STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

06/14/2023

Olympia Special Care LLC
GARDEN COURTE ALZHEIMER COMMUNITY
626 LILLY RD NE
OLYMPIA, WA 98506

RE: GARDEN COURTE ALZHEIMER COMMUNITY # 1111

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 25348 (Completion Date 06/14/2023) and 20265 (Completion Date 04/11/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/14/2023 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2610 Infection control.

(2) The assisted living facility must:

(d) Provide all resident care and services according to current acceptable standards for infection control;

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(b) Provide the necessary care and services for residents, including those with special needs;

WAC 388-78A-2100 On-going assessments. The assisted living facility must:

(2) Complete an assessment specifically focused on a resident's identified problems and related issues:

(a) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(b) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

(c) When the resident has an injury requiring the intervention of a practitioner.

The Department staff who did the On Site verification:
Anissa Bearden, Licensor

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: GARDEN COURTE ALZHEIMER COMMUNITY
License/Cert.#: 1111
Compliance Determination #: 20265
Investigator: Cory Cisneros
Investigation Date(s): 02/22/2023 through 04/11/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 61049
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1) allegation that residents were not being changed on night shift and being left.. Some residents that are not typically wet were heavily wet.
2) allegation of infection control with dried bowel movement left on the residents linens.

Investigation Methods:

Sample:	Total residents: 85 Resident sample size: 5 Closed records sample size: 2
Observations:	ADL care on night rounds Staff to resident interactions Resident rooms Residents Infection control and prevention
Interviews:	Residents Nursing staff Family members
Record Reviews:	Medical records Incident investigation Staff training records Staff patterns Facility policies

Investigation Summary:

1) after observation, interview, and record review, there were no residents that care was observed that were heavily soiled with urine. there was no dried BM on the resident. the alleged employee provided care appropriately w/out any concerns. no failed practice
2) after observation, interview, and record review the facility failed to maintain infection control when employees didn't change their soiled gloves and wash their hands in between residents.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: GARDEN COURTE ALZHEIMER COMMUNITY
License/Cert.#: 1111
Compliance Determination #: 20265
Investigator: Cory Cisneros
Investigation Date(s): 02/22/2023 through 04/11/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 67618
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
1) resident had a fall from their wheelchair with the wheelchair landing on them and enduring facial injuries.

Investigation Methods:

Sample:	Total residents: 85 Resident sample size: 5 Closed records sample size: 2
Observations:	Activities Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Residents
Interviews:	Identified staff Nursing staff Residents Management staff Family members
Record Reviews:	Facility policies Incident investigation State reporting log Medical records

Investigation Summary:
1) after interview and record review the facility failed to follow their own policy and procedure for supportive devices. the facility failed to assess the appropriateness of the device for the resident and obtain consent and review the risks and benefits with the responsible party. The facility failed to document the assessment or that the consent was obtained in the residents record. the facility's failure to assess the supportive device contributed in the resident to have multiple falls. Those falls caused the resident to endure facial injury when they attempted to get out of the supportive

device.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
6639 Capitol Blvd SW, Floor 1or 1, Tumwater, WA 98501

Statement of Deficiencies	License #: 1111	Compliance Determination # 20285
Plan of Correction	GARDEN COURTE ALZHEIMER COMMUNITY	Completion Date
Page 1 of 11	Licensee: Olympia Special Care LLC	04/11/2023

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 02/22/2023, 03/15/2023, 03/20/2023 and 03/20/2023 of:

GARDEN COURTE ALZHEIMER COMMUNITY
626 LILLY RD NE
OLYMPIA, WA 98506

This document references the following complaint number(s): 67818, 67618, 63018, 61737, 61049, 72433

The following sample was selected for review during the unannounced on-site visit: 5 of 85 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

Anissa Bearden, Licensor
Cory Cisneros, Field Manager

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
6639 Capitol Blvd SW, Floor 1or 1
Tumwater, WA 98501

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Cory Cisneros
Residential Care Services

04/24/2023
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) — Date: 5/1/23

WAC 388-78A-2610 Infection control.

(2) The assisted living facility must:

(d) Provide all resident care and services according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on observation, interviews, and record review the facility failed to follow infection control practice by not washing their hands and changing their gloves after care was provided or were visibly soiled. This failure placed 7 of 7 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7) all at risk for cross contamination and infection when care was provided to them by the facility staff.

Findings included...

Record review of the Centers for Disease Control and Prevention (CDC) document, titled, "Hand Hygiene in healthcare Settings Guidance", dated 01/30/2020, showed health care personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: immediately before touching a patient, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patients immediate environment, after contact with blood, body fluids, or contaminated surfaces, immediately after glove removal. Health care facilities should require healthcare personal to perform hand hygiene in accordance with CDC recommendations.

Record review of the facility policy and procedure for "Handwashing", undated, showed the "purpose of good handwashing is to be the front-line protection of spread of infections." Hand washing was the single most important measure for preventing the spread of infection and disease. All staff were responsible for carrying out the hand washing policy. Staff were to wash their hands after handling soiled laundry or items with body fluids and housekeeping tasks, before and after helping resident with personal care task of daily living, whenever staff change from doing a "dirty" task to a "clean" task, and whenever hands were obviously soiled. The use of gloves did not replace hand washing.

In an observation on 03/15/2023 at 4:12 AM, Staff C, Caregiver, applied gloves on her hands. Staff C took Resident 1's (R1) brief off that was soiled with urine. Staff C did not change their gloves. They then placed the new, clean brief under the resident. They then

applied barrier cream to R1's buttocks and coccyx area. Staff C assisted the resident with rolling on their other side with the same gloves. Staff C completed fastening the brief on R1. Staff C covered R1 with their blankets with their soiled gloves on, picked up the soiled brief with one gloved hand, turned R1's bedside table lamp off with the other gloved hand, walked out of the room to their linen cart to discard the brief in a bag. Staff C then removed her gloves. Staff C then applied a new pair of gloves from her linen cart. Staff C did not use soap and water or an alcohol-based hand rub prior to applying new gloves.

In an observation on 03/15/2023 at 4:19 AM, Staff C asked Resident 2 (R2) to toilet. Staff C assisted R2 to the bathroom. Staff C removed R2's urine soiled brief and discarded it. Staff C then assisted R2 to put on and pull up the new brief. Staff C assisted R2 to bed, covered R2 with their blankets, turned the bed alarm on with the same gloves on. Staff C picked the trash bag up from the bathroom, turned the light off and exited the room. Staff C's gloves were removed at the linen cart at 4:24 AM after exiting R2's room. Staff C was not observed to use any alcohol-based hand rub or washed their hands with soap and water during the entire observation. Staff C's gloves were not changed during the entire observation of care.

In an observation on 03/15/2023 at 4:26 AM, Staff C applied new gloves to their hands. Staff C did not use soap and water or an alcohol-based hand rub prior to applying new gloves. Staff C, touched Resident 3's (R3) shoulder. Staff C asked R3 if they needed to use the bathroom. R3 stated that they didn't think they needed to be changed. R3 gave permission for Staff C to check their brief to ensure they didn't need to be provided care. Staff C had touched R3's brief to ensure they were dry. Staff C then adjusted R3's pillow and pulled their blankets up. Staff C went to the other side of the room to R3's roommate, Resident 4 (R4). Staff C touched R4's arm to wake them while still wearing the same gloves she entered the room with. Staff C asked R4 if they needed to use the bathroom and R4 declined. Staff C left the room. Staff C then went to the linen cart, removed their gloves and discarded them in the trash. No observed use of alcohol-based hand rub, washing of their hands with soap and water, or changing their gloves during the entire observation of care.

In an observation on 03/15/2023 at 4:29 AM, Staff C, put on new gloves by the linen cart without washing their hands prior. Staff C entered Resident 5's (R5) room. Staff C encouraged R5 to use the bathroom. R5 went to the bathroom. Staff C stayed at R5's bed. They were observed to touch with gloved hands, R5's incontinent (urine or bowel leakage) pad. One pad was soiled with urine and removed. Staff C then assisted R5 with removing their urine soiled brief in the bathroom and discarded it into the trash. Staff C removed R5's pants that were soiled with urine. Staff C tied the trash bags. Staff C handed R5 a new brief to put on. R5 walked back to bed. Staff C assisted R5 with covering up with their blankets. Staff C opened the door of the room to exit. Staff C discarded the bag of garbage and soiled linen in big bags on the linen cart. Staff C then removed and discarded their gloves. Staff C was not observed to use alcohol-based hand rub, wash their hands with soap and water, or change their gloves during the entire observation of care.

In an observation on 03/15/2023 at 4:39 AM, Staff C put on clean gloves by the linen cart. Staff C was not observed to wash their hands or apply alcohol-based rub on their hands prior to applying the new gloves. Staff C went in to assist Resident 6 (R6) with toileting.

Staff C noted R6's brief was soiled with urine. Staff C removed the soiled brief and discarded it into a trash bag. Staff C grabbed a new brief and assisted R6 with putting it on. Staff C then grabbed R6's walker to place in front of them. After R6 stood up, Staff C grabbed a tube of barrier cream from their pant pocket, squeezed a small amount on their glove, replaced the tube of cream back into her pant pocket, applied the cream to R6's buttocks area, assisted R6 with pulling the brief on all the way on. Staff C then walked back to R6's room. Staff C was observed to grab their keys on their lanyard around their neck. Used the keys to open R6's room. Staff C then removed their gloves after opening the door. They assisted R6 in bed with their blankets and exited the room. Staff C then discarded their used gloves and bag of trash in bag on the linen cart in the hallway. Staff C was not observed to use alcohol-based hand rub, wash their hands with soap and water, or change their gloves during the entire observation of care.

In an interview on 03/15/2023 at 4:49 AM, Staff C stated that they did not have alcohol-based rub on them to use. They stated that they didn't have any alcohol-based rub on their linen cart. Staff C stated they were to wash their hands with either soap and water or alcohol-based rub in between each resident. They stated that they usually wash their hands with soap and water. They were unable to explain why they hadn't washed their hands in between providing care for the six residents that was observed.

In an observation on 03/15/2023 at 4:50 AM, Staff C was observed to wash their hands with soap and water for the first time after providing personal care assistance for six residents in a 50 minute observation.

In an observation on 03/15/2023 at 5:01 AM, Staff E, Caregiver, provided incontinent care to Resident 7 (R7). Staff F, Caregiver accompanied Staff E for assistance. R7 had soiled their brief with a bowel movement. Staff E provided incontinent care. Staff E positioned the new brief under R7 and applied barrier cream to R7's buttocks. Staff E did not change their gloves after cleaning the bowel movement or prior to applying the barrier Cream. Staff F asked Staff E if they should have been changing their gloves in between tasks. Staff E stated "probably". Staff E continued to apply the new brief and fasten it closed. Staff E was then observed to reposition R7's pillow and blankets with the same soiled gloves.

In an interview on 03/20/2023 at 11:35 AM, Staff I, Delegated Medication Technician, stated that they were to change their gloves anytime they were visibly soiled.

In an interview on 03/20/2023 at 11:37 AM, Staff J, Licensed Practical Nurse, stated that staff were to wash their hands before and after care was provided, in between glove changes, or if they were visibly soiled. Staff J, stated gloves were to be changed if they were visible soiled, in between residents, and after care tasks. All staff members were to have alcohol-based rub in their pockets at all times for use.

In an interview on 03/20/2023 at 12:48 PM, Staff A, Executive Director, stated that all staff had participated in multiple trainings for hand washing. Staff were to wash their hands all the time in between residents, if they were visibly soiled, before and after meals, and other occasions.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 5/25/23

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Lawrence Lau — 5/1/23

Administrator (or Representative) — Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(b) Provide the necessary care and services for residents, including those with special needs;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to follow the facility's policy and procedure for supportive devices for 1 of 7 residents (Former Resident 1). The facility failed to follow the facility's policy and procedure for obtaining consent and evaluating a resident for safe use of a supportive device. This failure resulted in harm to Former Resident 1 when they obtained facial injuries with the use of the supportive device.

Findings included...

Record review of the facility policy for "Supportive Devices", undated, showed "it is the philosophy of this community to promote residents independent, comfort, and safety. Independence, comfort and safety at times can be maximized with the use of supportive devices." Under the section of the policy for the definition of a supportive device showed a supportive device may have restraining qualities that supports and improves a resident's physical functioning. Also known as an assistive device. Some examples of supportive devices were tilt wheelchairs. Under procedures showed the resident or the resident's responsible party must request or approve the supportive device. The facility's Registered Nurse (RN) must complete a thorough assessment of the resident, the device requested, the resident's ability to safely use the device, and other less restrictive alternatives prior to use of the device. The resident or the resident responsible party must be informed of the risk and benefits of the device prior to the use of the supportive device. The assessment was to be documented in the resident's record. Residents and their use of the assistive devices was to be reassessed with changes in condition, quarterly assessments, and on an

as needed basis. The supportive device was to be installed by a professional such as a community maintenance director, durable medical equipment technician, health care professional, or other appropriate individual determined by community Administrator. Details of the use of the assistive device must be service planned and was to include what the supportive device was, when the supportive device was to be used, who to report to if the resident's safety was jeopardized by the use of the supportive device, and who to contact if the supportive device became loose, damaged, or malfunctions.

Record review of the face sheet for Former Resident 1 (FR1), showed they moved into the facility on [redacted]/2022 with multiple medical diagnoses including [redacted].

Record review of the document titled "Master Assessment", dated 01/17/2023, showed that FR1 was assessed related to a 90 day evaluation and change in condition, decline in activities of daily living abilities, and moving to the south side of the facility. Under the section titled "functional capabilities", showed FR1 did not use any assistive equipment. FR1 was independent with all ambulation and didn't require any level of assistance with this. FR1 was oriented to self. FR1 had some difficulty using the call system. FR1 was able to communicate and make their needs known. FR1 had no history of falls and their ambulation status was "up".

Record review of the document titled, Service Plan Agreement, dated 01/31/2023 showed FR1 had some difficulty making their needs known. FR1 had moderate to severe confusion at times. FR1 would often speak in word salad (confused or a mixture of seemingly random words and phrases). FR1 was unable to use a call light. Staff were to anticipate their needs. FR1 required being escorted to all meals, activities and to their room by staff. FR1 was unsteady on their feet, requiring a tilt wheelchair (a wheelchair that reclines back) for ambulation and safety. FR1 was at risk for falls due to their weakness, unsteadiness, and confusion. FR1 required frequent safety checks. Staff were directed if FR1 was trying to get up out of the wheelchair to redirect them back into the chair. FR1 was unable to notify staff when they required the need to use the bathroom. FR1 required physical assistance with toileting and transfer needs.

Record review of FR1 progress notes, dated 01/18/2023 thru 02/06/2023, showed there was no documented assessment by the facility's RN for use of a tilt wheelchair.

Record review of FR1 progress notes, dated 01/18/2023 thru 02/06/2023, showed there was no documented resident or responsible party consent for use of the tilt wheelchair by the facility RN.

Record review of a document titled, "Incident Notification", originally dated 01/19/2023, showed that Collateral Contact 1 (CC1), Advanced Registered Nurse Practitioner, replied on 01/25/2023, "care plan for wheelchair using tilt seat to help prevent forward falls."

In an interview on 02/20/2023 at 12:14 PM, Staff A, Executive Director, stated that they did not have an assessment or consent to provide to the Department for the tilt wheelchair

for FR1.

In an interview on 02/24/2023 at 2:33 PM, Collateral Contact 2 (CC2), Daughter of FR1, stated that they saw FR1 sitting in a wheelchair that was tilted back like a recliner chair. CC2 stated that FR1 was very active and if they needed to get up to use the bathroom or go somewhere, they would get up and go. CC2 stated that the facility didn't call to get permission to use the tilt wheelchair. CC2 stated the facility had put FR1 in a tilt wheelchair because of the falls they had but did not ask for consent or permission.

In an interview on 03/20/2023 at 11:23 AM, Staff B, Resident Care Coordinator, stated that the consent from the responsible party for the use of the supportive device, and review of the risk and benefits of the supportive device would have been documented in the resident's progress notes.

In an interview on 03/20/2023 at 11:37 AM, Staff J, Licensed Practical Nurse, stated that all assessments for the residents that used supportive devices were documented in the progress notes. They stated that an assessment and consent was completed with all supportive devices prior to the resident using them. The assessments were completed by one of the facility's licensed nurses. Staff J was unable to provide a progress note that showed the assessment was completed for FR1's use of a tilt wheelchair. Staff J was unable to provide a progress note of the consent, risks and benefits reviewed with the responsible party or resident for review.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 5/25/23

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Lawyer Law — Administrator (or Representative)

5/1/23 — Date

WAC 388-78A-2100 On-going assessments. The assisted living facility must:

(2) Complete an assessment specifically focused on a resident's identified problems and related issues:

(a) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(b) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

(c) When the resident has an injury requiring the intervention of a practitioner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that a resident was assessed for the use of a supportive device for 1 of 7 sampled residents (Former Resident 1). The facility failed to assess, receive consent, and evaluate the appropriateness of the supportive device for the resident. This failure contributed to Former Resident 1 having multiple falls that caused harm with facial injuries.

Findings included...

Record review of the facility policy for "Supportive Devices", undated, showed "it is the philosophy of this community to promote residents independent, comfort, and safety. Independence, comfort, and safety at times can be maximized with the use of supportive device." Under the section of the policy for the definition of a supportive device showed a supportive device may have restraining qualities that supports and improves a resident's physical functioning. Also known as an assistive device. Some examples of supportive devices were tilt-wheelchairs. The supportive device was to be assessed by the facility Registered Nurse to ensure resident ability to safely use the device. Other least restrictive alternatives were to be used prior to the use of the supportive device. The service plan was to indicate who to report to if the resident's safety was jeopardized by the use of the supportive device.

Record review of the face sheet for Former Resident 1 (FR1), showed they moved into the facility on [redacted]/2022 with multiple medical diagnoses including [redacted].

Record review of the document, titled, "Master Assessment", dated 01/17/2023, showed that FR1 was assessed related to 90-day evaluation and change in condition, decline in activities of daily living abilities, and moving to the south side of the facility. Under the section titled "functional capabilities", showed FR1 did not use any supportive equipment. FR1 was independent with all ambulation and didn't require any level of assistance with this. FR1 was oriented to self. FR1 had some difficulty using the call system. FR1 was able to communicate and make their needs known. FR1 had no history of falls, and their ambulation status was "up". The assessment showed no documentation of the need for a supportive device.

Record review of FR1's Service Plan Agreement, dated 01/31/2023, showed FR1 had some difficulty making their needs known. FR1 had moderate to severe confusion at times. FR1 would often speak in word salad (confused or a mixture of seemingly random words and phrases). FR1 was unable to use a call light. Staff were to anticipate FR1's needs. FR1 required being escorted to all meals, activities, and their room by staff. FR1 was unsteady on their feet, requiring a tilt wheelchair (a wheelchair that reclines back) for ambulation and safety. FR1 was at risk for falls due to their weakness, unsteadiness, and confusion. FR1 required frequent safety checks. Staff were directed if FR1 was trying to get up out of

the wheelchair to redirect them back into the chair. FR1 was unable to notify staff when they required the need to use the bathroom. FR1 required physical assistance with toileting and transfer needs.

Record review of FR1's progress note, dated 01/18/2023 at 4:02 PM, showed that FR1 returned to the facility from a hospitalization stay. FR1 was shaky when they walked and required staff assistance to maintain their balance.

Record review of a document, titled, "Incident Notification", originally dated 01/19/2023, showed that Collateral Contact 1 (CC1), Advanced Registered Nurse Practitioner, documented on 01/25/2023, "care plan for wheelchair using tilt seat to help prevent forward falls."

Record review of document titled, "Initial Record of Incident", dated 01/19/2023 at 3:30 PM, showed that FR1 had a history of falls. They had a "reduction plan" in place for using a tilt back wheelchair and safety checks. The report showed that FR1 had a non-injury fall to the floor in the activity room. They were previously seen sitting in a chair five minutes prior to being found on the floor.

Record review of FR1's progress note, dated 01/20/2023 at 7:06 AM, showed FR1 was assisted with walking around with a walker by staff, but was noted to be very unsteady. FR1 had to sit back in a wheelchair. Staff had to escort FR1 back to their bed.

Record review of FR1's progress note, dated 01/20/2023 at 10:46 PM, showed FR1 had ambulated by self-propelling in a wheelchair. FR1 was using a donor wheelchair that tilted.

Record review of FR1's progress note, dated 01/22/2023 at 10:09 PM, showed FR1 remained in a wheelchair. FR1 continued to attempt to get out of the wheelchair and walk.

Record review of a document, titled, "Initial Record of Incident", dated 01/24/2023 at 11:10 PM, showed FR1 was found on the floor in the activity room. FR1 told the staff that they had fell out of their wheelchair and hit their head. They were experiencing neck pain. Under the section "describe what you saw and heard", showed that FR1 was face down with the tilt wheelchair on top of him. The wheelchair was in a tipped position.

Record review of FR1's progress note, dated 01/25/2023 at 7:10 AM, showed FR1 was found on the floor with their wheelchair tipped on top of him face down. FR1 was checked and noted to have bruising to their left cheek, bridge of nose, and a bump to center of forehead.

Record review of FR1's progress note, dated 01/25/2023 at 2:05 PM, showed FR1 was seen up walking on their own without staff.

Record review of FR1's progress note, dated 01/25/2023 at 11:49 PM, showed FR1 had been ambulating with staff with the assistance of the tilt wheelchair. FR1 was unable to safely gauge their physical limitations (weakness, dizziness) that caused frequent falls.

Record review of FR1's progress note, dated 01/26/2023 at 3:17 AM, showed CC1, responded about the fall that occurred on 01/19/2023 to have FR1 care planned to use a wheelchair that tilted to help prevent forward falls. That order was placed for review on 01/25/2023.

Record review of a document titled, "Initial Record of Incident", dated 01/27/2023 at 7:40 PM, showed FR1 had a fall with a wound to the head in the activity room. Under the section "what did the resident tell you about what happened", showed FR1 told care staff they stood from their wheelchair and hit their face on the ground. The description of the incident showed that FR1 had been previously observed 10 minutes prior, watching television in their tilted wheelchair. When FR1 was found they were standing upright near their tilted wheelchair with blood on their face from a cut on the bridge of the nose with swelling and bruising. Under the section "Incident Investigation", showed the reduction plan in place to help prevent further falls was the use of a tilt wheelchair and increased safety checks. FR1 had contributing factors that included their dementia, gait/balance impairment, his of falls, weakness, and lack of safety awareness.

In an interview on 02/20/2023 at 12:14 PM, Staff A, Executive Director, stated that they did not have an assessment or consent to provide for the supportive device, tilt wheelchair, for FR1.

In an interview on 02/24/2023 at 2:33 PM, Collateral Contact 2 (CC2), Daughter of FR1, stated that they saw FR1 sitting in a wheelchair that was tilted back like a recliner chair. CC2 stated that FR1 was very active and if they needed to get up to use the bathroom or go somewhere, they would get up and go. CC2 stated that the facility didn't call to get permission to use the tilt wheelchair. CC2 stated the facility had put FR1 in a tilt wheelchair because of the falls FR1 had but did not obtain consent or permission from CC2.

In an interview on 03/15/2023 at 4:05 AM, Staff C, Caregiver, stated that FR1 had been in a long back tilt wheelchair when they had the fall on 01/25/2023 that landed on top of them.

In an interview on 03/15/2023 at 5:10 AM, Staff F, Caregiver, stated that for the fall that happened on 01/24/2023, FR1 on was in the tilt wheelchair when they fell, and it had landed on top of them. They stated that FR1 tried to get up out of the wheelchair all the time even in the tilted position. Staff F stated that FR1 continued to have falls. Staff F stated the facility got the wheelchair for FR1 to help keep him from getting up on their own.

In an interview on 03/15/2023 at 5:13 AM, Staff E, Caregiver, stated that FR1 wanted to

move and that if they didn't have the footrests on or the wheelchair tilted, then FR1 would have been able to self-propel with their legs.

In an interview on 03/20/2023 at 11:23 AM, Staff B, Resident Care Coordinator, stated that FR1 was unable to request their needs after they had returned from the hospital in January 2023. Staff B stated that they needed consent from the resident's responsible party for the facility to use supportive devices such as tilt wheelchairs. Staff B stated that the facility process was to get permission to use the supportive device, risk and benefits of the supportive device was explained to the responsible party, and then was to be documented in the resident's progress notes. Staff B was unable to provide documentation to show assessment, consent or that the risks and benefits were explained to the responsible party for FR1.

In an interview on 03/20/2023 at 11:37 AM, Staff J, Licensed Practical Nurse, stated that all assessments for the residents that used supportive devices were documented in the progress notes. The assessments were completed by one of the facility's licensed nurses. Staff J was unable to provide a progress note to review that showed consent had been obtained by the facility from the resident's sponsible party for FR1. There was no documented conversation that the risks and benefits of the tilted wheelchair had been reviewed with the responsible party for FR1. Staff J stated that in February 2023 they were told about a new document for supportive devices that they there were to fill out. The document was titled "Assistive device assessment". Staff J was unable to provide documentation that an assessment was completed prior to FR1's use of the tilt wheelchair.

This is a recurring deficiency previously cited on 04/13/2021.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, GARDEN COURTE ALZHEIMER COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 5/25/23.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Lawrence Lau — Administrator (or Representative)

5/1/23 — Date