

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER North Auburn Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0687 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate foot care. Based on observation, interview, and record review, the facility failed to implement preventive measures to protect residents' feet from injury, monitor the feet of high-risk residents, identify changes in skin integrity, report changes in wounds, seek treatment from the physician, ensure foot care treatments were completed consistently and according to physician orders, and arrange timely appointments with a podiatrist or wound care specialist for 2 of 3 Residents (Resident 1 and 2) reviewed for foot care. These failures placed residents at risk for impaired skin integrity, wound infection, hospitalization, and diminished quality of life. Resident 1, who was at an increased risk of skin impairment due to underlying diabetes, impaired circulation and sensation in their lower extremities, experienced harm when the facility staff did not identify changes in, or take timely action for, a diabetic foot ulcer (an open wound with skin loss, caused by trauma, poor circulation and/or nerve damage) between the right toes that became infected, required hospitalization for treatment of a systemic infection, and two separate surgeries for amputation of their right toes then amputation of their partial right foot. Findings included. The facility policy for Wound Prevention and Treatment revised on 02/03/2023 showed all residents were considered at risk for skin impairment, intensive efforts would be directed at managing risk factors, preventative interventions and provision of treatment for wounds including diabetic ulcers. The policy showed wounds would be monitored weekly and documented for size, color, odor, healing progression, notification and other pertinent information in the medical record. <Resident 1> Review of the 12/22/2025 quarterly Minimum Data Set (MDS, an assessment tool) showed Resident 1 was admitted for rehabilitation following an amputation below the knee of their left leg. The MDS showed Resident 1 had diagnoses of diabetes, impaired circulation, and decreased sensation in their lower legs. Review of the 03/11/2026 closed Care Plan (CP) showed Resident 1 had a left below the knee amputation with a surgical wound from a prior bone infection in the ankle. The CP showed Resident 1 had diabetic neuropathy (decreased sensation in the foot with decreased ability to feel pain). The 09/10/2025 diabetic CP interventions directed nursing staff to ensure socks were clean and absorbent and not too tight daily, ensure the use of non-skid footwear at all times to protect toes, nurses to inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness and report any of the above to the physician, and refer to podiatrist/foot care provider to provide foot care needs and to cut toenails. The 10/01/2025 CP intervention for Activities of Daily Living (ADL) showed Resident 1 required staff assistance with a shower twice a week and staff should check Resident 1's skin while providing ADL care daily. Review of the February 2026 and March 2026 Treatment Administration Records (TAR) showed nurses were directed to assess Resident 1's feet weekly (not daily as stated in the CP), cut the toenails related to the diagnosis of diabetes, and notify the physician of skin issues noted. The TARs showed nurses signed on 02/06/2026, 02/13/2026, 02/20/2026, 02/27/2026, 03/06/2026, that Resident 1's right foot was assessed, and toenail care was provided. A 02/11/2026 Physician (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 0687 Level of Harm - Actual harm Residents Affected - Few	Operations) stated the facility's prior Administrator and the prior Director of Nursing (both no longer employed at the facility) completed the investigation after Resident 1 was hospitalized and identified that the facility staff did not arrange podiatry services for Resident 1 when the diabetic ulcer was identified. In an interview on 07/16/2026 at 3:59 PM, Staff DD (Medical Records Coordinator) stated the podiatrist visited the facility every couple of months and was at the facility on 02/18/2026 (seven days after the blister was identified and the physician ordered a podiatry referral). Staff DD stated Resident 1 was not on the podiatrist list for 02/18/2026 and did not see the podiatrist. Staff DD reviewed Resident 1's electronic medical record and stated there were no podiatry visits or wound care specialist documents in Resident 1's records. Staff DD stated if Resident 1 saw the podiatrist or wound care specialist there would be documents in their medical record. In a phone interview on 07/16/2026 at 4:20 PM, Staff EE (Regional Director of Clinical Operations) stated they were involved in the investigation of Resident 1's diabetic ulcer. Staff EE stated the biggest issue was the nurses lack of assessment, lack of documentation, and lack of follow up on Resident 1's diabetic ulcer. Staff EE stated the facility recognized during the investigation that the ulcer worsened and the nurse staff did not recognize, report, or seek treatment as expected. <Resident 2> Review of the June 2026 facility incident report log showed on 06/23/2026 Resident 2 had a blister with an identified origin related to their condition. Review of the 06/26/2026 incident investigation packet showed Resident 2 had diagnoses of diabetes, poor circulation and poor sensation to their lower legs and feet with multiple other medical conditions. The investigation showed a two-centimeter round blister was found on the side of Resident 2's right heel, notifications were made to the provider and the RR, and a topical treatment was ordered and implemented. Interventions for care included directions to staff to float Resident 2's heels to offload pressure. In an observation and interview on 07/01/2026 at 4:22 PM, Resident 2 was in their bed with the head of the bed slightly elevated, both feet had non-skid socks on, both heels were resting on the mattress and there were no pillows under the resident's feet or legs. Resident 2 had an extra wide bed and showed they could move their own feet in bed. Resident 2 stated they had pain in the right heel, and someone took a lidocaine patch off the heel that morning and pulled the blister off their heel. Resident 2 stated the nurses had been applying a lidocaine patch for about a week because the blister hurt, but the patch did not do a whole lot to make it better. Staff FF (Assistant Director of Nursing) removed the sock on the right foot and stated the blister was open, was the size of a nickel, the wound surface was wet and there was some slough (dead tissue that is yellow, sticky, and stringy) in the middle of the wound. Staff FF stated the wound care provider visited that morning and removed the lidocaine patch, and the blister cover came off. Staff FF stated Resident 2's heels should be up on pillows to keep the pressure off the heels. In an interview and record review on 07/01/2026 at 4:50 PM, Staff FF stated the blister was found on 06/23/2026. Staff FF stated the wound care provider came weekly on Wednesdays and evaluated Resident 2's other wounds on 06/24/2026. Staff FF looked at the wound care provider notes and stated the blister on the right heel was not evaluated by the wound care provider on 06/24/2023. Staff FF stated the wound care provider first evaluated the blister on 07/01/2026 and the lidocaine patch was removed and opened the blister. In an interview on 07/01/2026 at 5:06 PM, Staff BB (Director of Nursing) stated Resident 2 had a blister on their heel because they preferred to lay on their back when in bed and there was friction on the heel that created the blister. Staff BB stated floating residents' heels while in bed is a standard of practice for all residents and staff were expected to float Resident 2's heels. Staff BB stated the blister was found on 06/23/2026 and should have been evaluated, but was not, by the wound care provider on 06/24/2026. Staff BB reviewed Resident 2's electronic medical record and stated the provider ordered a topical skin treatment when notified of the blister on 06/23/2026. (continued on next page)		

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F 0687 Level of Harm - Actual harm Residents Affected - Few	Staff BB stated on 06/25/2026 another provider ordered a lidocaine patch for heel pain. Staff BB stated a lidocaine patch would not be indicated for a heel blister. In an interview on 07/16/2026 at 5:10 PM, Staff BB stated documentation from the nurses or the prescriber regarding heel pain and implementation of the lidocaine patch could not be found. Staff BB stated the lidocaine patch should have been discontinued on 07/01/2026 and was not discontinued until 7/06/2026. Staff BB stated the lidocaine patch was not indicated for a blister on Resident 2's heel and should not have been applied over a blister. Staff BB stated a nurse did place it over the blister and was how the blister opened on 07/01/2026 when the wound care provider removed the patch and opened the blister. REFERENCE WAC: 388-97-1060(1)(3)(j)(viii).		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from abuse for 3 of 3 residents (Residents 4, 5, & 6) reviewed for resident-to-resident altercations. This failure placed the residents at risk of physical injury, fear, intimidation, mental anguish, and emotional distress. Findings included. Review of the facility policy titled Abuse Prevention and Reporting revised on 08/2025 showed residents have the right to be free from abuse. The facility prohibited abuse of a resident by anyone including staff, residents, resident representatives, family, and friends. The policy defined types of abuse as verbal, sexual, physical or mental and was a willful infliction of injury, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The policy defined willful as the individual must have acted deliberately, with the knowledge and understanding that their actions would result in injury or harm. Review of the May 2026 and June 2026 facility incident report logs showed Resident 3 had three separate incidents of resident-to-resident altercations on 05/16/2026, 06/23/2026 and on 06/25/2026. Review of the 05/16/2026 facility investigation showed Resident 3 was in the dining room at dinnertime and was throwing things at Resident 4 while sharing the same table. The staff escorted Resident 3 to the hallway where they were able to self-propel in their wheelchair to their room. The investigation showed a witness saw Resident 3 in the doorway of Resident 5, moving their hands up and down in a motion to hit Resident 5; when the witness arrived at the doorway, they saw Resident 5 had fallen backwards onto the floor. The investigation showed staff intervened, Resident 3 was removed from the area, Resident 5 was assessed and not injured. The investigation concluded that Resident 3 deliberately caused Resident 5 to fall to the floor. Review of the 06/23/2026 facility investigation showed Resident 3 was leaving the dining room in their wheelchair upset at another resident for wearing Resident 3's pants. When Resident 3 exited the dining room, Resident 4 entered the dining room, they tried to get past each other in the doorway when Resident 3 grabbed Resident 4's left index finger and twisted it, then Resident 4 yelled at Resident 3. The staff intervened and the residents were separated. When the nurse arrived, Resident 4 was crying and holding their left index finger. The investigation showed witnesses saw both residents verbally arguing and had their fists up. Resident 4 was evaluated by the physician onsite, after an x-ray, severe injury to the fingers was ruled out. The investigation found Resident 3 was the aggressor but could not substantiate Resident 3 intended to hurt Resident 4 as they were upset about something else and often reached for objects to help self-propel the wheelchair. The investigation showed Resident 3's actions caused Resident 4 to cry related to inflicted pain to their finger. Review of the 06/25/2026 facility investigation showed Resident 3 was banging on the dining table demanding food at 4:15 PM. The investigation showed when Resident 6 told Resident 3 the staff were serving food, a verbal altercation occurred between Resident 3 and Resident 6, then Resident 3 threw a cup at Resident 6. As staff intervened and moved Resident 3 to another table, Resident 3 grabbed a second cup to throw at Resident 6 but accidentally hit Resident 7. The investigation showed neither Resident 6 nor Resident 7 were injured. The facility investigation included witness statements which determined Resident 3 was the aggressor who intended to harm Resident 6 by throwing two cups at them. The facility investigation substantiated abuse from Resident 3 to Resident 6 and implemented one-to-one staff supervision for Resident 3 to ensure other residents' safety. In an interview, on 07/01/2026 at 2:08 pm, Staff BB (Director of Nursing) stated Resident 3 was easily irritated, and one-to-one staff supervision was initiated to ensure residents' safety. Staff BB stated Resident 3 had a private room and had ongoing evaluations (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	by various medical practitioners to assist the facility in managing Resident 3's behaviors. Staff BB stated Resident 3's representatives were aware of interventions and on-to-one staff supervision. In an observation and interview, on 07/01/2026 at 2:40 PM, Resident 4 stated a few days ago someone grabbed their finger and hurt it. Resident 4 stated the finger was ok, not broken, and could not provide any further information. Resident 4 was observed to not be distressed by the incident. In an interview, on 07/01/2026 at 2:47 PM, Resident 6 stated they had an argument with another resident in the dining room a few days ago and the other resident threw a cup at them. Resident 6 stated they were not harmed and the staff intervened. Resident 6 stated [Resident 3] now always had staff with them. On 07/01/2026 Resident 7 was not available for interview and Resident 4 was not able to be interviewed. In an observation and interview, on 07/01/2026 at 2:31 PM, Resident 3 was in their room, lying in bed looking at their cell phone. Resident 3 did not have a roommate and Staff GG (Certified Nursing Assistant) provided one-to-one supervision. Resident 3 stated they were mad at their prior roommate because they wore Resident 3's pants to the dining room. When asked, Resident 3 did not recall the incidents of Resident 5, Resident 4 or Resident 6. Staff GG stated Resident 3 required one-to-one supervision because of the prior behaviors toward other residents. Staff GG stated they were instructed to stay with Resident 3 so Resident 3 did not go on their own around other residents. In an interview, on 07/16/2026 at 4:48 PM, Staff BB reviewed the incidents of Resident 3 towards Residents 4, 5, and 6. Staff BB stated residents had the right to be safe and free from abuse. Staff BB stated interventions were in place to protect residents from the behaviors of Resident 3 because the facility had the responsibility to protect all residents from abuse. REFERENCE: WAC 388-97-0640(1)(a).		