STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505463	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Post Acute	2520 Madison Everett, WA 98203

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on interview and record review the facility failed to ensure resident grievances were filed and addressed for 1 of 1 resident (Resident 11) reviewed for grievances. The failure to address and resolve resident grievances placed residents at risk for diminished dignity, unresolved missing property and diminished quality of life. Findings included . Review of the facility's policy on 08/02/2024 titled, Grievances, showed a grievance report would be initiated for all concerns, the resident would be communicated with, and an attempt was made to resolve the grievance within 5 days. There would be follow up with the resident or representative about the grievance to ascertain satisfaction with the resolution of the reported concern. Resident 11 readmitted to the facility on [DATE] and was alert and oriented. Review of the record showed the resident had a recent prior stay 03/21/2024 through 05/16/2024. In an interview on 07/31/2024 at 11:05 AM, Resident 11 stated they ended up back in the hospital and readmitted to the facility a couple of months ago. Resident 11 stated they had a roommate during their prior stay in March, who was inconsiderate with their loud television volume and encroaching on their space in the room. Resident 11 stated they had verbalized the concern to the staff several times and asked to move rooms which they did a few days later. Resident 11 stated they were missing a pair of plaid lounge pants that had been missing for at least a month. Resident 11 stated the laundry person was still looking for them, but they had not received any updates. Resident 11 stated there had been a nursing assistant (Staff K) that they requested not to have provide care to them because they were unsanitary and just did not like their care, but they stated that the staff member did come back and care for them on two days after they requested not to have them. Resident 11 stated Staff K confronted them about it stating, do you have a problem with me? which Resident 11 stated made them upset and they told Staff K to get out of their room. Resident 11 stated they did not say anything about Staff K coming back to their room until they were in the resident council meeting at the end of July (July 23, 2024). Review of the prior 6 months of the facility grievance logs on 08/05/2024 showed no grievances found for Resident 11 related to missing property or a roommate concern. The log showed a grievance for Resident 11 that was dated 07/01/2024 and labeled as handwashing. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/05/2024 at 9:20 AM, Staff D, Laundry Manager, stated they were aware of Resident 11's missing lounge pants, stating Resident 11 had told them they were missing and stated they thought maybe they got mixed up with the briefs and got thrown away. Staff D stated they had not personally ever seen the lounge pants Resident 11 mentioned and added that sometimes residents did not want their clothing labeled, so items could get lost. Staff D was able to state the process for filling out a grievance when a resident reported a concern but stated they had not completed a grievance for the missing pants for Resident 11 yet. Review of the 07/01/2024 grievance report on 08/05/2024 showed that Resident 11 did not want Staff K to be their aid anymore because they did not wear gloves and the resident did not want to get an infection. The documented action taken was Staff K received education on infection prevention and included copies of the in-service education provided to Staff K. The grievance was signed by Staff J, Infection preventionist, and a therapy (witness) on 07/02/2024, stating that the resident could not sign due to wet nails. The grievance form did not include further follow up with the resident or a conclusion to ascertain satisfaction with the reported concern, including whether Staff K would or would not provide any further care to Resident 11. The grievance was not signed as being completed and was not signed by the Director of Nursing or Administrator. Staff K was no longer a current employee. Review of Resident 11's July 2024 care record on 08/05/2024 confirmed that Staff K had documented providing care to Resident 11 on two days following the grievance report, on 07/09/2024 and 07/11/2024. In an interview on 08/06/2024 at 10:30 AM, Staff J, Infection Preventionist, stated they had received the grievance form and completed the in-service with Staff K. Staff J stated they had verbally reviewed what they had done with Resident 11 and they were okay with the education, but they still did not want Staff K to be their aid, (Resident 11) was not comfortable, they said. Staff J stated they forgot to mark the box on the grievance that stated the resident was notified of the action taken and satisfied with the outcome. In an interview on 08/06/2024 at 2:14 PM, Staff I, Scheduler, stated they were aware that Staff K was not supposed to be scheduled to care for Resident 11, but stated sometimes staff would be assigned to a certain section, but they would just trade a resident, such as if one resident on a section preferred only female aids, they may have a male aid on that section but they would just trade one resident with another aid who was female. Staff I stated they recalled it being sometime in July that there had been an allegation and even though Staff K was assigned on that section, they knew they were not supposed to have Resident 11 and were supposed to trade with another staff. In an interview on 08/07/2024 at 10:17 AM, Staff B, Director of Nursing Services stated there should have been grievances for the missing item and noisy roommate concern but had not been aware of those issues. They reviewed grievances every day in their stand-up meeting. Staff B stated that they had not been aware that Staff K had Resident 11 on their care assignment on those dates. Staff B stated that they had provided education to Staff K related to the grievance and when they had done their investigation regarding the allegation that Staff K had come back to the room stating, do you have a problem with me?, they had denied that allegation, and they had not been able to substantiate it. Staff B stated they became aware of that allegation at the July 23,2024 resident council meeting, and it was reported as an allegation of potential abuse. Staff B stated they have been working on their grievance process but needed to continue education. (continued on next page)

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