STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505188	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Federal Way	1045 South 308th Street Federal Way, WA 98003

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 - 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** 46471 Based on interview and record review, the facility failed to ensure 2 of 5 residents (Residents 1 & 2) reviewed for Pressure Ulcer/Pressure Injury (PU/PI) were provided the necessary treatment and services consistent with professional standards of practice, to promote healing and prevent the occurrence of a PU/PI. Resident 1 experienced harm when their Moisture Associated Skin Damage (MASD) developed into a Stage 4 PU (a full thickness wound with tissue loss and exposed bone, tendon, or muscle) on their buttock and acquired Osteomyelitis (a bone infection). This failed practice placed other residents at risk for skin breakdown and a diminished quality of life. Findings included . <Facility Policy> Review of the facility policy titled, Skin Integrity & Pressure Ulcer/Injury Prevention and Management, revised 07/09/2024, showed the facility would provide the necessary treatment and services, consistent with professional standards of practice, to a resident with PU/PI to promote healing, prevent infection, and prevent new ulcers from developing. The policy showed preventative measures identified to maintain and improve the resident's skin condition were implemented in the Care Plan (CP) including repositioning at least every 2-4 hours as consistent with the resident's overall goal and medical condition and the use of a pressure redistribution mattress. <Resident 1> According to the 04/16/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 1 admitted to the facility on [DATE] for skilled rehabilitation needs after hospitalization due to an alteration in their mental status. The MDS showed Resident 1 had medical diagnoses including urinary infection, left hip pain, respiratory failure, and generalized muscle weakness. The MDS showed Resident 1 was always incontinent of their bowel and bladder and had MASD. The MDS showed Resident 1 was dependent on staff for their daily cares and was assessed to require total assistance with bed mobility (rolling from left to right when in bed), transfers, and toileting. The MDS showed Resident 1 was not turned/repositioned during the assessment period. Review of the 04/10/2024 Nursing Admission/Readmission Collection Tool showed Resident 1's skin condition upon admission and listed the presence of MASD on their buttocks area. (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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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the 04/10/2024 skin CP showed Resident 1 had a break in their skin integrity and an intervention directed the nursing staff to provide treatment as ordered. Resident 1's CP did not show preventative pressure-relieving instructions for staff to perform including turning/repositioning or off-loading (to not bear any weight). The CP did not show the facility addressed Resident 1's refusal with off-loading. Review of Resident 1's physician orders from April 2024 to July 2024 did not show a treatment was put in place to manage the identified MASD on Resident 1's buttocks during admission. On 09/26/2024 at 1:52 PM, Resident 1's representative stated the resident's PU was not adequately cared for while Resident 1 was in the facility, .[Resident 1] was always on their back when we come in to visit .we stay for long periods during the day and visited at least 3-4 times in a week .staff never came to reposition [Resident 1] or at least attempt or mention turning [Resident 1]. Resident 1's representative stated the facility notified them when an open area was first observed on Resident 1's buttocks but were not told the PU was worsening. Resident 1's representative stated a nurse told them Resident 1's PU was so big that they could put their fist in it. Review of the 05/23/2024 incident report investigation showed the facility identified a PU measuring 4 centimeters (cm) long x 3 cm wide, but no depth was listed, to Resident 1's buttocks. The facility attributed the cause of the injury to Resident 1's altered mental status and limited mobility. Review of the 05/28/2024 wound care note showed Resident 1 had an unstageable PU (a full-thickness skin and tissue loss where the extent of the tissue damage could not be seen) on their buttocks measuring 4 cm x 2 cm x 0 cm and an antifungal cream was initiated. Review of the 06/04/2024 wound care note showed Resident 1's unstageable PU measured 2.5 cm x 3 cm x 0 cm and Iodosorb (an antimicrobial gel) was added to the resident's wound treatment. The note showed Resident 1 remained fully dependent on nursing staff for off-loading. Review of the 06/11/2024 wound care note showed Resident 1's unstageable PU developed depth and measured 3cm x 3 cm x 0.2 cm. The note showed the Iodosorb was changed to Santyl (an ointment used to breakdown and remove dead tissue from wounds). Review of the 06/25/2024 wound care note showed the PU was assessed to be a Stage 4 PU after the wound nurse performed surgical debridement (removal of the top layer of skin tissue covering the wound opening) that measured 5 cm x 4.5 cm x 0.6 cm deep; the subcutaneous (layer of the skin made up of fat and connective tissue), tendon (a fibrous connective tissue attaching the muscle to the bone), and ligament (a fibrous connective tissue attaching bone to bone) were exposed. The note showed Resident 1's PU was deteriorating and that healing was compromised by Resident 1's incontinence and poor participation/refusal with off-loading. The note showed a wound culture was taken for suspected wound infection and the treatment was changed back to Iodosorb. Review of the 07/02/2024 wound care note showed Resident 1's Stage 4 PU was bigger and measured 5.5 cm x 3.5 cm x 1.5 cm deep, with newly identified 1 cm undermining (a type of complication where the wound's edges separate from the health tissue around it and create a dead space/pocket beneath); the wound culture showed the presence of multiple bacteria (germs) and indicated Resident 1 was at risk for osteomyelitis. The note showed the wound nurse recommended to discontinue the daily treatment using Iodosorb and changed it back to Santyl ointment and was to be performed every other day. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the July 2024 Treatment Administration Record (TAR) showed the staff did not discontinue the Iodosorb and was continuously applied on Resident 1's PU daily from 07/01/2024 until 07/10/2024. The TAR showed a 06/12/2024 order for Santyl ointment that was continuously applied on Resident 1 daily (as opposed to every other day as ordered). The TAR showed that from 07/01/2024 until 07/15/2024, both the Iodosorb gel and the Santyl ointment were simultaneously applied on Resident 1's PU. In a joint interview on 09/26/2024 at 4:54 PM with Staff A (Administrator) and Staff B (Director of Nursing), Staff B reviewed Resident 1's medical records and stated there should be orders and preventative interventions put in place early on when the nursing staff identified Resident 1's MASD during admission, but there were none. Staff B stated that Resident 1's CP did not include information directing staff to provide turning/repositioning. Staff B stated it was important to follow the treatment recommended/ordered by the wound care provider so the resident's PU would receive the proper treatment and heal/resolve and not deteriorate, .[we] should be monitoring the PU to ensure they do not get worse. When asked if they expected nursing staff to carry out and implement the PU treatment as ordered, Staff A stated, Absolutely. <Resident 2> According to the 05/06/2024 Admission MDS, Resident 2 admitted to the facility on [DATE], had clear speech, intact memory, and medical conditions including heart and kidney failure, malnutrition, and cancer. The MDS showed Resident 2 had cancer lesion(s) and MASD during the assessment period. The MDS showed Resident 2 was dependent on staff for their daily cares and was assessed to require substantial/maximum assistance with bed mobility (rolling from left to right when in bed), transfers, and toileting. Review of the 05/28/2024 Discharge Return Anticipated MDS showed Resident 2 had one unstageable PU that was not present on admission. Review of the 04/29/2024 Nursing Admission/Readmission Collection Tool showed Resident 2's skin condition upon admission and listed the presence of three open wounds: Sacrum wound measuring 2.5 cm x 1 cm x 0.1 cm; right buttock wound measuring 3 cm x 0.2 cm; and left buttock wound measuring 3 cm x 0.1 cm. Review of the 04/29/2024 skin CP showed Resident 2 was at risk for skin impairment and CP interventions directed nursing staff to provide treatment as ordered. Review of the 05/07/2024 wound care note showed Resident 2's cancer lesion (from their anal cancer radiation treatment) on their coccyx (tail bone) measured 3.5 cm x 4 cm x 0 cm and the wound base was all covered in slough (dead skin tissues). The wound nurse ordered treatment with Santyl and the use of an air mattress for pressure redistribution. Review of Resident 2's medical records did not show an air mattress was put in place. The facility was not able to provide any documentation to support Resident 2 was provided an air mattress as ordered by the wound nurse. A 05/15/52024 nursing progress note showed staff observed a left hip abrasion on Resident 2 during daily cares measuring 4 cm x 2 cm. The note showed Resident 2 told staff it was probably due to them sitting up for an extended period during transport when they went out for surgery the day prior. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the 05/21/2024 wound care note showed Resident 2's left hip abrasion was classified as an unstageable PU and measured 4 cm x 1.5 cm x 0.1 cm. The wound nurse recommended aggressive off-loading and treatment with Santyl ointment daily and as needed. Review of the May 2024 TAR did not show the treatment order for Santyl ointment recommended by the wound care provider on 05/21/2024 to treat Resident 2's left hip PU was implemented by the nursing staff. The facility was not able to provide any documentation to support Resident 2 was provided the treatment they were assessed to require to help heal their left hip PU. In an interview on 09/26/2024 at 4:08 PM, Staff B reviewed Resident 2's medical records and stated the facility did not implement the treatment for the resident's left hip PU as ordered. Staff B stated they do not have any documentation to support an air mattress was put in place for Resident 2 as ordered by the wound nurse. Staff B stated that Resident 2's CP did not include any instructions for staff to provide aggressive off-loading measures. Staff B stated they expected the nursing staff to provide PU treatment and care to residents who were assessed to need them. REFERENCE: WAC 388-97-1060(3)(b).