STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505086	A. Building B. Wing	03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark Care and Rehabilitation	710 North 39th Avenue Yakima, WA 98902

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review, the facility failed to ensure residents and/or their resident representatives (RR) provided an informed consent (the process in which a health care staff educates a resident and/or their RR about the risks, benefits, and alternatives treatment of a given procedure, intervention, or medication therapy and obtains the resident consent), in advance of implementing psychotropic (a type of drug [like antidepressants, anti-anxiety, and antipsychotics] that affects brain activities associated with mental processes and behaviors) medications for 2 of 3 residents (Residents 3 and 4) reviewed for psychotropic medications. This failure placed the resident and/or their RR at risk of not being fully informed, a lack of knowledge regarding the risks/benefits of psychotropic medications and prevented them from exercising their right to participate in treatment options. Finding included . Review of the facility's policy titled, Antipsychotic and Psychotropic Medication Use, dated 10/28/2023, showed that a resident or their power of attorney (POA, a written and authorized documented that states that another person is legally able to act on a resident's behalf) .must sign the psychotropic consent form prior to starting the medications, this includes reviewing the risks and benefits with that person. <Resident 3> Review of the resident's medical records showed they were admitted to the facility on [DATE] with diagnoses including urinary tract infection, partial blindness, altered mental status and repeated falls. The comprehensive assessment, dated 01/09/2024, showed the resident had a moderately impaired cognition, was assessed to no physical or verbal behaviors, and was not talking any psychotropic medications. Review of Resident 3's February 2024 medication administration record (MAR) showed that Quetiapine (an antipsychotic medication used to treat mental/mood disorders) was started on 02/27/2024. Review of Resident 3's medical record showed that a psychotropic medication consent form had not been completed for the resident. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/06/2024 at 10:38 AM, when asked if they had been informed/educated on the psychotropic medication that was started on 02/27/2024, Resident 2's RR/POA stated they had not been informed about the Quetiapine medications risk benefits, alternative therapies or that the facility had started Resident 3 on the psychotropic medication. RR stated they had visited the resident in the facility on 03/01/2024 and was informed the medication was started after they asked why Resident 2 was out of it. <Resident 4> Review of the resident's medical records showed they were admitted to the facility on [DATE] with diagnoses including malnutrition, anxiety, and fracture of the left arm bone. The comprehensive assessment, dated 01/24/2024, showed the resident was cognitively intact and able to make their needs known. Review of Resident 4's February 2024 MAR showed Duloxetine (an antidepressant medication) was started on 01/18/2024 and Quetiapine was started on 01/18/2024. Review of Resident 4's medical record showed that a psychotropic medication consent form had not been completed for the resident. During an interview on 03/07/2024 at 10:56 AM, Staff E, Licensed Practical Nurse/Resident Care Manager, stated that part of the process for new orders of psychotropic medications were to obtain an informed consent from the resident and/or the RR. Staff E reviewed Resident 3 and Resident 4's records and stated that neither of the residents and/or their RR had completed informed consents regarding their psychotropic medications. During an interview on 03/07/2024 at 12:05 PM, Staff B, Director of Nursing, stated that psychotropic medication consents were not obtained for Resident 3 nor Resident 4 and that they did not follow their normal process. Reference: WAC 388-97-0260

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652 Based on observation, interview and record review the facility failed to provide the vital services needed for wound healing and treatment of serious infection by consistently providing dressing changes and initiating antibiotics timely for 3 of 3 residents (Resident's 1, 2 and 8) reviewed for pressure injuries (wounds over a bone caused by pressure). Resident 1 experienced harm when the Stage 4 pressure injury (a wound with full tissue loss and exposed bone, tendon and muscle) that was acquired at the facility worsened, they experienced pain and the osteomelitis (a high risk infection in the bone that can lead to full body system wide infection) was not treated timely. The facility's lack of ensuring residents received the treatment needed for healing placed residents at serious risk for worsening of pressure injuries, pain, infection and a significant decline in health status and was determined to be an emergent situation. On 03/07/2024 at 4:20 PM the facility was notified of an Immediate Jeopardy (IJ) at CFR 483.2(b)(1), F686 Treatment/Services to Prevent/Heal Pressure Injuries related to the failure to provide wound care consistent with professional standards of care for pressure injury wounds. This included a pattern of missed dressing changes occurring on the weekends and a failure to timely start an oral antibiotic for a resident with a wound infection. It was determined that the IJ began on 03/01/2024 and the immediacy was removed on 03/08/2024 with an onsite verification from investigators. The facility removed the immediacy by implementing education for licensed nurses to be completed prior to their next scheduled shift. The facility initiated a supervisory plan to ensure weekend dressing changes were completed. The oral antibiotic was started for the resident with the wound infection on 03/07/2024. The measures put in place by the facility ensured that wound care for pressure injuries would be completed according to physician ordered treatments. Findings included . Review of the National Pressure Injury Advisory Panel (leading expert in pressure injuries/wounds), September 2016 defines pressure injury stages as follows; Stage 1 Pressure Injury has intact skin with a localized area of non-blanchable erythema (redness). Stage 2 Pressure Injury is a partial thickness skin loss with exposed dermis (the top inner layers of skin). Stage 3 Pressure Injury is a full thickness loss of skin, in which adipose (fat) tissue is visible in the ulcer. Slough (dead tissue) and or eschar (dried blood and tissue) may be visible, granulation tissue and epibole (rolled or curled under edges) may include with undermining (a pocket of dead space under the visible wound edges) and tunneling (a passage way under the wounds surface which may be shallow or deep and impairs wound closure). Stage 4 Pressure Injury is a full thickness loss of skin and tissue with exposed or directly palpable fascia (a layer of connective tissue), muscle, tendon, ligament, cartilage, or bone in the ulcer. Epibole undermining and tunneling often occur. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Unstageable Pressure Injury is a full thickness skin and tissue loss to which the extent of the tissue damage cannot be seen. Review of an undated facility policy titled, Skin Integrity showed the facility will provide care consistent with professional standards of practice to prevent pressure ulcers and promote healing and prevent infection. <Resident 1> Review of Resident 1's medical record showed they were admitted to the facility on [DATE] with diagnoses including peripheral vascular disease (narrowing of the blood vessels related to a buildup of plaque) and Type 2 Diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Record review of Resident 1's most recent comprehensive assessment dated [DATE] showed the resident was cognitively intact. Review of the care plan dated 02/28/2024 showed the resident required extensive assistance from staff for dressing, bed mobility and used a wheelchair for mobility needs. Record review of Resident 1's February 2024 and March 2024 physician orders showed Resident 1 had a facility acquired Stage 4 pressure injury (not present on admission to the facility) on their sacrum (a bony structure located at the base of the spine) which required wound care twice daily and included application of an antibiotic ointment to the base of the wound to prevent infection. Record review of a recent hospital discharge summary dated 02/27/2024 showed Resident 1 was hospitalized from 02/23/2024 to 02/27/2024 for surgery on their right leg with an above the knee amputation. The record showed while in the hospital Resident 1 had received intravenous (IV, a medication given directly into the blood stream by a tube inserted into a blood vessel) antibiotics for osteomyelitis in their Stage 4 sacral pressure injury. The discharge summary showed Resident 1 continued to require aggressive wound treatment to their sacral wound as their bone was exposed. Additional recommendations included to re-start an oral antibiotic related to the resident's sacral wound infection. During a concurrent observation and interview on 03/06/2024 at 11:26 AM, Staff C, Registered Nurse (RN), completed wound care on Resident 1's Stage 4 sacral pressure injury. The wound was noted to be a deep crater the size of a 50 cent piece coin that was observed to have a larger area of tissue loss under the wound opening which was undermining. The wound had a foul smell with brownish colored drainage on the soiled, removed bandage. Staff C placed a cotton swab into a tunnel in the wound and removed it which showed a three centimeter (cm, a unit of measure) depth to the pressure injuries tunneling. Staff C completed wound care per orders and finished with placing a clean dressing over the wound and securing it. Resident 1 stated the wound was painful and sore. During the same interview, Staff C stated they had concerns about Resident 1's wound care over the past weekend and had notified the provider on 03/05/2024 as the resident had not received their twice daily wound care as ordered. Staff C explained the dressing that had been removed on Monday 03/04/2024, still showed a date of 03/01/2024 written on the dressing which demonstrated the twice daily wound care had not been completed on Saturday 03/02/2024, or Sunday 03/03/2024. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a provider notification document, dated 02/19/2024, showed a pattern of Resident 1's wound care not being completed as ordered on the weekend. The provider had been notified that Resident 1 had not received twice daily wound care to their sacral pressure injury on the weekend. The dressing removed on Monday, 02/19/2024 still showed a date of 02/16/2024 written on the dressing which demonstrated that no wound care had been provided for the resident on Saturday 02/17/2024, or Sunday 02/18/2024 as ordered. During an interview on 03/06/2024 at 11:40 AM, Resident 1 stated the weekend nurse hardly ever changes my dressings. It sure was not done this past weekend. It really only gets done during the week. Review of a wound consultant progress note, dated 02/29/2024, showed Resident 1 had been assessed with a plan to continue providing twice daily wound care. The plan also recommended to re-start a course of oral antibiotics for three weeks. The recommendations were received by the facility on 03/01/2024. Review of Resident 1's March 2024 medication administration record showed the ordered oral antibiotic had not been initiated until 03/07/2024 at 8:00 PM (six days later). During an interview on 03/07/2024 at 11:55 AM, Staff C, stated that the oral antibiotic order for Resident 1 had not been started until 03/07/2024 and should have been started on 03/01/2024. Record review of Resident 1's sacral pressure injury measurement documents showed the worsening of the wound over a two-week period. 02/28/2024 length 2.17 cm and 2 cm in depth. 03/07/2024 length 2.33 cm (which showed an eight percent increase), depth 4.4 cm (which showed a 110% increase). <Resident 2> Review of Resident 2's medical record showed the resident was admitted to the facility on [DATE] with diagnoses including atrial fibrillation (an irregular heart rate that often causes poor blood flow) and weakness. Review of Resident 2's most recent comprehensive assessment, dated 02/07/2024, showed the resident was cognitively intact. Review of the resident's care plan, dated 01/15/2024, showed the resident required extensive assistance for dressing, grooming and bed mobility. Review of the Resident 2's March 2024 physician orders showed Resident 2 required daily wound care to an unstageable coccyx (tailbone) pressure injury. During an interview on 03/06/2024 at 1:40 PM, Staff C stated they had notified the provider as Resident 2 had also not received their daily wound care over the weekend. The dressing which had been removed on 03/04/2024 was dated 03/01/2024 which showed that no wound care had been completed on Saturday 03/02/2024, and Sunday 03/03/2024 as ordered. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/11/2024 at 11:20 AM, Resident 2's representative (RR) stated they had been contacted by the facility to inform them that Resident 2 had not received wound care for the entire weekend on 03/02/2024 and 03/03/2024. RR stated they had concerns about Resident 2's wound care because it was not the first [NAME] they received a report that the wound care had not been completed on the weekend. During an interview on 03/11/2024 at 2:10 PM, Resident 2 stated they did not remember if the wound care to their coccyx pressure injury was completed on the weekend. Resident 2 stated they were resting and did not want to have their wound care observed or treated at this time, I'm too tired and want to rest. Record review of the licensed nursing weekend schedule for 02/17/2024, 02/18/2024, 03/02/2024 and 03/03/2024 showed Staff D, Licensed Practical Nurse (LPN), was the nurse who worked on the above weekends. Staff D was the licensed nurse assigned for Residents 1 and 2 on the South Hall and was responsible for their pressure injury dressing changes. During an interview on 03/07/2024 at 2:45 PM, Staff D, stated they worked double weekend shifts at the facility on the South Hall where Resident 1 and 2 resided, which included day and evenings on Saturdays and Sundays. Staff D stated they changed Resident 1's dressing usually daily during their shifts and only twice daily if the dressing was soiled. Staff D further stated that Resident 2 did not have daily wound care orders for dressing changes to their coccyx wound therefore they just checked it and provided pressure injury care only if the dressing was visibly soiled. <Resident 8> Review of Resident 8's medical record showed the resident admitted to the facility on [DATE] with diagnoses including epilepsy (a brain condition that causes repeated seizures) and Type 2 Diabetes. Review of the most recent comprehensive assessment dated [DATE] showed Resident 8 was cognitively impaired. Review of the care plan dated 03/01/2024 showed the resident required extensive assistance for dressing, transfers and mobility. Record review of March 2024 physician orders showed Resident 8 required daily wound care to their Stage 2 left lateral knee pressure injury. Record review of a provider notification document dated 03/05/2024 showed Resident 8 had not received wound care to their left lateral knee pressure injury as ordered on Saturday 03/02/2024, and Sunday 03/03/2024. During an interview on 03/11/2024 at 3:45 PM, Staff B, Director of Nursing stated their expectation for pressure injury wound care was that the provider orders were to be followed and if wound care was ordered daily, that would include the weekend shifts. Reference: WAC 388-97-1060(3)(b) This is a repeat citation from the statement of deficiency dated 11/29/2023 and 08/28/2023

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 39652 Based on interview and record review the facility failed to implement an effective Quality Assurance Performance Improvement (QAPI) program that identified or corrected deficiencies related to the facility's skin program that did not meet professional standards for pressure injury care for 3 of 3 residents (Resident's 1, 2 and 8) reviewed for pressure injuries. This failure resulted in an emergent situation and placed other residents at risk to receive poor quality of care. Findings included . Refer to CFR 483.2 (b)(1) F 686 Treatment/Services to Prevent/Heal Pressure Ulcers During an interview on 03/12/2024 at 10:20 AM, Staff A, Administrator stated their QAPI process had not identified or corrected the deficient practice related to management and treatment of pressure injuries that resulted in resident harm. Reference WAC 388-97-1760(1)(2)