STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505512	A. Building B. Wing	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace Healthcare Center of Federal Way	491 South 338th Street Federal Way, WA 98003

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46471 Based on interview and record review, the facility failed to provide written transfer/discharge notices as required for 3 of 3 residents (Resident 1, 6, & 7) reviewed for hospitalization . Failure to provide notification to the resident and/or the resident's representative of the reason(s) for the transfer or discharge in writing placed residents at risk for a discharge that did not meet the resident's and/or their representative's stated goals for care and preferences. Findings included . <Facility Policy> The Transfers and Discharges facility policy, revised 06/28/2024, showed the facility would provide transfer/discharge notice to the resident/responsible party in accordance with federal regulations. The Notice of Transfers and Discharges facility policy, revised 10/29/2024, showed the facility must notify the resident and the resident's representative of the transfer or discharge and the reasons for the move in writing and in language and manner they understood. The policy showed the written notice in the resident's medical record must include the reason(s) for the transfer or discharge. <Resident 1> According to the 11/13/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 1 admitted to the facility on [DATE] and had medical conditions including COVID-19 (a communicable respiratory infection that could cause death in elderly people), heart disease, uncontrolled blood sugar levels, memory impairment, malnutrition, and adult failure to thrive (a syndrome in older adults characterized by a significant decline in physical and mental health). The 11/15/2024 Discharge Return Anticipated MDS showed Resident 1 discharged to the hospital. The 11/07/2024 discharge care plan showed Resident 1 wished to return home after short-term skilled rehabilitation from weakness and deconditioning following their hospitalization due to recurrent falls. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An 11/15/2024 nursing progress note showed Resident 1 was transferred to the hospital due to increased confusion, elevated body temperature of 100.5 degrees Fahrenheit, and high pulse rate of 105 beats per minute. The note showed Resident 1 was being monitored after the resident fell inside their room on 11/13/2024. The note showed the facility staff was not able to reach Resident 1's representative. On 12/03/2024 at 11:18 AM, Resident 1's representative stated they did not receive any notification from the facility regarding Resident 1's transfer/discharge to the hospital on 11/15/2024. Resident 1's representative stated they learned of the resident's hospital transfer from a call they received from the hospital staff. Review of Resident 1's medical records showed no written notice was completed or provided to Resident 1 and/or their representative regarding the resident's hospital transfer/discharge on 11/15/2024. The facility was not able to provide documentation to support a written Notice of Transfer or Discharge form was completed for Resident 1 as required. In a joint interview with Staff A (Executive Director) and Staff B (Director of Nursing) on 12/03/2024 at 2:56 PM, Staff A stated the Social Services Director was responsible for the completion of the Notice of Transfer or Discharge form and confirmed they did not complete one for Resident 1's hospital transfer on 11/15/2024, . it was missed. Staff A stated it was important to provide residents and their representative written transfer/discharge notification to communicate the resident's current location and to ensure the resident and their representative were notified of the rights and regulations associated with their transfer/discharge. Staff A stated they expected every staff member involved to do their part in the notification process. <Resident 6> According to the 10/29/2024 Discharge MDS, Resident 6 discharged to the hospital. Review of Resident 6's medical records showed no written notice was provided to the resident and/or their representative regarding the resident's hospital transfer/discharge on 10/29/2024. The facility was not able to provide documentation to support a written Notice of Transfer or Discharge form was completed for Resident 6 as required. <Resident 7> According to the 10/24/2024 Discharge MDS, Resident 7 discharged to the hospital. Review of Resident 7's medical records showed no written notice was provided to the resident and/or their representative regarding the resident's hospital transfer/discharge on 10/24/2024. The facility was not able to provide documentation to support a written Notice of Transfer or Discharge form was completed for Resident 7 as required. In a correspondence on 12/10/2024 at 11:18 AM, Staff A stated, Unfortunately, I don't have the ones [Notice of Transfer or Discharge forms] in October. Staff A stated they were transitioning staff in social services and that part of the transfer/discharge process was overlooked. Refer to F689- Free Of Accident Hazards/Supervision/Devices. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	REFERENCE: WAC 388-97-0120(2)(a-d), -0140(1)(a)(b)(c)(i-iii).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46471 Based on interview and record review, the facility failed to: Provide an environment that was free from accident hazards; and ensure each resident received adequate supervision and/or assistance to prevent accidents, for 1 of 2 residents (Resident 1) reviewed for falls. These failures placed residents at risk for injuries, avoidable accidents, and a decreased quality of life. Findings included . <Facility Policy> Review of the undated facility guidance, Lippincott procedures- Fall Prevention, long-term care showed the factors that contribute to falls among older adults included conditions that affect mobility, medication use, increasing physical disability, and impaired vision, hearing, or mental status. The guidelines showed preventing falls begin with identifying residents at greatest risk. The guidelines showed fall prevention care plans should be individualized and comprehensive for each resident. The guidelines showed documentation associated with fall prevention included measures taken to help prevent falls and the times and frequency a resident at risk for fall was checked. <Resident 1> Review of the 11/07/2024 Initial Fall Risk Assessment showed Resident 1 was a fall risk due to factors identified including history of falls, impaired cognitive ability, presence of behaviors such as restlessness, incontinence, impaired mobility, existing medical conditions, and use of high-risk medications. The 11/07/2024 baseline fall Care Plan (CP) showed Resident 1 was at risk for falls due to the factors identified in their initial fall assessment. The CP did not show Resident 1's bed should be positioned low or that Resident 1 needed frequent visual checks considering the resident was a high-fall risk and their door needed to remain closed after testing positive for COVID-19. According to the 11/13/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 1 had active medical conditions including COVID-19 (a communicable respiratory infection that could cause death in elderly people), uncontrolled blood sugar levels, history of alcohol abuse, memory impairment, false perception of objects or events, false beliefs or judgment about external reality, and was unsteady on their feet. The MDS showed Resident 1 was administered high-risk medications including a blood sugar medication, a drug promoting increased urination, an antipsychotic, and an antidepressant during the assessment period. The MDS showed Resident 1 was assessed to require the use of a walker during ambulation and was totally dependent on staff for walking at least 10 feet in a room or similar space. The MDS showed Resident 1 had a history of recurrent falls prior to their admission and experienced a fall once while the resident was in the facility. A 11/15/2024 Discharge MDS showed Resident 1 was discharged to the hospital and was not available for observation or interview. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 11/13/2024 facility incident report showed Resident 1 was found by staff lying on the floor in their room; the bed was in low position. The investigation determined Resident 1's discomfort from COVID-19 and having loose bowel movement precipitated Resident 1 to get up on their own and caused them to fall. Review of Resident 1's medical records showed no safety assessment was completed for Resident 1's bed being positioned low. The facility was not able to provide any documentation to support Resident 1 was assessed to be safe when their bed was placed in the lowest position. In an interview on 12/03/2024 at 2:17 PM, Staff F (Registered Nurse) stated Resident 1 was a high-fall risk and putting the resident's bed in the lowest position was one of the interventions they implemented. Staff F stated Resident 1 could not use the bed controller independently because of their memory impairment. Staff F stated they kept Resident 1's room door closed all the time because of the resident's COVID-19 positive status for infection prevention and control. In a joint interview with Staff A (Executive Director) and Staff B (Director of Nursing) on 12/03/2024 at 2:56 PM, Staff B reviewed Resident 1's medical records and confirmed there was no safety assessment completed for the resident's bed being placed at the lowest position to ensure it was safe for Resident 1. In an interview on 12/03/2024 at 3:41 PM, Staff E (Infection Preventionist) stated they had dedicated rooms (room [ROOM NUMBER] & 341) for COVID-19 positive residents who were high-fall risk so the doors could remain open for staff monitoring and fall prevention. Staff E stated the rooms were fully occupied at the time Resident 1 was diagnosed as COVID-19 positive on 11/13/2024, so Resident 1 stayed in their current room. Staff E stated appropriate nursing interventions, including frequent visual checks, should be in place for Resident 1 because they were assessed to be a high-fall risk and their room door needed to be kept closed to prevent the spread of the infection in the facility. On 12/03/2024 at 3:45 PM, review of the November 2024 Treatment Administration Record (TAR) showed no orders for the nursing staff to implement frequent visual checks to prevent Resident 1 from falling while the resident was isolated inside their room from COVID-19 infection. In an interview on 12/03/2024 at 4:28 PM, Staff D (Resident Care Manager) reviewed Resident 1's CP and TAR and stated the CP did not include Resident 1's bed to be placed in the lowest position as a fall prevention intervention. Staff D stated there was no order in the TAR instructing the nursing staff to perform frequent visual checks on Resident 1. Staff D stated there was no documentation in Resident 1's medical records to support the resident was actively monitored by staff to prevent Resident 1 from falling with the bed in the lowest position and behind closed doors. Refer to F623- Notice Requirements Before Transfer/Discharge. REFERENCE: WAC 388-97-1060(3)(g).