STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505093	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Park Health Care & Rehab Center	4755 South 48th Tacoma, WA 98409

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and/or implement an individualized comprehensive care plan, for 1 of 3 sampled residents (Resident 1) reviewed for Pressure Injuries (PI's- localized skin and underlying tissue damage from prolonged pressure). This failure placed residents at risk of developing PI's, pain, and a decreased quality of life. Findings included. The facility's Skin Integrity Management - General Policy Guidelines, dated 05/26/2025, directs facility staff to Develop comprehensive, interdisciplinary plan of care including prevention and wound treatments as indicated, review care plans and revise as indicated. Facility staff is directed to implement PI prevention for identified risk factors, determine the resident's need for offloading devices, turning and repositioning, implement special wound care treatments/techniques, and support surface for a resident's bed. In addition, facility staff are to review care plans and revise as indicated. Resident 1admitted to the facility on [DATE] with diagnoses including Diabetes (the body has trouble controlling the amount of sugar in blood), Malnutrition (imbalance of nutrients the body needs), and muscle weakness. The admission Minimum Data Set (an assessment tool), dated 10/16/2025, identified Resident 1 was at risk of developing PI's, admitted to the facility with existing PI's, and was totally dependent on staff for repositioning and turning in bed. Review of Resident 1's wound care specialist progress note, dated 10/08/2025, showed a list of 9 recommended interventions and preventative measures related to Resident 1's PI's. These recommendations included: Turn patient every two hours Keep the skin clean and dry Avoid massaging bony prominences Use positioning devices to prevent prolonged pressure bony prominences Keep HOB as low as possible to reduce risk of shearing Keep sheets dry and wrinkle free Please remove all products with fragrance, including body washes and lotions. Family & patients were instructed to order wipes without fragrance Ideally, the resident should use chemical-free fragrance-free disposable wash cloths. On 10/22/2025 wound care specialist progress notes included a 10th recommended intervention of, Aggressive offloading (reducing or removing pressure and weight from a specific body part, to promote healing of wounds and/or prevent them from forming). Review of Resident 1's care plans, on 11/19/2025, showed none of the 10 wound care specialist's recommended interventions or preventative measures were added to Resident 1's existing care plans or Kardex (A communication tool used by Certified Nursing Assistants (CNA) that identifies a resident's key care needs and treatments).On 12/17/2025 at 4:42 PM, Staff B, the Director of Nursing (DON), reviewed Resident 1's care plans, Kardex, and the wound care specialists 10/18/2025 and 10/22/2025 progress notes, including associated recommendations for Resident 1. After the review, Staff B said there were no provider orders for the recommended interventions and none of the 10 recommendations were care planned or appeared on the residents' Kardex. When asked how CNAs would have been made aware of the wound care specialist's recommended interventions for Resident 1, Staff B said CNA's go by what is on the resident's Kardex and information they are provided from the previous shifts (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verbal report.

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide care and services to promote pressure injury (PI-localized skin and underlying tissue damage from prolonged pressure) prevention and healing, for 1 of 3 residents (Resident 1) reviewed for PIs. This failure placed residents at risk of developing new or worsening PIs, pain, infection and loss of limb Findings included.The National Pressure Injury Advisory Panel (NPIAP) PI definitions and stages included:A PI is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open injury and may be painful. The injury occurs as a result of intense pressure, prolonged pressure or pressure in combination with shear (a mechanical force that damages skin that occurs when skin stays put while underlying tissues slide in the opposite direction). The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.Stage 4 PI: Full-thickness loss of skin and tissue Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the injury. Slough (yellow to tan tissue that attracts bacteria to a wounds surface), increased levels of exudate (wound fluid) and/or eschar (dry, dead tissue in a wound) may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable PI.Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the injury cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. The facility's Skin Integrity Management Policy and Guidelines, dated 05/26/2021, documented the facility was to Provide safe and effective care to prevent the occurrence of PI's, manage treatment, and promote healing of all wounds and Develop comprehensive, interdisciplinary plan of care including prevention and wound treatments, as indicated.Review of Resident 1's Minimum Data Set (MDS), an assessment tool, dated 10/16/2025, documented the resident required substantial/maximal assistance to roll left or right, had one Stage-4 PI on the right heel/foot, one Stage-4 PI on the left heel/foot, no diabetic, venous or arterial foot ulcers, and Resident 1 did not have a foot-related infection at the time of the assessment. The MDS showed the resident had no moisture associated skin damage (MASD). The MDS documented Resident 1 was not placed on a Turning/Repositioning program.Review of Resident 1's Care Plan, initiated 10/07/2025, documented the resident was totally dependent on staff for repositioning and turning in bed. The Care Plan showed actual skin breakdown actual pressure ulcer LEFT HEEL P/U, RIGHT HEEL P/U, WOUNDS TO RLE. Healing Goal: The resident's wound /skin impairment will heal as evidenced by decrease in size, absence of erythema and drainage and/or presence of granulation by the next review period. Interventions included the following: Provide preventative skin care i.e. lotions, barrier creams as ordered; Use heel protectors as ordered; Observe skin for signs/symptoms of skin breakdown i.e. redness, cracking, blistering, decrease sensation, and skin that does not blanche easily; Evaluate for any localized skin problems, i.e. dryness, redness, pustules, inflammation; Observe skin condition daily with ADL care and report abnormalities; Observe for verbal and nonverbal signs of pain related to wound or wound treatment and medication as ordered; Provide wound treatment as ordered.Review of Resident 1's EHR showed the facility utilized a contracted wound care and treatment company (WCTC) to treat the residents' PIs.<Right Heel/Foot Stage 4 PI>The WCTC's initial visit Right Heel/Foot Stage 4 PI progress note, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 10/08/2025, documented Resident 1's right heel/foot PI wound bed (open area of the wound) had a pre-debridement (the process of removing dead skin and foreign material from a wound) measurement of 15.75 centimeters (cm) squared with the wound bed consisting of 100 % necrotic (dead/non-viable) tissue with no odor or exudate. The post-debridement wound measurement was documented to be 19.11 cm squared.A WCTC progress note dated 10/15/25 documented a pre-debridement wound measurement of 18.62 cm squared with wound bed tissue consisting of 10% slough, 90% granulation tissue (protects the wound surface from microbial invasion and further injury) with no odor, and moderate exudate. The post-debridement wound measurement was documented to be 18.62 cm squared.A WCTC progress not dated 10/22/2025 documented a pre-debridement wound measurement of 18.62 cm squared, The wound bed tissue consisting of 10% slough, 80% necrotic and 10% granulation tissue with no odor and minimal exudate. The post-debridement wound measurement was documented to be19.5 cm squared. This wound assessment identified Resident 1's peri-wound skin now showed mild maceration (occurs when skin is in contact with moisture for too long. It may look lighter in color and wrinkly, feel soft, wet, or soggy, can slow wound healing, make skin more vulnerable to infection, and can be associated with improper wound care).A WCTC progress not dated 10/29/2025 documented a pre-debridement wound measurement of 48.0 cm squared, a 29.3 cm squared increase from the previous visit's post-debridement wound size. The wound bed tissue was documented to consist of 10% slough, 90% necrotic and 0% granulation tissue with no odor and moderate exudate. The post-debridement wound measurement was documented to be 48 cm squared. This wound assessment identified Resident 1's peri-wound skin showed moderate Erythema (redness) and moderate maceration.Review of Resident 1's October 2025 Medication Administration Record (MAR) showed Resident 1 admitted to the facility with an order for antibiotic medication that started 10/07/2025 and completed on 10/17/2025. Resident 1's October 2025 and November 2025 MAR showed no additional antibiotics were ordered for Resident 1 between 10/17/2025 and the resident's transfer to the hospital on [DATE].A review of Resident 1's facility provider follow up note, with an 11/04/2025 documented date of service, a provider follow up note, with an 11/06/2025 documented date of service, and an acute care Note, with an effective date of 11/15/2025, all documented, [Resident 1] reports stabbing pain in bilateral feet in back and side of heels, just above the heels, and occasionally has symptoms all the way to knees. Says that gabapentin used to be more effective but has lost its juice over the last few weeks to days. Discussed that he could likely benefit from higher gabapentin dosing. No documentation related to a physical examination of Resident 1's feet or foot wounds were found within these documentations.A Nurses Progress Note, dated 11/15/2025 at 10:37 PM, documented Resident 1 was transported to the hospital, for a non-Pressure injury/pain-related care need.Review of Resident 1's hospital EHR showed wound nurse consult documentation, dated 11/16/2025, Resident 1 had an unstageable pressure injury to the right heel, a deep tissue pressure injury to the left lateral (outside) ankle, and an unstageable Sacral (bony structure located at the base of the lowest vertebrae) PI present at the time of Resident 1's hospital admission.Review of Resident 1's facility EHR showed no documentation related to Resident 1 having or receiving treatment for an unstageable Sacral PI.A hospital inpatient podiatry consult note, dated 01/17/2025, documented Xray shows right heel ulcer consistent with osteomyelitis (infection in a bone). Left heel is suspicious for osteomyelitis. Hospital Provider documented Resident 1's right foot was non-salvageable and recommended amputation.Review of resident 1's hospital EHR included attestation (action of certifying something) documentation, [Resident 1's] right lower extremity is not salvageable given the extent of infection, including calcaneal (heel bone) osteomyelitis. And On the left there is a smaller necrotic ulcer with findings concerning for osteomyelitis of the calcaneus.WCTC progress notes, dated 10/08/2025 and 10/15/2025, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed nine recommended PI-related interventions for the facility to implement for Resident 1. See additional information in citation F-656.WCTC progress notes, dated 10/22/2025, 10/29/2025, 11/05/2025, and 11/12/2025 included an additional recommendation of Aggressive offloading (reducing or removing pressure and weight from a specific body part, to promote healing of wounds and/or prevent them from forming).Review of Resident 1's EHR showed no nursing/provider orders, care plans or Kardex (A communication tool used by Certified Nursing Assistants that identifies a resident's key care needs and treatments) documentation that showed any of the 10 WCTC recommended PI-related interventions for Resident 1 were implemented.<Left 4th Toe>Review of Resident 1's WCTC initial visit progress note, dated 10/29/2025, documented Resident 1 was seen for a Left 4th Toe/Foot non-pressure chronic ulcer of other part of left foot with fat layer exposed. The wound bed was documented to be 100% necrotic tissue. The peri wound skin (skin around the wound bed) was documented to be fragile, with mild erythema and mild maceration.WCTC's progress notes, dated 11/05/2025 documented Resident 1's left toe wound as a Pressure ulcer [PI] of other site, unstageable. The wound bed was documented to be 100% necrotic tissue. The peri wound skin was documented to be fragile, with no documented erythema or maceration.WTCT's progress note, dated 11/12/2025, documented Resident 1's left toe PI wound bed was 100 % necrotic tissue. The peri wound skin was documented to be fragile with severe erythema and severe maceration.Review of Resident 1's electronic health records (EHR) showed no documentation the left 4th toe PI was present on the residents 10/07/2025 admission to the facility, identified or treated by the facility prior to the Resident's 11/15/2025 transfer to the hospital.<Left Lateral (outside) Ankle>Review of resident 1's hospital EHR showed wound nurse consult documentation, dated 11/16/2025, that said Resident 1 had a deep tissue pressure injury to the left lateral (outside) ankle present at the time of Resident 1's 11/15/2025 hospital admission.Review of Resident 1's electronic health records (EHR) showed no documentation the left lateral ankle PI was identified or treated by the facility prior to the Resident's 11/15/2025 transfer to the hospital.<Sacral PI>Review of resident 1's hospital EHR showed wound nurse consult documentation, dated 11/16/2025, that said Resident 1 had an unstageable Sacral) PI present at the time of Resident 1's hospital admission.Review of Resident 1's electronic health records (EHR) showed no documentation the sacral PI was identified or treated by the facility prior to the Resident's 11/15/2025 transfer to the hospital.Interview on 11/19/2025 at 12:45 PM, Staff D, RN, said Resident 1 had wounds on his buttocks and bilateral heels when he admitted . Staff D said when he came, the wounds looked more like DTI's, dark tissue and the other leg was a stage 4. Staff D said Resident 1 was mostly compliant, other times not; 50/50. Resident 1 was supposed to keep boots on but sometimes he would decline. Staff D said it was the responsibility of everyone to keep them on.In an interview on 12/17/2025 at 3:58 PM, Staff C, East Unit Manager, said Certified Nursing Assistant's use a resident's Kardex (A communication tool that identifies a resident's key care needs and treatments) to learn a resident's care needs. Staff C said Resident 1 could not turn without staff assistance and was not sure if he was on a turning schedule. Staff C said she had not seen any special instruction regarding Resident one requiring special wipes or restrictions on scents, perfumes, or dyes. When asked if Resident 1 had a pressure relieving mattress Staff C said she did not see an order and it was not care planned so Resident 1 probably did not have one.In an interview on 12/17/2025 at 4:42 PM, Staff B, Director of Nursing Services, said the facility's Inner Disciplinary Team (IDT) meets with the wound care providers to get wound measurements and any new information about a resident's wound care needs. Staff B said when they receive the wound visit notes, they crossmatch any new orders and any recommendations are added to the residents' orders. Staff B said once all orders and documentation is received the expectation would be for the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders/recommendations to be care planned within five days of when they were made. When asked if Resident 1 had a pressure-relief mattress on his bed Staff B said she was thinking about requesting a low air-loss mattress, but the resident went to the hospital. After reviewing Resident 1's care plans, orders, and Kardex Staff B said none of the WCTC recommended interventions were ordered or care planned. When asked how direct care staff were made aware of a resident's care needs, Staff B said they would look at the resident's Kardex. Reference WAC 388-97-1060 (3)(b).