STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50A260	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fircrest Nursing Facility	15230-15th Northeast Seattle, WA 98155

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 - 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. 49619 Based on observation, interview, and record review the facility failed to follow the plan of care and provide adequate supervision for 1 of 1 resident (Resident 1), reviewed for accident hazards. This failure placed the residents at risk for further fall, injury, and a diminished quality of life. Findings included . Review of the facility's policy titled, Fall Protocol, revised on 01/23/2023, showed Falls require prompt response to determine cause, injury, and adherence to Care Plan (CP) or Individualized Habilitation Plan (IHP) expectations. The policy showed that if a client [resident] is unable to get up from a fall they will remain where they are until a nurse comes to assess them. The policy further showed that the Attendant Counselors (AC/Certified Nursing Assistant [CNA]) were responsible for following the resident's individualized plan of care as developed by the Interdisciplinary Team. Review of Resident 1's Activities of Daily Living (ADL) care plan initiated on 01/12/2023, showed, Always stay [sic] [in front] of client when giving her a shower. Review of Resident 1's fall risk care plan initiated on 01/12/2023, showed, Always keep client at line of sight at all times for safety, and Do not leave client by herself at any time. Review of Resident 1's clinical note dated 03/28/2025, showed, Ac [AC/CNA] staff reported to this RN [Registered Nurse] about [Resident 1's] fall in the bathroom post shower. Ac staff stated that after she gave shower to [Resident 1], she turned to pick the lotion leaving the client in her w/c [wheelchair] and the client flipped off and fell on the floor. Further review of the clinical note showed that upon arrival at the scene, Resident 1 was found back in their wheelchair and looked stable upon initial RN assessment. Review of Resident 1's fall investigation that occurred on 03/28/2025, showed, [Staff E, CNA] stated that after giving [Resident 1] a shower, she briefly stepped away to place lotion on the counter. During the short interval, [Resident 1] flipped to her left side, and [Staff E] found her lying on the floor alongside her wheelchair. [Staff E] noted that [Resident 1] appeared agitated that morning and exhibited continuous rocking behavior. The investigation showed it was noted that the wheelchair was placed on a curved section of the floor designed for water drainage, which likely contributed to the incident as [Resident 1] rocked. Further review of the investigation showed that Staff E failed to follow Resident 1's care plan. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/23/2025 at 1:50 PM, showed Resident 1 was mobile in their wheelchair, and an unknown staff member following them. In an interview on 05/02/2025 at 1:24 PM, Staff F, CNA, stated that Resident 1 was on a one on one because they had behaviors and could move easily in their wheelchair and to accompany them for safety. In a phone interview on 05/02/2025 at 3:03 PM, Resident 1's Collateral Contact 1 (CC1), stated that Resident 1 had a fall because their chair was not on a flat surface. CC1 stated that Resident 1 rocked and bounced in their chair and that if it was not positioned on a flat surface, they would be able to tip over pretty easily. In an interview and joint observation on 05/06/2025 at 10:48 AM, Staff E stated that if a resident was one on one, staff had to remain with the resident the entire time and not be left unattended. A joint observation showed a shower room on the Hickory Unit with a slight slope. Staff E stated that on 03/28/2025 they assisted Resident 1 with their shower. Staff E stated that they turned towards the counter to set a lotion container down, when Resident 1 was reaching for the shower hose and tipped over in the shower chair. Staff E stated that they were expected to follow the care plan. On 05/02/2025 at 11:33 AM, Staff D, Licensed Practical Nurse 4, stated that if a resident had a fall a RN was responsible for assessing the resident on the ground, and once they were safe to move, they would be assisted to do so. In an interview and joint record review on 05/06/2025 at 11:46 AM, Staff C, RN 2, stated that staff were expected to follow the care plan. A joint record of Resident 1's ADL care plan showed an intervention to Always stay in front of client when giving her a shower. Staff C stated that staff should not have turned their back to Resident1 when setting something on the counter. Staff C further stated that the RN was responsible for assessing the resident post fall. On 05/06/2025 at 12:32 PM, Staff B, RN 4, stated that it was their expectation that staff followed a resident's care plan. Staff B stated that on 03/28/2025 Resident 1 had a fall in the shower and that their chair had not been positioned on a flat surface when the resident fell forward. Staff B stated that it was the RN's responsibility to assess a resident post fall prior to moving them. Staff B further stated that the fall on 03/28/2025 could have been avoidable and that they expected staff to be attentive to the residents' environment, equipment, and know the care plan of each resident they provided care for. On 05/06/2025 at 1:45 PM, Staff A, Administrator, stated that there was a slope in the shower room that could have contributed to Resident 1's fall on 03/28/2025. Staff A stated that they would expect staff not to place the shower chair on the slope surface. Reference: (WAC) 388-97-1060 (3)(g)