were admitted to the facility on [DATE] with multiple diagnoses including dementia (decline in mental ability), difficulty walking, and Osteoporosis (a disease that weakens your bones). Review of Resident 1's care plan, initiated on 08/22/2016, showed an intervention to use a gait belt when the resident needed more help due to weakness. Review of the hospital notes dated 06/09/2025, showed that Resident 1 was in the Emergency Department (ED) on 06/09/2025. Resident 1 reported they had a shoulder injury after staff members at the facility transferred them from the wheelchair into the bed. The note further showed Resident 1 stated a yank [a sudden, forceful pull or tug] was involved during this transfer. The x-ray done at the ED showed Resident 1 had sustained a left clavicle fracture. Review of the investigation report dated 06/13/2025, showed Resident 1 was too weak to bear weight when Staff C, Certified Nursing Assistant (CNA) and Staff D, Licensed Practical Nurse (LPN) tried to assist Resident 1 from the floor and into bed without using a gait belt. Staff C and Staff D were not able to transfer Resident 1 and Staff E, CNA, was called to help, then all three staff members transferred Resident 1 to bed without the use of a gait belt. In a phone interview on 08/08/2025 at 11:32 AM, Staff D stated that on the night of the 06/08/2025 incident, they went to the room after hearing Staff C calling for help, then saw Resident 1 on the floor with Staff C behind them. Staff D stated they did an assessment and Resident 1 denied they were in any pain. Staff D stated that they called another staff member to help Resident 1 off the floor since Resident 1 did not have the strength to bear weight. They then transferred Resident 1 to the wheelchair. Staff D stated that a gait belt was not used with either one of these transfers. Staff D further stated that they felt Resident 1 may be in pain and gave Resident 1 pain medication and applied a pain-relieving cream on Resident 1's shoulders, neck, and arm after the transfer. In an interview on 08/11/2025 at 11:02 PM, Staff C, stated that on the night of the fall incident (06/08/2025) they found Resident 1 attempting to transfer themselves into the wheelchair. Staff C stated that they ran to Resident 1 and assisted them onto the floor as Resident 1's legs started buckling. Staff C stated that as they guided Resident 1 down to the floor, Resident 1 grabbed onto the wheelchair brakes causing the chair to unlock, which then caused the wheelchair to roll back as they held onto it. Staff C stated that Staff D came into the room after hearing Staff C call for help. Staff C stated that Staff D and Staff E were on each side of the resident, lifting Resident 1 up as Staff C was behind the resident lifting her bottom and guiding the resident onto the bed. Staff C stated that they usually use a gait belt but did not have a chance to get one since they had to act fast. Staff C stated that Resident 1 grimaced during the transfer. Staff C further stated that Resident 1 was quieter than usual the next day, which indicated to Staff C that Resident 1 was in pain. In an interview on 07/08/2025 at 1:30 PM, Staff B, Director of Nursing, stated that they expected the care staff to follow the residents' care plan on how to transfer residents. Staff B further stated that staff should have used a gait belt with Resident 1 to help minimize injury. In an interview on 07/08/2025 at 3:19 PM, Staff A, Administrator, stated that they expected the care staff to follow the care plan and use the gait belt. Reference: (WAC) 388-97-1060 (3)(g).</p>		