STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505185	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olympic View Care	1116 E Lauridsen Boulevard Port Angeles, WA 98362

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45203 Based on interview and record review, the facility failed to ensure resident representatives were notified of changes in condition for 2 of 4 sampled residents (1 and 2) reviewed for notification of changes when resident family members were not notified of new pressure wounds. This failure prevented the residents' representative from participating in discussions about resident care decisions and placed the residents at risk for delayed medical treatment, diminished quality of life, and increased pain. Findings included . The facility policy titled, Notification of Change in Condition, revised 05/2024, showed the residents' representative should be made aware of any significant changes in the residents' physical, mental or psychosocial status. If the residents' condition was not crucial the representative would be notified at the earliest convenient time during business hours. Notification should be documented in the progress notes. <Resident 1> Resident 1 was admitted to the facility on [DATE]. The quarterly minimum data set (MDS), an assessment tool, dated 07/07/2024, documented Resident 1 had moderate cognitive impairment, required substantial to maximal assist for activities of daily living (ADLs), was always incontinent of bowel and bladder, had no pressure injuries, and was at risk for pressure injuries. The care plan focus for potential for pressure ulcer of coccyx and heels related to decreased mobility and incontinence, initiated on 03/03/2020 and revised on 06/16/2021, included the goal for the resident to have intact skin free of redness, blisters or discoloration. Interventions included to inform resident/family/caregivers of any new areas of skin breakdown. A wound provider note, dated 07/18/2024, showed Resident 1 had a new unstageable wound measuring 4. 66 centimeters(cm) in length and 4.38 cm in width and was covered by 100% necrotic (slough/eschar) tissue to the right lateral buttock and identified the wound as not unavoidable. A wound provider note, dated 08/15/2024, showed Resident 1 had a new stage 2 pressure ulcer, measuring 7.5 cm in length and 5.02 cm in width, to the center midline coccyx and identified the wound as not unavoidable. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A wound provider note, dated 09/19/2024, showed the center midline coccyx wound had the status of deteriorating and had clinical signs of infection that included redness, purulent (white/yellow/green) drainage, increased wound size, delayed healing, and change in wound appearance. The wound had increased in size and measured 7.26 cm in length and 7.0 cm in width. Review of Resident 1's electronic health record (EHR) from 06/27/2024 through 09/19/2024 did not show any documentation that Resident 1's FM was informed of the discovery of either wound. On 10/09/2024 at 4:40 PM, Collateral Contact (CC 1) said they were not informed the resident had wounds and was shocked at the state of them when made aware of them on 09/18/2024. On 09/19/2024 The family called 911 and had the resident transported to the ER. <Resident 2> Resident 2 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], showed Resident 2 had severe cognitive impairment, was dependent on staff for all ADLs, was always incontinent of bowel and bladder, was at risk for pressure injuries, was not on a turning/repositioning program and had one stage 3 pressure ulcer (full thickness loss of skin, fat and granulation tissue (pink red tissue composed of blood vessels and collagen may be visible) that was not present on admission. The care plan focus for an [unstaged] pressure ulcer of center midline sacrum (lower back) related to decreased mobility, initiated on 07/30/2024, included the goal for the pressure wound to show signs of healing and remain free of infection. A physician's order, dated 08/16/2024, directed staff to cleanse the wound with wound cleanser, pat dry with gauze, apply collagen to the wound bed, followed with calcium alginate with silver, apply skin prep to peri wound and cover with a silicone bordered dressing, in the morning every Tuesday, Thursday (done by wound provider), and Saturday. A wound provider note, dated 09/19/2024, showed a stage 3 center midline sacrum wound, measuring 0.88 cm in length and 0.87 cm in length, with a status of unchanged. The wound care orders included dressing changes 3 times weekly and as needed for soiled or loose dressing. Review of Resident 2's EHR record from 07/19/2024 through 10/18/2024 did not show documentation Resident 1's family member was notified of the discovery of the stage 3 sacral wound. On 09/26/2024 at 5:12 PM, CC 2, said they were aware of a recent incident regarding bruises and something on his face but was not aware that Resident 2 had any wounds. On 10/18/2024 at 1:46 PM, Staff C, RN, RCM, said when new wounds were discovered, staff were to notify the provider, Staff B (Registered Nurse and Director of Nursing) and the resident's family or POA. At 2:44 PM, Staff B, said they try to notify family when new wounds are discovered and she would have expected there to be documentation in the record if they attempted to contact family. At 3:58 PM, Staff A, Administrator, said they usually notify family of new wounds, and they would expect that to be documented in the medical record. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-0320 1(a)(b)(c)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45203 Based on interview and record review the facility failed to provide care and services consistent with professional standards for 1 of 4 residents (Resident 2) reviewed for quality of care when the facility staff failed to document assessment and monitoring of the resident for latent injuries, resolution of injuries, and potential adverse side effects of medications for multiple incidents involving the resident. This failure placed all residents at risk for unmet needs, declining health, and decreased quality of life. Findings included . The policy titled, Alert Charting, revised on 05/2023, documented that residents were to be placed on alert for a minimum of 72 hours for the following: resident care issues, changes in condition, medication changes, falls, and psychosocial harm. Documentation should include vital signs, physical assessment, resident's response, and symptoms. Resident 2 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS/an assessment tool), dated 07/25/2024, showed Resident 2 had severe cognitive impairment and was dependent on staff for all ADLs. The care plan focus for at risk for falls, initiated 03/07/2020 and revised on 06/14/2021, included interventions to monitor/document/report for 72 hours post fall for signs and symptoms of pain, bruising, change in mental status .and required the use of a mechanical lift for transfers. A facility investigation report, dated 09/13/2024 at 6:30 AM, showed Resident 2 was observed to have bruising to the left forearm measuring 9.0 centimeters (cm) x 1.5 cm, bruise to right eyebrow measuring 3.7 cm x 1.4 cm and a blister, bruise and swelling to right upper lip measuring 3.6 cm x 2.5 cm x 2 cm. The facility investigation found the lip swelling/bruising/blister was attributed to a recent oral procedure and the resident was started on an antibiotic to for an oral infection. The arm and forehead bruising was attributed to potentially being caused by the mechanical lift. The facility ruled out abuse and all parties were notified. A physician's order, dated 09/14/2024, instructed staff to give an antibiotic twice daily for 10 days, for oral infection. Review of Resident 1's progress notes, from 09/13/2024 to 09/19/2024, did not show any documentation of monitoring of Resident 1 for injuries noted or response to the initiation of antibiotics. An incident note, dated 09/19/2024 at 12:24 AM, showed the resident was found on the floor next to his bed with an abrasion above his right eye. A facility investigation report, dated 09/19/2024 at 2:16 AM, showed Resident 2 was found on the floor, assessed for injuries and an abrasion was noted above his right eye. Nursing staff were to continue to monitor for any post-fall injuries or complications (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress notes, from 09/19/2024 to 09/29/2024, showed only one entry for monitoring the use of antibiotics, and no entries for monitoring for latent injuries or resolution of injuries. On 10/17/2024 at 9:48 AM, Staff E, Nurse Tech, said she could document some things on residents but not all things, as she was not permitted to assess. Staff E said she would alert the Registered Nurse (RN) if there was something that needed to be documented. On 10/18/2024 at 1:13 PM, Staff G, Med Tech, said she did not document on the residents on alert and identified Staff C as the one who would do that if needed. At 1:46 PM, Staff C, RN, Resident Care Manager, said if a resident had a fall, a new skin issue, or an antibiotic was started, the resident would be placed on alert and a daily skilled note would be completed by staff. When asked if nurse techs and med techs can perform that task, Staff C said nurse techs should be doing that. If the med techs needed to document on a resident, they would alert a nurse and they would make the note. Staff C said she reviewed the dashboard and looked at alerts and if there was no charting she would talk to staff to get a note in there. At 2:36 PM, Staff B, RN, DNS, said residents should be placed on alert if new bruising was found, experienced a fall, or a new antibiotic was started. Staff B said she would expect the resident to be monitored and assessed for latent injuries for at least 72 hours and would expect a daily skilled note documented in progress notes or daily skilled evaluations. At 3:58 PM, Staff A, Administrator, said they would expect documentation in the medical record of monitoring residents following falls, discovering of bruising, and initiation of antibiotics. Reference WAC 388-97-1060(1)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45203 Based on interview and record review, the facility failed to prevent the development of pressure ulcers (PU - injury to skin and underlying tissue resulting from prolonged pressure), perform/document regular skin assessments, and to consistently complete provider ordered wound care for 4 of 4 sampled residents (Residents 1, 2, 3, & 4) reviewed for pressure ulcers. These failures placed residents at risk for continued deterioration or pressure ulcers/injuries, infection and pain. Findings included . According to the Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Manual, dated October 2023, pressure ulcers/injuries occur when tissue is compressed between a bony prominence and an external surface. In addition, external factors, such as excess moisture and tissue exposure to urine or feces, can increase the risk. The Documentation-Skin Conditions facility policy, dated 02/24/2023, showed a weekly skin assessment would be documented using the total body skin evaluation/assessment. <Resident 1> Resident 1 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment, dated 07/07/2024, documented Resident 1 had moderate cognitive impairment, required substantial to maximal assist for activities of daily living (ADLs), was always incontinent of bowel and bladder, had no pressure injuries, was at risk for pressure injuries and was not on a repositioning/turning program. Review of the care plan focus, initiated 03/03/2020 and revised 06/16/2021, for potential pressure ulcer of coccyx and heels related to decreased mobility and incontinence, showed the goal was for Resident 1 to have intact skin, free of redness, blisters or discoloration. Review of the care plan focus for bowel incontinence, initiated 10/10/2022, included the goal the resident would not have skin breakdown related to bowel incontinence. Review of the care plan focus for complete bladder incontinence, initiated 01/03/2024, included the goal for the resident to remain free from skin breakdown. Review of Resident 1's weekly skin evaluation, under evaluations, showed the resident's last recorded total body skin evaluation was 06/19/2024. Review of a wound provider note, dated 07/18/2024, showed Resident 1 had a new unstageable wound measuring 4.66 centimeters (cm) in length and 4.38 cm in width and was covered by 100% necrotic (slough/eschar) tissue to the right lateral buttock and identified the wound was avoidable. Review of the care plan focus for unstageable pressure ulcer of right buttock related to impaired mobility, and bowel and bladder incontinence, initiated 07/22/2024, included the goal for the pressure wound to show signs of healing and remain free of infection. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a wound provider note, dated 08/15/2024, showed the right lateral buttock wound measured 2.76 cm in length and 3.47 cm in width and had a status of deteriorating. Review of a wound provider note, dated 08/15/2024, showed Resident 1 had a new Stage 2 pressure ulcer measuring 7.5 cm in length and 5.02 cm in width to the center midline coccyx and identified the wound as avoidable. Review of a wound provider note, dated 08/22/2024, recommended a dressing change three times weekly and as needed for soilage and loose dressing. Review of a physician's order, dated 08/23/2024, instructed staff to cleanse the wound with wound cleanser and pat dry with gauze, apply medical grade honey to the wound bed followed by calcium alginate. Apply skin prep generously to peri wound, cover with silicone bordered dressing and secure with tape. Every Tuesday, Thursday (done by wound provider) and Saturday, for unstageable pressure ulceration. Review of a wound provider note, dated 08/29/2024, showed the center midline coccyx wound measured 2. 85 cm in length and 2.4 cm in width and covered by 100% necrotic tissue. The wound status was changed from Stage 2 to unstageable since wound bed is now obstructed by necrotic tissue. The wound care recommendations included dressing changes 3 times weekly and as needed for soiled or loose dressing. Review of a physician order, dated 08/30/2024, instructed staff: Wound care to Right lateral Buttock cleanse with wound cleanser and pat dry with gauze, apply collagen to wound bed followed by oil emulsion gauze and calcium alginate, ply skin prep to peri wound and cover with silicone foam dressing. Every Tuesday, Thursday (done by wound provider) and Saturday, for unstageable pressure ulceration. Review of a wound provider note, dated 08/29/2024, showed the right lateral buttock wound status was unchanged and measured 3.17 cm in length and 2.88 cm in width. Review of a wound provider note, dated 09/19/2024, showed the right lateral buttock wound status was unchanged and measured 3.62 cm in length and 2.95 cm in width. Review of a wound provider note, dated 09/19/2024, showed the center midline coccyx wound had the status of deteriorating and had clinical signs of infection including redness, purulent (white/yellow/green) drainage, increased wound size, delayed healing, and change in wound appearance. The wound had increased in size and measured 7.26 cm in length and 7.0 cm in width. Review of the July, August, and September 2024 Treatment Administration Record (TARs) showed the following: July 2024 TAR -showed documentation Resident 1 did not have any skin impairments identified with weekly skin assessments, with all four-week entries showing a (-), indicating no skin impairment. August 2024 TAR (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-showed wound care was not performed on 08/24/2024. -showed no skin assessments were documented for Resident 1. September 2024 TAR -showed wound care was not performed on 09/14/2024. -showed no skin assessments were documented for Resident 1. Review of the Hospital admission record, dated 09/19/2024 through 09/26/2024, showed Resident 1 was emergently transported to the ER at the request of family due to a pressure wound. On 09/20/2024 at 5:32 PM, Collateral Contact (CC) said they had visited Resident 1 on 09/18/2024 and was concerned when staff informed them the resident was declining and had a wound. When CC requested to see the wound, staff pulled up Resident 1's dress and pulled down her brief and the wound had no dressing on it and was covered in feces. On 10/09/2024 at 4:40 PM, CC said they visited Resident 1 on 09/19/2024 and had to insist Resident 1 be transported to the ER for care. Resident 1 was admitted for sepsis and osteomyelitis, and they felt the resident should have been transported sooner. CC said they were never notified about the wounds or the severity of them. On 10/10/2024 at 12:58 PM, Staff D, Nursing Assistant (NAC), said if a wound did not have a dressing on it, they would tell the nurse so they could change it. Staff D said she did recall times when the wound did not have a dressing on it. On 09/18/2024, in particular, she reported it to the nurse, and it was changed. Staff D said the wound had an odor for a week or two and she reported it to the student nurse (nurse tech). On 10/11/2024 at 9:00 AM, Provider B, Nurse Practitioner and Wound Specialist, said Resident 1 had two wounds and one had worsened over the last two weeks. When she saw the resident last, the wound looked infected. Provider B said she removed the old dressing as part of her routine care; and if it is not in place, it would be documented on their notes. After reviewing their notes, Provider B indicated during visits on 08/15/2024, 08/29/2024, 09/05/2024, 09/12/2024 and 09/19/2024 the notes showed there was no dressing present. Provider B said if a wound was not covered it would likely impede healing and increase risk of infection. When asked if she had a concern the facility staff were not keeping the wound covered by a dressing, Provider B said they had prescribed the dressing to be three times a week and as needed, and it was up to the facility to manage that. Provider B said they discussed her concerns of the wound not being covered with Staff B, Director of Nursing Services and Registered Nurse (RN). On 10/17/2024 at 9:48 AM, Staff E, Nurse Tech, said she assisted with wound care for Resident 1 and said due to bowel and bladder incontinence and location of the wound, it would be hard to keep a dressing on. At 1:28 PM, Provider A, Physician's Assistant, said they were not highly involved in the management of the facility's wounds. Provider A said she was aware Resident 1 had a wound but had not seen the wound, and they had not been informed there was a healing issue with the wounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 4:06 PM, Staff F, Nurse Tech, said she had dressed Resident 1's wound on two occasions, and she let Staff B know there was an odor. On 10/18/2024 at 1:13 PM, Staff F, Medication Assistant, said they do not perform wound care. They would get Staff C if a resident needed wound care. Staff F said wound care typically was done on Tuesdays, Thursdays (by wound specialist) and Saturdays. If a wound needed to be dressed due to soilage and loose dressing, she would tell Staff C. When asked if they would document the as needed dressing on the treatment record, Staff F stated, I guess you would. I would have to check. That would be a good idea. At 1:46 PM, Staff C, RN and Resident Care Manager (RCM), said Resident 1 had wound care ordered three times a week, but she had daily dressings due to soilage. Staff C said she had not observed the wound but was under the impression it was healing. At 2:36 PM, Staff B said she had not seen Resident 1's wounds. Staff had not reported to her the wound had an odor. Staff B said Provider B did not say there was a concern Resident 1's wound was not being kept covered or it needed to be changed if it was soiled. Staff B said she knew staff were changing it if it got soiled. Because of the location, it was easy to become soiled and would be changed as needed. When asked if that would be documented in the record, Staff B said it would be documented in a progress note. <Resident 2> Resident 2 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], showed Resident 2 had severe cognitive impairment, was dependent on staff for all ADLs, was always incontinent of bowel and bladder, was at risk for pressure injuries, was not on a turning/repositioning program and had one Stage 3 pressure ulcer (full thickness loss of skin, fat and granulation tissue-pink red tissue composed of blood vessels and collagen may be visible) that was not present on admission. Review of the care plan focus for potential for pressure ulcers related to impaired mobility and bowel and bladder incontinence, initiated 03/03/2021, included the goal for the resident to have intact skin free of redness, blisters or discoloration. Review of the care plan focus for bowel incontinence, initiated 06/09/2020 and revised 04/21/2021, included the goal the resident would not have skin breakdown related to bowel incontinence. Review of the care plan focus for bladder incontinence, initiated 06/09/2020, included the goal for the resident to remain free from skin breakdown. Review of the care plan focus for an un-staged pressure ulcer of center midline sacrum (lower back) related to decreased mobility, initiated 07/30/2024, included the goal for the pressure wound to show signs of healing and remain free of infection. Review of a physician's order, dated 08/16/2024, directed staff to cleanse the wound with wound cleanser, pat dry with gauze, apply collagen to the wound bed, followed with calcium alginate with silver, apply skin prep to peri wound and cover with a silicone bordered dressing in the morning every Tuesday, Thursday (done by wound provider), and Saturday. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a wound provider note, dated 09/19/2024, showed a Stage 3 center midline sacrum wound, measuring 0.88 cm in length and 0.87 cm in length, with a status of unchanged. The wound care orders included dressing changes three times weekly and as needed for soiled or loose dressing. Review of Resident 2's July 2024, August 2024 and September 2024 TAR showed wound care was not performed on 08/24/2024, 8/27/2024, 09/03/2024, 09/10/2024 and 09/14/2024. No documentation could be found that the wound care was provided by the oncoming shift. Review of Resident 2's weekly skin evaluation under Evaluations showed the resident's last recorded total body skin evaluation was 06/19/2024. Review of August 2024 TAR showed no skin assessments were documented for Resident 2. Review of September 2024 TAR showed no skin assessments were documented for Resident 2 On 10/17/2024 at 9:48 AM, Staff E, Nurse Tech, said they were not able to complete wound care. They had 20 residents to care for and there was not enough time. Staff E said they reported to Staff B and to the oncoming shift that tasks were not completed. At 4:06 PM, Staff F, Nurse Tech, said they were not able to complete wound care on 09/10/2024 because they had 10 wound dressing to do. They reported to the oncoming shift it was not done. On 10/18/2024 at 2:44 PM, Staff B said they were not aware of staff concerns they were not able to complete wound care. When asked if wound care was done on Tuesday, Thursday and Saturday and needed to be completed as needed for soilage or loose dressing, and where would that be documented, Staff B said they had just been documenting it on a progress note, and wound care as needed for soilage or loose dressing was not entered into the TAR as a separate order. <Resident 3> Resident 3 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], documented Resident 3 was medically complex, had moderate cognitive impairment, required substantial to maximal assist for ADL's, was always incontinent of bowel and bladder, was at risk for pressure injuries, was not on a turning/repositioning program and had one Stage 4 pressure injury (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) that was not present on admission. Review of the care plan focus for potential for pressure ulcers related to impaired mobility and frequent bladder incontinence, initiated 02/23/2023 and revised 06/11/2024, included the goal for the resident to have intact skin free of redness, blisters or discoloration. Review of the care plan focus for bladder incontinence, initiated 02/24/2023, included the goal for the resident to remain free from new skin breakdown. Review of the care plan focus, initiated 06/11/2024, for a Stage 4 pressure ulcer of the sacrococcyx (lower back/tailbone) related to decreased mobility and incontinence included the goal for the pressure wound to show signs of healing and remain free of infection. (continued on next page)

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	505185	A. Building B. Wing	10/18/2024

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Olympic View Care	1116 E Lauridsen Boulevard Port Angeles, WA 98362

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan focus for bowel incontinence, initiated 06/18/2024, included the goal that the resident would not have skin breakdown related to bowel incontinence. A wound provider note, dated 09/12/2024, showed a sacrococcyx Stage 4 pressure ulcer measuring 0.65 cm in length and 1.02 cm in width with a status of unchanged. Review of Resident 3's weekly skin evaluation under Evaluations showed the resident's last three recorded total body skin evaluations were 06/19/2024, 08/21/2024, and 10/01/2024. Review of August 2024 TAR showed no skin assessments were documented for Resident 3. Review of September 2024 TAR showed no skin assessments were documented for Resident 3. Review of October TAR showed no skin assessments were documented for Resident 3. <Resident 4> Resident 4 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], documented Resident 4 had severe cognitive impairment, required substantial to maximal assist for ADLs, was always incontinent of bowel and bladder, was at risk for pressure injuries, was not on a repositioning/turning program, had one unstageable pressure injury that was not present on admission. Review of the care plan focus for bowel incontinence, initiated 11/18/2019 and revised 04/21/2021, included the goal that the resident would not have skin breakdown related to bowel incontinence. Review of the care plan focus for bladder incontinence, initiated 02/18/2020 and revised 08/19/2020, included the goal for the resident to remain free from new skin breakdown. Review of Resident 4's weekly skin evaluation under Evaluations showed the resident's last recorded total body skin evaluations was on 06/19/2024. Review of a wound provider note, dated 07/11/2024, showed Resident 4 had a new unstageable center midline coccyx pressure injury, measuring 3.5 cm in length and 5.1 cm in width and identified the wound as not unavoidable. Review of the care plan focus for potential for pressure ulcers related to impaired mobility and dermal frailty, initiated 08/01/2024, included the goal for the resident to have intact skin free of redness, blisters or discoloration. Review of the care plan focus, initiated 08/01/2024, for an un-staged pressure ulcer of the center midline coccyx (tailbone) related to decreased mobility and dermal frailty, included the goal for the pressure wound to show signs of healing and remain free of infection. Review of a wound provider note, dated 09/25/2024, showed the coccyx wound status was unchanged, and measured 3.61 cm in length and 2.5 cm in width. Review of August 2024 TAR showed no skin assessments were documented for Resident 4. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Some	Review of September 2024 TAR showed no skin assessments were documented for Resident 4. Review of October TAR showed no skin assessments were documented for Resident 4. On 10/18/2024 at 1:46 PM, Staff C, RN and RCM, said resident skin was monitored by documenting a total body evaluation weekly in the electronic charting system. Staff C said NA staff also alert her if they find an issue and then she assessed the resident, and the resident was placed on alert and monitored and an order for treatment was obtained. Staff C said she reviewed daily charting and looked at alerts on the dashboard to see if documentation was not done. At 2:44 PM, Staff B said her expectation was resident skin was monitored weekly under evaluation with a total body skin evaluation, and some residents were on the TAR under weekly skin checks. When asked what the facility was doing to address pressure wounds in the facility, Staff B said they were starting this month to have LN and NA staff training with a focus on wounds and shadow the wound providers. At 3:58 PM, Staff A, Administrator, said they do discuss wounds as part of QAPI (quality assurance, performance improvement) meetings. The facility did not have a structured meeting to focus on pressure wounds. They discuss it as part of the daily clinical meeting. Reference WAC 388-97-1060 (3)(b)