STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505532	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Healthcare at Renton	17420 106th Pl SE Renton, WA 98055

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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44296 Based on interview and record review the facility failed to treat residents with dignity and respect and provide a dignified existence that promoted quality of life for 1 of 1 resident (Resident 2) reviewed for resident rights. The failure to have a process for staff to provide a comfortable environment for residents after the death of a roommate, placed residents at risk of feeling scared, unsafe, distressed, and have a diminished quality of life. Resident 2 was harmed, using the reasonable person concept, when their roommate (Resident 1) died and they were left in the same room with the deceased resident from 10:00 PM on [DATE] until 5:30 PM on [DATE], 19.5 hours. Resident 2 was placed in a situation to cause harm to their mental well-being, safety, and dignity when they were not separated from their dead roommate's body. Findings included . The [DATE] admission nursing assessment and [DATE] admission progress note showed Resident 2 admitted to the facility on [DATE], was cognitively intact, had some forgetfulness, was able to make their needs known, had adequate hearing, had adequate speech, was able to make themselves understood and able to understand others. The admission diagnoses for Resident 2 included depression and anxiety. In an interview on [DATE] at 5:30 PM, Staff C (Registered Nurse) stated there was an incident involving multiple staff and the Fire Department responders on [DATE] when Resident 1 died . Resident 1's body was kept in the room with Resident 2 until the mortuary came during the next evening shift ([DATE] @ 5:30 PM) to pick up the body. Staff C stated the night shift and the day shift did not move Resident 1 or Resident 2 to another room. Staff C stated they did not talk to Resident 2 about the death of their roommate on [DATE] or [DATE], because the body of Resident 1 was still in the room and Staff C did not want to scare Resident 2. Staff C stated it would be a natural reaction for any person to be scared when being around a dead person. Staff C stated they (Staff C) would not want to share a room with a dead body for 19.5 hours, but no one thought of moving either resident to another room. (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 0550 Level of Harm - Actual harm Residents Affected - Few	In an interview on [DATE] at 11:10 AM, Staff B (Director of Nursing) confirmed the body of Resident 1 was kept in the room with Resident 2 for over 19 hours which included overnight while Resident 2 slept and most of the waking hours of the following day. Staff B stated the nursing staff could have offered Resident 2 a different room or moved Resident 1's body to a different room, but the staff did not offer or move either resident. Staff B stated a reasonable person would be uncomfortable, and possibly scared, to be in a room with a dead body. Staff B stated they, themselves, would not want to stay in the room and would have moved to another room if their roommate died and the body remained in the room that long. Staff B stated because the body remained in the room, the environment of the room was not homelike, did not maintain the mental well-being, safety or dignity of Resident 2. Refer to F678 Cardiopulmonary Resuscitation (CPR) REFERENCE: WAC [DATE](,d+[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 - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44296 Based on interview and record review, the facility failed to ensure violations of alleged neglect, involving serious bodily injury, were reported immediately to the state survey agency in accordance with State law for 1 of 3 residents (Resident 1) who did not receive CPR when there was a Physician Order (PO) directing staff to perform Cardiopulmonary Resuscitation (CPR- an emergency procedure consisting of chest compressions combined with giving breaths of air when the resident's heart stops and they stop breathing). The facility's failure to identify and report alleged neglect after a catastrophic change in condition, that involved the death of Resident 1, placed 39 of 48 other residents who had POs to receive CPR, at serious risk of harm including death. Findings included . The facility policy Unusual Occurrence Reporting, dated ,d+[DATE] showed the facility reported unusual occurrences and other reportable events which affect the health, safety or welfare of residents as required by federal or state regulations. Review of the [DATE] nurse progress note showed Resident 1 admitted on [DATE] and died on [DATE] when their heart stopped beating and they stopped breathing. The progress note showed no CPR was started on Resident 1. Review of Resident 1's [DATE] PO showed POLST: Attempt Resuscitation/CPR. Medical Interventions: Full Treatment. In an interview on [DATE] at 6:10 PM, Staff B (Director of Nursing) stated Resident 1's death was unexpected. Staff B stated on [DATE] Resident 1 stopped breathing and did not have a pulse and staff neglected to follow the PO for full code and did not start CPR. Staff B stated the facility should have, but did not, report the incident to the state agency as required. Refer to F678 - Cardiopulmonary Resuscitation (CPR) Refer to F610 - Investigate/Prevent/Correct Alleged Violations REFERENCE: WAC [DATE](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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44296 Based on interview and record review the facility failed to timely initiate, document, and complete a thorough investigation involving an incident of serious bodily injury for 1 of 3 residents (Resident 1) reviewed for investigations of abuse and neglect. There was no investigation completed to rule out abuse or neglect or to determine the need for system interventions. The failure to investigate the system failure related to the lack of implementing the facility CPR policy placed 39 of 48 other residents at serious risk of harm, including death. Findings included . The facility policy Abuse Investigation and Reporting dated ,d+[DATE] showed all reports of resident abuse and neglect were promptly reported to state agencies and thoroughly investigated by facility management. The investigator would review documents, resident medical record, interview person reporting the event, interview witnesses, interview the physician, interview staff who hand contact with the resident, interview the resident's roommate, review all events that led up to the incident, consult with the administrator with progress/findings of the investigation, upon conclusion of the investigation the investigator would record the results of the investigation and provide the completed documentation to the administrator. Findings of abuse and neglect investigations would also be reported. The policy showed the administrator would ensure further potential abuse or neglect was prevented. In an interview on [DATE] at 3:13 PM, Staff C (Registered Nurse) stated Resident 1 admitted on [DATE], had a medical event that required CPR, and Resident 1 died . Staff C stated they were the nurse in charge of Resident 1 and called 911. Staff C stated there was confusion about Resident 1's CPR status, there was a Physician's Order (PO) to initiate CPR, but Resident 1 did not receive CPR. Staff C stated they did not initiate an investigation because it was protocol to notify the Director of Nursing (DON) if a resident died . Staff C stated they called the DON after Resident 1 died and reported there was a PO for CPR and Resident 1 did not receive CPR. In an interview on [DATE] at 3:50 PM, Staff D (Licensed Practical Nurse, LPN) stated they worked on [DATE] when Resident 1 died . Staff D stated they were not interviewed or asked questions about the emergency event or the death of Resident 1. In an interview on [DATE] at 4:11 PM, Staff E (Certified Nursing Assistant, CNA) stated they were the caregiver assigned to Resident 1 on [DATE]. Staff E stated they were not asked any questions or interviewed about what happened to Resident 1 or what they witnessed during the incident. In an interview on [DATE] at 4:40 PM, Staff B (DON) provided a one page Incident Summary for [Resident 1] which showed a progress note copied from Resident's medical record. The summary was undated, unsigned and did not include interviews of any staff who participated in the CPR code, no interviews of witnesses, and no interview of Resident 1's roommate (Resident 2). There was no documentation how abuse and neglect was ruled out. Staff B stated only a verbal investigation was completed and there was not a full written report completed. (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 on [DATE] at 6:15 PM, Staff B stated a thorough investigation should have been, and was not, conducted and documented. Staff B stated the incident should have been, and was not, reported to the state agency. Refer to F678 - Cardiopulmonary Resuscitation (CPR) Refer to F609 - Reporting Alleged Violations REFERENCE: WAC [DATE](6)(a-c).

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44296 Based on observation, interview, and record review the facility failed to ensure staff performed Cardiopulmonary Resuscitation (CPR- an emergency procedure consisting of chest compressions combined with giving breaths of air when the resident's heart stops and they stop breathing) to 1 of 3 residents (Resident 1) reviewed for unexpected death in the facility. The failure to ensure staff followed the facility's policy for CPR including staffs ability to accurately assess signs of irreversible death, immediately verify the Physician's Order (PO) for CPR status, immediately access the resident's POLST form (Physician Order for Life-Sustaining Treatment - a document the resident completes to declare their wishes for CPR or No CPR), initiate CPR, communicate effectively to the 911 operator, communicate effectively to the Emergency Medical Services (EMS) personnel, provide accurate residents records to EMS personnel placed 39 additional residents (Residents 3, 4, 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) who had current PO to receive CPR, at serious risk for adverse outcomes including death, and constituted an Immediate Jeopardy (IJ -noncompliance that has caused or is likely to cause, serious injury, harm, impairment, or death to a resident). On [DATE] at 6:26 PM, the facility was notified of an IJ in F678. The facility removed the immediacy on [DATE] after they audited the records of all residents, audited the resident POLST forms, educated staff on the facility's revised CPR policy and procedure, performed CPR drills, and implemented a plan of correction to sustain ongoing compliance. Findings included . <Facility Policy> The facility Emergency Procedure - CPR policy, dated ,d+[DATE], showed facility personnel completed training on the initiation of CPR for victims of cardiac arrest (heart stops beating, leading cause of death among adults). The policy directed staff: to initiate CPR if an individual was found unresponsive and not breathing normally; have a CPR team would be responsible to coordinate and direct other team members during the rescue efforts; to assess the unresponsive individual for abnormal or absence of breathing and begin CPR unless a DNR (Do Not Resuscitate) order specifically prohibited CPR; administer CPR if the individual's CPR/DNR status was unclear until status can be verified; CPR efforts by the CPR team continue until EMS personnel arrived. Review of the [DATE] face sheet showed Resident 1 admitted to the facility on [DATE] with a diagnosis of sepsis (a blood infection) and pneumonia (a lung infection) after a COVID-19 infection with respiratory failure. The [DATE] 3:54 PM nursing progress note showed Resident 1 was admitted for rehabilitation, was alert and oriented, had a normal heart rate, clear lung sounds, denied chest pain and shortness of breath. POs were reviewed by two nurses and the physician was informed of Resident 1's admission. Review of Resident 1's [DATE] PO showed POLST: Attempt Resuscitation/CPR. Medical Interventions: Full Treatment. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the POLST form signed by Resident 1 on [DATE] showed Resident 1 wanted CPR if they had no pulse and was not breathing and wanted full medical treatment with the primary goal to prolong life by all medically effective means. The POLST form was signed by the practitioner on [DATE] and scanned into the electronic medical record (EMR) on [DATE]. A [DATE] 11:25 PM nursing progress note showed at 9:55 PM Resident 1 was walking with a Certified Nursing Assistant (CNA) in the hallway, became weak and short of breath, and sat down on a bench. Staff brought Resident 1 back to their room in a wheelchair and started oxygen, Resident 1 was alert, pale, and talking, vital signs were taken, the oxygen level was 77% (normal ,d+[DATE]%), respirations were 28 breaths per minute (normal ,d+[DATE]), pulse was 136 beats per minute (normal ,d+[DATE] average 72), blood pressure (BP) did not register on machine (normal less than ,d+[DATE]), 911 was called at 10:00 PM. Review of the [DATE] voice transcript from the 911 call showed at 10:00 PM Staff C (Registered Nurse) provided Resident 1's name, facility address, room number, and identified that Resident 1 was becoming unconscious and CPR was in process. The transcript showed 10:01 PM Staff C stated Resident 1 was DNR. Review of the [DATE] audio recording from the 911 call showed Staff C told the operator that Resident 1 was short of breath, then did not answer the 911 operator's questions of: what was happening? was the patient unconscious? were they breathing? was anyone doing CPR? Staff C was talking to others in the background and then stated Resident 1 was a DNR. The operator asked if anyone was doing CPR and Staff C stated they still needed EMS to come to the facility. The 911 operator clarified Resident 1's name and stated EMS was dispatched. Review of the [DATE] Fire Department (FD) incident report showed the FD arrived at 10:10 PM with lights and sirens for an emergency response for advanced life support for Resident 1 in cardiac arrest. At 10:10 PM, the FD found Resident 1 sitting upright in a chair surrounded by staff, skin was cool, pale, clammy, eyes fixed, mouth gaping open, no pulse, not breathing, and incontinent of urine. FD assessment of Resident 1 was cardiac arrest prior to FD arrival. The report showed that staff told the FD they witnessed Resident 1's cardiac arrest, called 911, and staff claimed Resident 1 had a pulse and low BP when FD arrived. The report showed the patient was deceased at 10:10 PM with DNR paperwork provided by staff. The patient's name on the incident report was Resident 2's name. Resident 2 (Resident 1's roommate). Review of the [DATE] 11:25 PM nursing progress note showed facility staff was about ready to do CPR when the FD arrived, vital signs absent at time of FD arrival, FD decided not to initiate CPR, Resident 1 pronounced dead with no palpable pulse, no BP, no respirations, Resident Representative, Director of Nursing (DNS) and Physician were notified of Resident 1's death. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on [DATE] at 3:13 PM, Staff C stated when they left the room to call 911 Resident 1 was unresponsive, but had a pulse, oxygen was on, and Resident 1 was sitting in the wheelchair. Staff C stated they instructed the CNAs in the room to get Resident 1 on the floor in case Resident 1 needed CPR, then Staff C left Resident 1 to call 911. Staff C stated when calling 911 they thought Resident 1 had a DNR. Staff C stated the physician order in the Electronic Medical Record (EMR) showed Resident 1 was a full code with CPR and full medical treatment. Staff C stated they could not find the POLST form in the binder at the nurse station and it should have be there. Staff C showed the investigator where the binder was located, opened the binder and found Resident 2's POLST form in the binder. Staff C stated, Resident 1's POLST was not in the binder on [DATE]. Staff C stated if a resident did not have a DNR the staff had to do CPR, and it could be stopped if a DNR was located. In an interview on [DATE] at 3:50 PM, Staff D (LPN, Licensed Practical Nurse) stated when the incident occurred on [DATE], they saw Staff C on the phone with 911, went to Resident 1's room, Resident 1 was sitting in a chair while two CNAs were rubbing Resident 1's chest over Resident 1's heart. Staff D went back to the nurse station, Staff C asked Staff D to get the crash cart. Staff C told Staff D that Resident 1 was not a full code, but Staff C was still looking for the CPR status. When Staff D delivered the crash cart to the room, they saw Resident 1 still sitting in the chair with two CNAs in the room. Staff D stated FD personnel arrived and laid Resident 1 on the floor to start CPR; Staff D left the room. Staff D stated the CNAs did not start CPR on Resident 1. In an interview on [DATE] at 3:58 PM, Staff B (Director of Nursing) stated when a resident was admitted to the facility, staff completed the POLST form with the resident, then the practitioner needed to sign the form, the form was placed in the doctor's file to be signed, then the POLST is scanned to the EMR and the original goes into a multi-resident binder at the nurse's station. The nurse entered the PO into the EMR and it showed on the resident's screen for quick access. Staff B stated when a resident required CPR, staff should follow the PO in the EMR and locate the POLST form in the multi-resident binder at the nurse's station. Staff B stated Resident 1's POLST form was in the physician file to be signed and was why the nurse could not find it. Staff B stated the CNA staff should have identified when Resident 1 stopped breathing and initiated CPR right away by placing the resident on the floor in a flat position to do CPR. Staff B stated if there is no POLST form then staff should start CPR. In an interview on [DATE] at 4:11 PM, Staff E (CNA, Certified Nursing Assistant) stated they were in the room with Resident 1 when Staff C placed the oxygen and checked vital signs. Staff E stated Staff C left the room to call 911 and told Staff E and Staff F (CNA) to get Resident 1 on the floor in case CPR was needed. Staff C stated Resident 1 was a bigger person and tough to move, the CNAs did not put Resident 1 on the floor because they did not want to risk breaking Resident 1's bones. Staff E stated Staff D arrived with the crash cart and FD was on their way. Staff E stated at that time they did not think Resident 1 had a pulse but did not check for a pulse. Staff E stated no one started CPR then FD arrived and placed Resident 1 on the floor but decided not to do CPR. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on [DATE] at 4:50 PM Staff G (LPN) stated they were working on another floor and came to see what the emergency was about after Resident 1 had died . Staff G was told by Staff E and Staff F that Resident 1 was a DNR. Staff G went to the EMR and saw that Resident 1 was a full code, with CPR orders. Staff G asked Staff C about the code status and Staff C stated Resident 1 was a DNR. Staff G stated they looked in the multi-resident binder for the POLST form and observed Resident 2's POLST form with DNR status and no POLST form for Resident 1. Staff G stated Staff C looked in the EMR and stated Resident 1 was a full code with CPR. Staff G stated Staff C called the Director of Nursing and walked away. Review of a [DATE] written statement from Staff H (CNA) showed they were called to assist in Resident 1's room. When they entered, they saw Resident 1 sitting in a wheelchair with one CNA massaging the chest over the heart. Staff H stated they asked Staff C if the CNAs should get Resident 1 on the floor if the resident was a full code. Staff C left to check Resident 1's code status and came back and told them Resident 1 was a DNR then stepped out of the room to continue the phone call with 911. Staff C came back and stated Resident 1 was a full code and the three CNAs were getting ready to place Resident 1 on the floor when FD arrived. FD placed Resident 1 on the floor and dismissed the CNAs. The three CNAs left the room. Review of a [DATE] interview transcript completed by the Fire Chief of the responding FD unit showed the lead FD personnel stated in the initial dispatch Resident 1 was becoming unconscious, CPR was initiated, and the facility caller stated the patient was a DNR. Upon arrival FD found the patient unconscious, unresponsive and not breathing, in a seated position in a chair with staff supporting the patient upright. The FD lead stated the facility staff claimed the patient did have a pulse and low BP. When the FD personnel assessed Resident 1's carotid (neck) pulse for 10 seconds, there was no pulse. Resident 1 was moved to the floor to initiate CPR when the facility staff provided a POLST form marked DNR. Resident 1 was declared deceased , moved into their bed, and covered with a sheet. The patient information entered to the incident report was based on paperwork staff provided. The name on the incident report was Resident 2, not Resident 1. Observation on [DATE] at 3:13 PM with Staff C showed Resident 2's POLST form was in the binder at the nurse station. Resident 2's POLST form showed DNR and was signed by Resident 2 on [DATE]. Interview on [DATE] at 6:10 PM, Staff B (Director of Nursing) stated Resident 1's death was unexpected. Staff B stated the nurse should have followed the PO and started CPR. Staff B stated the nurse was not in the room with Resident 1 and the CNA staff did not identify when Resident 1 stopped breathing and did not have a pulse, which caused staff to not start CPR. Staff B stated Staff C should not have given Resident 2's POLST form, directing DNR to the FD personnel. Staff B stated the facility staff should have, but did not, identify when Resident 1 required CPR and did not follow the PO for full code and CPR. Refer to F609 - Reporting of Alleged Violations Refer to F610 - Investigate/Prevent/Correct Alleged Violation REFERENCE: WAC [DATE](1).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44296 Based on interview and record review the facility failed to ensure 1 of 3 residents (Resident 3) received care, consistent with professional standards of practice, to prevent Pressure Ulcers/Pressure Injuries (PU/PI, localized damage to the skin and underlying tissue from prolonged pressure, friction, or shear, causing pain). The failure to identify individual risk factors related to diagnoses, implement resident-specific interventions and ensure prevention of PU/PIs placed residents at risk for harm related to serious injury, development of pressure ulcers, medical complications, and diminished quality of life. Resident 3 was admitted to the facility with no PU/PIs, was assessed at high risk for developing PU/PIs and acquired a Deep Tissue Injury (DTI, a type of PU/PI described as a deep red, maroon, purple discoloration of skin due to damage of underlying soft tissue acquired by the friction or shearing of skin) to their left heel while at the facility. Findings included . The 07/11/2024 Facility Assessment (FA) showed the facility may accept patients with, or patients that develop, neurological conditions such as stroke (a medical emergency when blood flow in the brain is interrupted) with hemiparesis or hemiplegia (inability to move one side of the body normally), and skin impairments such as PU/PIs. The FA showed the facility would provide services and care for skin integrity for pressure injury prevention. The FA showed staff will be trained, and the competency of staff would be assessed, to ensure the type of care was provided to support the resident population. The facility policy Prevention of Pressure Ulcers/Pressure Injuries dated 08/2018 showed the resident's risk factors for PU/PI would be identified. The policy showed interventions were placed on the care plan for the specific risk factors identified for the resident at risk of PU/PIs. The policy stated interventions would be followed and reviewed for effectiveness on an ongoing basis. The 05/06/2024 Admission Minimum Data Set (MDS, an assessment tool) showed Resident 3 admitted to the facility on [DATE] with a diagnosis of stroke with left side hemiplegia, memory impairment, unable to understand others, unable to make their needs known, required maximum assistance with mobility including transferring from one surface to another, bed mobility and was unable to walk. Resident 3 was assessed to have no PU/PIs and was at risk of developing PU/PIs. The shower skin assessments dated 05/03/2024, 05/06/2024, 05/09/2024, 05/12/2024, 05/16/2024, 05/19/2024 showed Resident 3 had no skin injuries. The 05/08/2024 Care Plan (CP) showed Resident 3 was at risk for potential skin breakdown related to decreased mobility. The skin interventions included avoid friction and sheering during repositioning, elevate heels off the mattress, pressure reducing mattress, and skin observations during care. The CP did not show resident-specific interventions related to Resident 3's diagnosis of stroke and left hemiparesis, did not include how many staff should assist Resident 3 with bed mobility to protect Resident 3's heels from sheering and friction. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505532	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Healthcare at Renton	17420 106th Pl SE Renton, WA 98055

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 05/20/2024 investigation by the facility, after the skin injury occurred, showed Resident 3 had a DTI on the left heel that measured 3.0 cm x 5.0 cm (centimeters). The facility investigation identified multiple individual risk factors which placed Resident 3 at high risk for developing a DTI on their left heel. Resident 3's individual risk factors included a recent stroke with impaired mobility of their left leg, required maximum assistance from staff for bed mobility, was confused, had abnormal labs, decreased food intake, and used a blood thinner. These specific risk factors and specific interventions were not addressed on Resident 3's CP to prevent the DTI. In an interview on 08/09/2024 at 10:58 AM, Resident 3's Representative (RR) stated Resident 3 was discharged from the facility on 05/20/2024 and the RR was told Resident 3 had a blister on the left heel, but Resident 3 had a large, dark purple, DTI on the heel of their left foot. The RR stated Resident 3 was not able to walk because of the DTI and use of a cushioned boot. The RR stated the DTI was painful to Resident 3. The RR stated that two months after discharge the DTI has not healed. In an interview on 08/09/2024 at 1:20 PM, Staff B (Director of Nursing) stated Resident 3 had multiple individual risk factors that contributed to the DTI on the left heel. Staff B stated Resident 3 had a stroke, had left leg weakness, was unable to walk, required staff to reposition them in bed, and required staff to float their heels to reduce pressure. Staff B stated the heel was assessed by the nurse manager and classified as a DTI prior to Resident 3's discharge. Staff B stated Resident 3 required only one staff person for maximum assistance to reposition in bed and confirmed that one person assistance was not on the CP. Staff B stated to prevent shear and friction, the resident needed to be lifted off the surface of the bed for repositioning. Staff B stated two staff would be required to lift Resident 3 off the bed to prevent friction, shear and a DTI on the heels. In an interview and record review on 08/09/2024 at 1:39 PM, Staff B provided the investigator with the Certified Nursing Assistants (CNA) documentation for care provided in bed mobility for 08/19/2024. The CNAs documented on 08/19/2024 for the evening and the night shift that one staff person provided bed mobility assistance and Resident 3 required maximum assistance from staff. Review of the CNA documentation for 05/01/2024 through 05/18/2024 showed inconsistency with staff provision of bed mobility with one and two staff on all shifts. There were no specific directions on the CP for the staff to follow. When asked how the one staff prevented the friction or shear on Resident 3's left heel, Staff B was not able to answer. Staff B stated the facility investigation of Resident 3's DTI did not address if the left heel dragged on the bed surface to cause the DTI. Staff B stated Resident 3's DTI was unavoidable, then stated two staff assistance with bed mobility would have possibly prevented a DTI on the heel. REFERENCE: WAC 388-97-1060(3)(b).

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 44296 Based on interview and record review the facility failed to ensure nursing staff and nursing aide staff had the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physician, mental and psychosocial well-being of each resident according to the facility assessment, resident-specific assessments and resident plans of care for 11 of 11 staff (Staff K, L, E, M, H - Certified Nursing Assistants and Staff C, N, G, D, O, P - Licensed Nurses) reviewed for competency. The failure to develop and implement a process to evaluate staff's competency and skills to perform job expectations placed residents at risk for accidents, injuries, infections, diminished quality of life, and diminished quality of care. Findings included . The 07/2024 Facility Assessment (FA) showed the facility provides the staff with training and educational opportunities to ensure they can provide the necessary level and type of care to support the facility resident population. The FA showed the competency of staff's skills were assessed by skills validation, testing and face-to-face encounters. The FA showed competency of staff would be assessed related to specific job duties and licensure/certification and would include Person-Centered Care, Activities of Daily Living, Disaster Planning and Procedures, Infection Control, Medication Administration, Measurements, Resident Assessments and Resident Examinations. In an interview and record review on 08/12/2024 at 10:55 AM, Staff M (Staff Development Nurse) provided the training records of Staff C, D, E, F, G, H, I, J, K, L, and M. Staff M reviewed the training records with the investigator. The training records did not have documentation to show the facility verified the nursing staff was competent to perform the specific job duties as expected and according to the licensure/certification of each staff person. Staff M stated there was not a system in place to verify nursing staff was competent to perform their jobs. In an interview on 08/12/2024 at 3:12 PM, Staff B (Director of Nursing) stated the facility did not have a system to verify nursing staff's competency to perform their job on hire or on an annual basis. When asked if competency of nursing staff was evaluated by the facility to ensure care is provided to residents according to professional standards, Staff B stated no, but it should be. REFERENCE: WAC 388-97-1080(1).