STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505195	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Auburn Care	2830 I Street Northeast Auburn, WA 98002

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the residents right to be free from neglect when it failed to provide goods and services that were necessary to avoid physical harm, pain, mental anguish, and emotional distress for 1 of 5 residents (Resident 1) reviewed for admission and rehospitalization. The failure to identify Resident 1 required a wound vacuum (WV - specialized equipment for wound care that applies negative pressure to the wound to manage drainage and promote healing) to treat a surgical wound on admission, ensure nursing staff had the skill set and supplies to manage the WV, and implement monitoring of the operation of the WV, placed Resident 1 at risk for impaired wound healing, infection, and rehospitalization. Findings included.Review of the 03/10/2026 Facility Assessment (FA - a tool used to conduct a facility-wide assessment of the resident profile, services and care offered, and resources needed to provide competent care to residents) showed the facility would review the medical records for all referred residents for admission, prior to acceptance to the facility. The FA showed a resident requiring surgical wound care could be admitted to the facility. The FA did not show if the facility could manage a resident with a WV. The FA showed if a new diagnosis determined additional staff training, in-service training would be provided for staff. The FA showed staff would be trained and assessed for competency to provide specialized care, including wound care and wound dressings.Review of the 06/03/2026 hospital discharge summary showed Resident 1 had surgery on their right hip with complications. The summary showed after surgery Resident 1 had increased drainage from the surgical wound requiring a WV and medications to prevent infection. The discharge summary showed Resident 1 was stable and planned to discharge to a skilled nursing facility for therapy and nursing management. The discharge summary did not provide any instructions for monitoring or maintaining the WV.Review of a 06/03/2026 Nursing admission Assessment showed Resident 1 was admitted to the facility on evening shift on 06/03/2026 from the hospital after hip surgery, the assessing nurse documented Resident 1 had a surgical wound on their right hip with a wound bag.Review of the physician orders for 06/03/2026 through 06/04/2026 showed no indication that Resident 1 had a WV for their surgical incision drainage. The physician orders did not provide any directions to staff to monitor Resident 1's surgical site for drainage into the WV canister or to monitor the WV to ensure it was functioning.A 06/03/2026 nurse progress note showed Resident 1 was entered into the medical record to one room and needed to be changed to another room. This was the only nurse note entered on 06/03/2026 to describe the admission of Resident 1 to the facility; there was no documentation of the WV. A 06/04/2026 5:41 AM nurse progress note showed Resident 1 was alert and oriented, two-person assist for care, had pain in right leg, and wound bag was intact. There was no further assessment or monitoring of Resident 1.A 06/04/2026 4:33 PM nurse progress note showed the nurse manager documented Resident 1's WV was beeping, when checked it was full, canister was changed, line patent, and suctioning well. There was no documentation regarding the assessment of the wound, drainage, pain, notification of the doctor, or Resident 1's condition.A 06/04/2026 doctor visit note showed Resident 1 required skilled therapy after surgery for functional limitations, limited weight (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bearing, mobility precautions, skilled nursing care to manage the WV with active drainage, wound monitoring, and medication administration to prevent infection and control pain. The doctor's note directed staff to monitor the WV output, drainage character, dressing seal, tubing patency, and suction function, monitor surgical site for redness, warmth, swelling, increased pain, purulent drainage, odor, fever or wound opening and notify provider and surgeon for increased drainage, loss of suction, bleeding or infection. The doctor's note showed Resident 1 was at risk for complications of blood clots, infection, dislocation, and hardware failure of the hip prosthesis.A 06/05/2026 3:45 AM nurse progress note showed a one-line statement, wound bag is beeping.A 06/05/2026 6:00 PM nurse progress note showed Resident 1 was discharged to the hospital for wound evaluation per the doctors order.In a phone interview on 06/10/2026 at 1:35 PM, Collateral Contact (CC) stated they arrived at the facility on 06/04/2026 at about 1:00 PM to find Resident 1 being interviewed by facility staff. The CC stated Resident 1 was upset, stated she was in pain, had not received pain medication since last night, was worried that the surgical wound was draining so much the canister was full, then Resident 1 started crying. The CC stated they asked to see someone in charge, then at about 2:00 PM Staff B (Director of Nursing) and Staff C (Administrator in Training) arrived in the room, and the WV alarm was sounding, they checked it and saw the canister was full of wound drainage. The CC stated two other nurses came in at separate times to look at the WV and did not know what to do to make it stop beeping. The CC stated, finally, at 4:30 PM, two and a half hours later, another nurse came and changed the canister, and the WV was operating again. The CC stated the hospital sent an extra canister with Resident 1 because the wound was draining so much at the hospital. The CC stated they visited again on 06/05/2026 at 11:00 AM, and the WV again started alarming. The CC stated Staff B and Staff C came into the room, said the canister was full again and said the facility did not have any more WV supplies, discussed WV supplies needed to be ordered, and would not arrive for a few hours. The CC stated at 2:30 PM the supplies still were not delivered so the CC and Resident 1 discussed the situation with the facility doctor who was onsite. The CC stated the doctor told Resident 1 the facility staff did not have the skill set to manage the WV and did not have the supplies needed for that type of WV. The CC stated since it was a Friday afternoon, the CC did not want to leave Resident 1 at the facility, so they asked the doctor how to get Resident 1 sent to the hospital. The CC stated they would have the nurse on duty make necessary arrangements to send Resident 1 to the hospital. The CC stated Resident 1 left the facility at about 4:00 PM and was still admitted in the hospital on [DATE].In an interview on 06/10/2026 at 4:25 PM, Staff B stated the facility uses a central admissions team located offsite of the facility to review records of potential residents for admission. The central admissions staff notified Staff B and Staff C of Resident 1's admission for 06/03/2026 through email, then uploaded the hospital documents and admission orders into the electronic medical record. Staff B looked at the email notification from the central admissions and stated it did not have any information about Resident 1 having a WV. Staff B stated the nurse managers review the hospital documentation prior to admission and the admission nurse entered in the physician orders for medications and treatments and started the care plan. Staff B stated the facility staff was not made aware Resident 1 had a WV prior to admission on [DATE]. Staff B stated on 06/04/2026 when they walked into Resident 1's room and the WV alarm was sounding, and the drainage canister was full. Staff B stated the hospital sent an extra canister and it was changed on 06/04/2026. Staff B stated on 06/05/2026 the WV canister was full again and was alarming. Staff B stated Resident 1 had to go to the hospital so the WV canister could be changed because the facility did not have the supplies. Staff B stated no training was provided for staff prior to Resident 1's admission on how to operate Resident 1's specific WV, and Staff B expected nurses to know how to operate a WV.In a phone interview on 06/11/2026 at 12:05 PM Staff A, Staff B and Staff C stated they were not informed by the central admissions team that Resident 1 was being admitted with a WV. Staff B stated they became aware of Resident 1's WV the day after admission which did not allow time to ensure nursing staff were provided with training for Resident 1's specific WV or ensure the facility had the supplies (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed to manage the WV at the time of admission. Staff B stated nurses should have entered monitoring orders into the medical record to ensure nurses were assessing and monitoring Resident 1's surgical site, drainage into the canister, and ensure the WV was operating as expected.Staff A stated there was no communication from the central admissions team that Resident 1 had a WV and that it was important to know the needs of residents on admission to ensure staff were trained, competent to provide specialized care, and had the supplies needed to manage resident care. Staff A stated there was no excuse to miss the WV for Resident 1 on admission screening.REFERENCE: WAC 388-97-0640, -1660(1)(a-b), -1680(2)(b)(i-ii)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure 4 of 4 licensed nurse staff (Staff D -Registered Nurse, Staff E - LPN, Licensed Practical Nurse, & Staff F- LPN) and 3 of 6 nurse aide staff (Staff H, I & J) had the specified competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being for of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment. This failure placed residents at risk infection, injury, inadequate care, and rehospitalization.Findings included.In an interview on 06/10/2026 at 6:35 PM, Staff B (Director of Nursing) and Staff C (Administrator in Training) was asked to provide documentation which showed the facility had verified the competency and skill sets of licensed nurses Staff D, Staff, E, Staff, F and Staff G assigned to provide care to Resident 1's wound vacuum (specialized equipment for wound care that applies negative pressure to the wound to manage drainage and promote healing). Documentation for nurse aides Staff H, Staff I, and Staff J to show they were evaluated and able to demonstrate competency in assisting residents with mobility was requested. None of the documentation requested was provided for Staff D, E, F, G, H, I, or J.In a phone interview on 06/11/2026 at 12:05 PM, Staff A (Interim Administrator) stated it was important for licensed nurses and nurse aides to be trained, and verification of competent skill sets upon hire prior to providing care to residents and annually.Reference: WAC 388-97-1080(1), -1090(1), -1680(1)(2)(a)(b)(i)(ii)(c).