STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505387	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Mother Joseph Care	3333 Ensign Road Northeast Olympia, WA 98506

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 40914 Based on interview and record review, the facility failed to immediately report to the state agency potential financial exploitation for 1 of 1 resident (Resident 1) reviewed for allegations of misappropriation. Failure to immediately report alleged abuse and/or neglect placed residents at risk for potential unidentified mistreatment and a poor quality of life. Findings included . The facility policy, Abuse Prohibition and Protection, dated 01/2024, documented staff will immediately report allegations to the Administrator and the State Agency. Allegations reportable to the Administrator and State Agency include misappropriation of resident property defined as deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of resident's belonging or money without the resident's consent. Resident 1 was admitted to the facility on [DATE] with diagnoses of post-traumatic stress disorder (PTSD), recurrent major depressive disorder, and general anxiety disorder. The quarterly Minimum Data Set (MDS), dated [DATE], documented Resident 1 had moderate cognitive impairment and required moderate to total assistance on staff for activities of daily living (ADLs). On 07/29/2024 at 2:52 PM, Resident 1 reported a disagreement with their significant other (SO) because they received a bill from the facility for $11,000. Resident 1's SO was supposed to be managing their money including earnings they received from their pension and retirement. Resident 1 said they worked their whole life to try and make their lives comfortable and now they were not benefiting from their earrings. Resident 1 said they did not have access to their money for any reason. Resident 1 said their SO would give them $20-$30 but it always occurred after yelling and screaming or making demeaning comments. Resident 1 said they could not access money to spend if they wanted to make a larger purchase. Resident 1 said the way their SO treated them was traumatizing and humiliating. Resident 1 said they had reported concerns to Staff C, Social Services, and spiritual services but that staff had addressed the concerns. Resident 1 said they just wanted support to get through the situation. (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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(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 - Few	On 08/30/2024 at 3:20 PM, Staff E, Licensed Practical Nurse (LPN), said they had seen Resident 1's SO upset with the resident. Staff E said they had heard Resident 1's SO speaking about money with the resident then cursing at the Resident. Staff E said Resident 1 appeared sad after the witnessed interaction(s). Staff E said Resident 1 had recently required mental health visits and adjustments in their depression medication. Staff E said they did not document these instances because they did not think they were significant enough events to document. Staff E said there had never been direction to be on alert to the interactions between Resident 1 and their SO. On 09/03/2024 at 1:28 PM, Staff C, Social Services 1, said they were aware of the allegation Resident 1's SO was withholding money from the resident. Staff C said they were unsure if the resident's bill was unpaid. Resident 1 had confided to Staff C that the resident's SO yelled at them. Staff C said they visited with the resident regarding their concerns but did not chart their conversations. Staff C said these allegations were not reported to the facility or the State Agency. Staff C said they should have been reported the allegation. At 4:45 PM, Staff B, Registered Nurse and Director of Nursing, said they were aware of the allegation by Resident 1 regarding the SO withholding money for the resident. Staff B said they were unsure if the resident's bill was unpaid. Staff B said the facility should have had a discussion to determine if the allegation should have been reported. On 09/05/2024 at 11:00 AM, Staff A, Administrator, said Resident 1 had not reported the allegation to them and they had visited with the resident frequently. Staff A said they were unsure if the resident's bill was unpaid. Staff A said if one staff received an allegation from a resident, it should be reported. Reference WAC 388-97-0640(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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40914 Based on interview and record review, the facility failed to develop a personalized discharge plan based on each resident's identified needs, goals and preferences and implement it timely for 1 of 3 residents (Resident 2) reviewed for discharge planning. This failure placed residents at risk for delayed discharge, unmet care needs after discharge and a diminished quality of life. Findings included . Resident 2 was admitted to the facility on [DATE] with diagnoses including post-accident traumatic injuries and fractures. The admission Minimum Data Set (MDS), dated [DATE], documented Resident 2 had no cognitive impairment and required set-up assistance from staff for activities of daily living (ADLs). The care plan, dated 02/05/2024, documented the resident would improve in mobility prior to discharging home. On 08/02/2024 at 12:57 PM, Resident 2's family member (FM) said once admitted to the facility, staff did not explain what to expect while Resident 2 was admitted . The care conferences included staff who did not know the resident or seemed unfamiliar with the resident. Resident 2 and the FM asked for a COPES (community options program entry system - a service for older adults to receive assistance in the home) assessment to be completed so he could have additional services in the home. It became a long wait for the assessment and the FM felt they got inconsistent answers when they asked about the status. The resident opted to discharge with the understanding a COPES assessment would be done once the resident was home. When no one followed up, they found the resident could not get a COPES assessment. This caused frustration and alternate planning to make sure Resident 2's needs would be met. Therapy notes, dated 02/09/2024, documented Resident 2 would benefit from COPES. Therapy notes, dated 02/27/2024, documented Resident 2 would benefit from support in the home. Progress notes, dated 02/27/2024, documented Resident 2 would stay in the facility until COPES could be established. Progress notes, dated 03/05/2024, documented Resident 2 would be discharging home with family and social services would initiate home health services. Therapy notes, dated 03/05/2024, documented concerns with Resident 2 managing at home independently. Progress notes, dated 03/08/2024, documented Resident 2 was discharged with home health services and medications had been sent to the pharmacy. Discharge summary, dated 03/08/2024, documented Resident 2 had improved with therapy and was safe to go home. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/30/2024 at 3:45 PM, Staff F, Occupational Therapist (OT) and the Director of Rehab Services, said OT documented concerns the resident could discharge safely. OT documented COPES upon discharge would provide the support the resident required. On 09/03/2024 at 3:16 PM, Staff D, Social Services, said Resident 2 was wanting to go home and opted not to wait for a COPES assessment. Staff D said they did not consistently document the process of the discharge plan including the status of the COPES assessment or create a discharge care plan. At 4:36 PM, Staff B, Registered Nurse and Director of Nursing, said there was no follow through on the COPES program and there were inconsistent recommendations on the resident's ability to care for himself safely. Staff B said an individualize discharge care plan should be developed based on residents' discharge needs. Reference WAC 388-97-0080

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40914 Based on observation, interview, and record review the facility failed to ensure residents who were trauma survivors received culturally competent, trauma-informed care and services in accordance with professional standards of practice for 1 of 3 residents (Resident 1) reviewed for mood and behavior. This failed practice placed residents at risk for unidentified triggers, re-traumatization and unmet care needs. Findings included . The facility policy, Trauma Informed Care, dated 01/2022, documented staff would recognize the impact of trauma on recovery and establish standards for assessing the signs and symptoms of trauma. Staff would periodically assess and care plan resident-centered approaches to meet residents' emotional needs. Resident 1 was admitted to the facility on [DATE] with diagnoses of post-traumatic stress disorder (PTSD) (mental health condition triggered by a terrifying event), recurrent major depressive disorder, and general anxiety disorder. The quarterly Minimum Data Set (MDS), dated [DATE], documented Resident 1 had moderate cognitive impairment and required moderate to total assistance on staff for activities of daily living (ADLs). Care plan, dated 02/24/2024, documented Resident 1 was at risk for depressive disorder due to passive negative statements, major depression, and PTSD. The care plan goal was that Resident 1 would not make negative statements related to wishing they were dead. Interventions showed staff would encourage family visits, verbalizing of feelings, pastoral care, social services, and mental health services. Provider notes, dated 03/05/2023, documented Resident 1 had experienced increased weakness, falls, inability to walk, and assistance with ADLs since 10/2023. The resident reported feeling worthless, useless, and a burden on their significant other (SO). The resident did not feel in charge of their own person or medical goals. Progress notes, dated 03/14/2024, documented Resident 1 found out they were not going home and would need long-term care placement. Resident 1 voiced worry because of a fear their significant other (SO) did not want the resident back at home. Resident 1 said I feel like my marriage is over and I have been 'robbed of' a happy family. Progress notes, dated 06/13/2024, documented Resident 1 was worried about the relationship with their SO. Resident 1 verbalized they were sad about the change in their medical condition. Resident 1 was upset they were not able to go home and that was changing the dynamics of their marriage. Resident 1 said it was hard to cope and they felt isolated. Resident 1 said they had been unable to get out of bed or their room for some time. Resident 1 said they had not been able to attend religious services. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress notes, dated 07/02/2024, documented Resident 1 was tearful and asked for the social worker (SW). Resident 1 had an appointment with mental health services and the call was disconnected. The resident was unable to visit with them again until 08/09/2024. Resident 1 said they really needed a session that day. Resident 1 was encouraged to use the tools therapy suggested, such as writing letters. Resident 1 verbalized passive negative statements and suicidal thoughts. The resident wanted to visit their home and see their dog. An increase in anxiety reducing medication was ordered. The resident was monitored for further suicidal ideation. Progress notes, dated 07/02/2024, documented Resident 1 needs were not being met within their family circle. Resident 1 understood their limitations but wanted to be a part of the family unit. Resident 1 was upset because the therapy appointment did not happen. Resident 1 was frustrated and hurt regarding the situation. On 07/29/2024 at 2:52 PM, Resident 1 said disagreements with their SO regarding access to their money including earnings received from their pension and retirement and a large unpaid bill from the facility was causing the resident significant distress. Resident 1 said they didn't feel they had access to their money and that their SO would often yell, scream and make demeaning comments to the resident when they asked for money. Resident 1 said the way they were treated by their SO was traumatizing and humiliating. Resident 1 said there had been calls placed to Adult Protective Services (APS) regarding others having observed the treatment of Resident 1 by the SO prior to his admission to the facility. Resident 1 felt like because of this their SO would try and be quiet enough that staff wouldn't hear and also felt that staff would side with the SO when there was a conflict in making decisions which made it hard for Resident 1 to feel like they could voice their concerns. Resident 1 felt their role as a spouse was insignificant and meaningless as a result. Resident 1 was observed being tearful as they voiced sadness of the breakdown of their family. The resident said despite their concerns, they just want to have a loving relationship with their SO. Resident 1 felt the changes in their health, the total change in their function, mobility, ability to be a spouse, and changes in living arrangements had caused great trauma in their life. Resident 1 said they did not feel comfortable talking to everyone about these concerns as these issues were embarrassing to them. Resident 1 said they had reported concerns to Staff C, Social Services, and spiritual services (name unknown) but didn't feel staff had really done anything about the concerns. Resident 1 felt he hadn't been provided with a resolution regarding the APS investigation, either. Resident 1 said they just wanted support to get through the challenging situation they were in. Resident 1 said mental health services had been inconsistent. On 08/01/2024 at 11:10 AM, Resident 1 said their SO gave them $60 dollars after arguing about what they were going to do with the money. Resident 1 said again their SO did not want to give money to them because their SO thinks the resident will give the money to homeless people or spend it all on soda. Resident 1 said the SO told them today not to [NAME] up all the treats they buy. Resident 1 felt this was a derogatory statement regarding their weight. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/30/2024 at 3:20 PM, Staff E, Licensed Practical Nurse (LPN), said they did hear Resident 1's SO speaking about money with the resident then cursing at the resident. Staff E said Resident 1 appeared sad after the witnessed interaction(s). Staff E said Resident 1 had recently required mental health visits and adjustments in their depression medication. Staff E said they did not document these instances because they did not think they were significant enough events to document. Staff E said there had never been direction to be on alert to the interactions between Resident 1 and their SO. Staff E said there have not been any discussions regarding Resident 1 and trauma related to family dynamics or their health. At 3:37 PM, Staff G, nursing assistant (NA), and Staff H, NA, said they were not aware of any concerns with Resident 1 and their SO. Staff H said there had never been any direction to be alert to the interactions between Resident 1 and their SO. On 09/03/2024 at 1:28 PM, Staff C said they were aware of the allegation Resident 1's SO was withholding money from the resident. Resident 1 had confided to Staff C the resident's SO yells at him. Staff C reviewed Resident 1's medical record and said they did not see a trauma assessment completed on the resident. Staff C said the resident did have significant changes to their health which could contribute to trauma. Staff C said they visited with the resident regarding their concerns but did not chart their conversations. Staff C said these conversations should have been documented. Staff C said staff should have assessed the resident for trauma-informed care. Staff C said the resident care plan should have reflected the resident's concerns with their SO and family dynamic. Staff C said the facility was unaware of a pending APS case. At 4:45 PM, Staff B, Registered Nurse and Director of Nursing, said they were aware of the allegation Resident 1's SO was withholding money for the resident. Staff B said the facility did not have a discussion to determine if this allegation should have been reported and did not report the allegation. Staff B said residents should have a trauma evaluation upon admission or with a change in condition. Staff B said Resident 1 should have had a trauma evaluation completed. Staff B said they were unaware an APS report was open on Resident 1 and SO. On 09/05/2024 at 11:00 AM, Staff A, Administrator, said Resident 1 has not spoken to them about their concerns with family and finances. Staff A said the resident started speaking with Staff A one day, but stopped once the resident realized Staff A was not the person, they thought Staff A was. Staff A said the facility was not aware of active APS cases related to the SO and did not report any allegations made by the resident. Staff A said Resident 1 declined a trauma assessment upon admission but that it was not reattempted. Reference WAC 388-97-1060(3)(e)