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	01/16/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46471 Based on observation, interview, and record review, the facility failed to implement their abuse and neglect policies and procedures regarding prevention, identification, investigation, and reporting of abuse and/or neglect. The facility failed to thoroughly investigate the incident and allegation of physical abuse for 1 of 3 residents (Resident 1) reviewed for facility incidents. This failure placed residents at risk for abuse and/or neglect by caregivers, avoidable and unnecessary pain, and a diminished quality of life. Findings included . <Facility Policy> The 06/17/2024 Abuse - Protection of Residents facility policy showed the facility must develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents. The policy showed the facility must have evidence that all alleged violations were thoroughly investigated, including examining the alleged victim for any sign of injury, both physical and psychosocial. <Resident 1> According to the 12/23/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 1 admitted to the facility on [DATE] due to a subsequent encounter where the resident experienced dislocation of their internal left hip prosthesis (artificial joint) after hip replacement surgery. The MDS showed Resident 1 had intact memory, able to make their needs known, and was assessed to require substantial to maximum staff assistance from rolling left and right in bed. The revised 12/24/2024 Activities of Daily Living (ADL) Care Plan (CP) showed Resident 1 had ADL self-care performance deficit and needed two person assistance with their bed mobility. A 12/26/2024 CP intervention showed left hip precautions including no left leg hyperextension, flexion or crossing of the legs, and to use pillows between the legs to reposition and when turning in bed. Review of Resident 1's medical records showed a 01/04/2025 left hip x-ray result indicating the resident had an externally rotated left hip dislocation. A 01/04/2025 alert note showed the resident was sent to the hospital's emergency department for evaluation and treatment. (continued on next page)

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 01/04/2025 hospital records showed Resident 1 informed hospital staff they dislocated their left hip prosthesis during incontinent brief change while at the skilled nursing facility earlier that day. The notes showed the brief change was done too roughly and Resident 1 felt severe pain on their left hip during the process. Review of the facility census on 01/16/2025 at 10:20 AM showed Resident 1 was readmitted back to the facility on [DATE]. In an observation and interview on 01/16/2025 at 12:42 PM, Resident 1 was sitting in their wheelchair, in their room eating their lunch. Resident 1 stated every time the staff would change their brief, they do it too hard and too fast. Resident 1 stated when they tell staff to slow down, the staff would respond they know what they were doing. Resident 1 stated the staff do not put pillows between their legs when they were being turned and repositioned in bed. Review of the hospital discharge orders on 01/16/2025 at 1:43 PM showed Resident 1 was to be Non-Weight Bearing (NWB) on their Left Lower Extremity (LLE). Review of Resident 1's CP, physician's order list, and Treatment Administration Record showed no instructions for staff regarding the resident's NWB-LLE restrictions. In an interview on 01/16/2025 at 2:05 PM, Staff D (Resident Care Manager) stated they should have, but did not ask Resident 1 how they dislocated their left hip before the resident was sent to the hospital. Staff D stated they should have, but did not identify or rule out if abuse and/or neglect occurred with Resident 1's incident. In a joint interview on 01/16/2025 at 2:21 PM with Staff B (Director of Nursing) and Staff C (Administrator-In-Training), Staff B stated they were not aware Resident 1 was sent to the hospital due to a dislocated left hip. Staff B stated they expected nursing staff to notify them so they could conduct an investigation. Staff B stated it was important to identify the root cause of Resident 1's incident to ensure no abuse and/or neglect happened. Staff C reviewed Resident 1's medical records and stated the nursing staff should have included the resident's hospital order for NWB-LLE status in the CP for safety and to prevent reoccurrence, but did not. In a phone conversation on 01/22/2025 at 12:03 PM, Staff A (Administrator) stated an investigation should have, but was not conducted regarding Resident 1's incident to rule out resident abuse and/or neglect. REFERENCE: WAC 388-97-0640(2).