STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505017	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Care Center	2821 South Walden Street Seattle, WA 98144

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure each resident received assessed level of supervision and assistance to prevent accidents for 1 of 4 sampled residents (Resident 1) reviewed. Resident 1 experienced harm when they fell out of a mechanical lift without the assessed two caregiver assistance, landed on the floor, and sustained a traumatic brain injury (TBI), with multiple areas of bleeding in the brain, upper neck fracture and facial fractures. This failure placed other resident at risk that required assistance of two care givers and a mechanical lift for their Activities of Daily Living (ADLs). The admission Minimum Data Set (MDS-an assessment tool) dated 02/06/2025, Resident 1 required total assistance from staff with all ADLs including Hoyer (mechanical lift) transfers.The Quarterly MDS, dated [DATE], showed Resident 1 was able to make their needs known, could communicate with staff, and had significant cognitive impairment.The Kardex Policy, dated 12/2003, Certified Nursing Assistants (CNA) review the Kardex at the beginning of each shift to understand the current status of each resident, guiding CNAs in their daily routine, precautions for assistance needed to provide safe and appropriate care, and utilizing the Kardex can ensure that staff are giving appropriate care. Staff are to follow all care needs to reduce risky incidents like falls and skin injuries.Review of Resident 1's Kardex with admission date of 12/18/2019, showed Resident 1 was dependent on two staff, total assistance, with transfers.The Kardex, dated 07/17/2025, showed Resident 1 was at risk for falls, required mechanical lift with 2 persons assist for all transfers.According to the Nursing Progress Note, dated 09/03/2025 at 19:17 PM, Resident 1 was alert, responsive, and able to communicate their needs to staff.The Behavioral Health Team progress note dated 9/10/2025 at 08:15 AM showed Patient 1 was verbal and could communicate with staff effectively Review of a Nursing Progress Note dated 9/17/2025 at 11:35 PM showed Resident 1 fell from the mechanical lift, was on the floor unresponsive, had a bleeding wound on their forehead, 911 was called and Resident 1 was sent to the hospital.Review of the hospital Admit Progress notes, dated 09/17/2025 at 08:15 PM, showed Resident 1 was unconscious and unresponsive when admitted to the Emergency Room. A Computed Tomography scan (CT, a computerized, detailed, x-ray) scan of the spine showed a fracture of a vertebrae in the upper neck. CT of the head showed multiple areas of bleeding in the brain, between the brain and skull, and facial fractures.Review of the facility's initial investigation dated 09/17/2025 showed the assigned Certified Nursing Assistant (CNA), Staff C, provided care without a second staff member in attendance. The investigation showed the fall could have been prevented if the plan of care was followed. The failure to follow the plan of care resulted in harm to the resident and put all residents, that require 2-person assistance, at risk.In an interview on 09/18/2025 at 2:07 PM, Staff B, Director of Nursing, stated they would expect the CNA to review the Kardex prior to giving care to the residents to prevent injuries, that all aides were recently re-educated, that two caregivers were required to operate the mechanical lift, and could prevent the fall that resulted in significant injuries.In an interview on 09/18/2025 at 2:30 PM, Staff A, Administrator, stated this incident happened because staff did not follow the Kardex, that two care givers could have prevented the fall and injuriesIn an interview on 09/18/2025 at 3:07 PM, Staff D, Regional Director of Clinical Operations (RDCO), stated Staff C, Certified Nursing Assistant (CNA), was not following the Kardex and this incident could have been prevented. The intervention of 2 people is for resident safety, to help prevent injuries, and is our best practice.In an interview on 09/18/2025 at 3:10 PM, Staff E, Assistant Director of Nursing (ADON) stated by not following the Kardex Resident 1 fell. The intervention of 2 people was for residents and staff safety, to help prevent injuries and harm.Staff C unavailable for comment. REFERENCE: WAC: 388-97-1060 (3)(g)