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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>505202 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY COMPLETED<br><br>04/23/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Valley View Skilled Nursing and Rehabilitation |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>4430 Talbot Road South<br>Renton, WA 98055 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>29644</p> <p>Based on observation, interview, and record review, the facility failed to assess and document wound characteristics, monitor, and implement interventions to mitigate worsening of non-pressure skin issues for 4 of 6 sampled residents (Resident # 1, 2, 3 &amp; 4) reviewed for skin and non pressure wound management. This failure placed residents at risk for unidentified wounds, wound decline, infection, and diminished quality of life.</p> <p>Findings included .</p> <p>The facility's Skin Assessment policy revised 04/23/2024 stated a full body, or head to toe, skin assessment would be conducted by a Licensed Nurse (LN) or Registered Nurse (RN) upon admission/re-admission and weekly thereafter. The assessment might also be performed after a change of condition. For documentation of skin assessment and monitoring, nursing staff were directed to enter Y (Yes) for new skin issues and follow the protocol for notification and to initiate an incident report as indicated, and mark N (No) for no new skin issues.</p> <p>&lt;Resident 1&gt;</p> <p>Resident 1 admitted to the facility 12/03/2022. Review of the 04/12/2024 Annual Minimum Data Set (MDS - an assessment tool) showed Resident 1 was dependent on staff for toileting hygiene, bathing, and bed mobility and was always incontinent of bowel and bladder. Resident 1 was assessed as at risk of developing pressure ulcers/injuries, and was assessed with no skin impairments, including Moisture Associated Skin Damage (MASD - incontinence associated dermatitis). Treatments listed included applications of ointments/medications.</p> <p>Review of the Incontinence Care Area Assessment (CAA) dated 04/17/2024 showed incontinence placed Resident 1 at greater risk for impaired skin integrity. The LN and Nursing Assistants (NA) were to assist with Activities of Daily Living (ADLs) as indicated and LNs were to monitor and notify the Medical Doctor (MD) of any changes. Review of the 04/17/2024 CAA for skin showed Resident 1 was at risk but there were no new concerns at that time.</p> <p>Review of the at risk for unavoidable skin breakdown Care Plan (CP) dated 12/08/2023 showed a goal that Resident 1 would be free of skin breakdown. Interventions listed included, keep clean and dry, monitor for signs of skin breakdown, notify the MD of any new skin issues, and perform weekly skin checks by LNs.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Review of the April 2024 Treatment Administration Record (TAR) showed Physician Orders (PO) that instructed staff to conduct a weekly skin check, if a new skin injury was noted, staff were to complete the Weekly skin observation, notify the MD and family, open a risk management, and place the resident on alert charting. No new skin impairments were noted on the weekly skin checks dated 04/03/2024, 04/10/2024 and 04/17/2024.</p> <p>Review of the last 30 days of NA skin observation documentation retrieved 04/23/2024 showed a new open area was identified on 04/19/2024. Review of April 2024 progress notes, assessments, and other documentation in Resident 1's electronic medical record showed no documented assessment by an LN.</p> <p>Review of the April 2024 TAR showed POs for a cream ordered 12/15/2023 to be applied to Resident 1's bilateral buttocks, bilateral thigh folds, and groin area every shift for skin protection. The treatments were documented as done by Staff D (Licensed Practical Nurse - LPN) on 14 distinct dates in April, including 04/21/2024 and 04/22/2024. Another PO dated 02/23/2024 for a skin protectant external paste to be applied to perineum (groin) and sacrum (buttocks) three times a day for skin protection after peri-care (personal care) was documented as done 25 times in April by Staff D, including twice on 04/21/2024 and twice on 04/22/2024.</p> <p>During an interview on 04/23/2024 at 11:09 AM, Staff D stated they were unaware Resident 1 had any skin problems, open areas or bleeding. Staff D stated if an NA observed any concerns they would notify the LN. Staff D stated the resident did have a cream to be applied to their bottom. During an interview on 04/23/2024 at 11:57 AM, when asked who applied the cream, Staff D stated the NAs. Staff D was unable to recall the last time they looked at Resident 1's bottom.</p> <p>Resident 1 was discharged from the facility on 04/22/2024 to an Adult Family Home (AFH). Review of the 04/22/2024 Discharge Summary showed Resident 1's skin condition was noted as normal, clear, and intact.</p> <p>During an interview on 04/23/2024 at 11:02 AM, Staff C (Registered Nurse - RN, Resident Care Manager - RCM) stated Resident 1 was dependant on staff for care, was incontinent, and had no skin impairments prior to discharge.</p> <p>Review of documents provided by the receiving facility showed on 04/22/2024 the Registered Nurse Delegator of the AFH conducted a skin assessment and identified Resident 1 had open areas on their coccyx (tailbone), back, under their breasts, abdominal fold, and redness/bleeding on their peri-area (groin) skin. Photographs reviewed showed extensive MASD.</p> <p>During an interview on 04/25/2024 at 10:17 AM, Resident 1's son stated that the facility staff previously mentioned Resident 1 had a wound, but I didn't realize it was that bad. Resident 1's son stated that at discharge they were told that the wound resolved and there were no current skin issues.</p> <p>During an interview on 04/23/2024 at 11:12 AM, Staff B (Director of Nursing), stated Resident 1 had fragile skin, was incontinent, and had a history of open areas which quickly healed. Staff B stated Resident 1 had a PO for an ointment to be applied to Resident 1's groin, buttocks, and peri-area (groin) for preventative measures. Staff B stated the expectation was that an LN would apply the PO ointment and assess the resident's skin at that time. If the skin improved or worsened they would document this in a treatment note. Staff B stated a skin assessment was not, but should have been conducted by the nurse at discharge.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>&lt;Resident 2&gt;</p> <p>Review of the 04/15/2024 Annual MDS showed Resident 2 was dependent on staff for toileting hygiene and bed mobility, was occasionally incontinent of urine, and frequently incontinent of bowels. Resident 2 was assessed as at risk of developing pressure ulcers/injuries, and was assessed with no skin impairments, including MASD. Treatments listed included applications of ointments/medications.</p> <p>Review of the 04/17/2024 Urinary CAAs showed incontinence placed Resident 2 at greater risk for impaired skin integrity. The LNs and NAs were to assist with Activities of Daily Living (ADLs) as indicated and LNs to monitor and notify the MD of any changes. Review of the 04/17/2024 CAA for skin showed Resident 2 was at risk, the LN would complete weekly skin checks, monitor, and notify the MD of changes.</p> <p>The at risk for unavoidable skin breakdown CP initiated on 05/22/2023 listed the goal that Resident 2 would be free of skin breakdown. Interventions listed included: Monitor for signs of skin breakdown, weekly skin checks by LNs and notify the MD for any new skin issues.</p> <p>Review of the April 2024 TAR showed POs to staff to conduct a weekly skin check, if new a skin injury was noted, to complete the Weekly skin observation, notify the MD and family, open a risk management, and place the resident on alert charting. No new skin skin impairments were noted on the weekly skin checks dated 04/05/2024, 04/12/2024, and 04/19/2024.</p> <p>Review of the prior 30 days of NA documented skin observations, retrieved on 04/25/2024 showed staff noted Resident 2 had red and open areas on 03/31/2024, 04/02/2024, 04/11/2024, and 04/19/2024. According to the NA documentation, none of the areas were new.</p> <p>Review of the April 2024 TAR showed a 02/09/2024 PO to apply cream to the coccyx area redness every shift and notify the MD for signs of worsening. Review of progress notes showed a 03/31/2024 progress note that staff provided total assistance with peri care and applying cream to the resident's buttock, on 04/20/2024 Resident 2 had no new rash or new skin conditions.</p> <p>During an interview on 04/23/2024 at 12:19 PM Staff E (RN, RCM), stated Resident 2 had ongoing MASD. When asked how staff documented monitoring of the MASD, Staff E stated they entered a PO. Staff E looked in Resident 2's electronic medical record and stated, I don't see it. Staff E stated when the nurse applied the treatment, the nurse assessed the area and if the area worsened, staff were to notify the physician and write a progress note. Staff E stated, Resident 2 was assessed every Wednesday during wound rounds. When asked for the documented assessment, Staff E stated the last Wound Healing visit Resident 2 received was in January 2024. Staff E then stated the nurses conducted weekly head to toe skin assessments and if new issues were noted then a skin assessment would be completed. Staff C stated the MASD was present on Resident 2 from the coccyx down to the buttock circle (anus).</p> <p>Observation with Staff E on 04/23/2024 at 1:16 PM showed Resident 2 had pink colored cream visible on the whole area of the resident's buttocks and down the resident's thighs. Multiple scattered open areas were noted.</p> <p>During an interview on 04/23/2024 at 1:21 PM, Staff E stated the affected area had gotten bigger with open areas and soreness.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>&lt;Resident 3&gt;</p> <p>Review of the 03/08/2024 Annual MDS showed Resident 3 was dependent on staff for all mobility and ADLs and was assessed with no skin impairments.</p> <p>Review of the risk for skin impairment CP initiated 04/17/2023 showed interventions to include weekly skin check by the LN.</p> <p>Review of the NA skin observations for the prior 30 days, retrieved on 04/25/2024 showed no skin impairment was documented as observed 03/27/2024 through 04/24/2024.</p> <p>Review of the 2024 TARs showed a 02/11/2024 PO to conduct a weekly skin check. No new skin skin impairments were noted on the weekly skin checks dated 03/03/2024, 03/10/2024, 03/17/2024, 03/24/2024, 04/07/2024, 04/14/2024, and 04/21/2024.</p> <p>Review of the April 2024 TAR showed a 03/17/2024 PO to cleanse the open area to the right great toe, apply ointment to wound bed, and cover the area with border gauze every shift until healed.</p> <p>Review of progress notes dated 03/16/2024, showed Resident 3 was noted to have an open area to the right great toe 1.5 centimeters long with pink perimeters. The MD was notified and an order received. On 03/17/2024 the dressing to the right great toe was intact without signs of infection. Staff documented On 03/18/2024 the right great toe had an open area with a dry dressing and that was intact, with no signs of infection noted. No further documentation, monitoring, or assessments of the wound were located in Resident 2's electronic medical record.</p> <p>During an interview on 04/23/2024 at 12:15 PM Staff G (LPN) stated Resident 3 had an open area to their toe, which became infected, but was now healing. When asked where the assessments and ongoing monitoring were documented, Staff G stated the wound team assessed the wound every Wednesday.</p> <p>On 04/23/2024 at 12:47 PM Resident 3 was observed up in a wheelchair in their room, with a bandage on their right toe. Resident 3 was observed with redness on both sides of their face and eyebrows.</p> <p>During an interview on 04/23/2024 at 1:00 PM Staff F (Certified NA) stated Resident 3's face was crusted, with peeling skin. Staff F stated Resident 3 also had crust to their scalp which they tried to scrub off, but it was still there. Staff F stated they applied A &amp; D ointment to Resident 3's face. When asked if they reported it to the nurse, Staff F stated, Not yet, but they already know from before. Staff F stated they reported Resident 3's hair/head issue to Staff E two weeks prior.</p> <p>During an interview on 04/23/2024 at 12:54 PM, when asked what was wrong with Resident 3's face, Staff E stated they did not notice anything. On 04/23/2024 at 1:01 PM, Staff E denied having been told about Resident 3's skin issues of the hair/head concerns.</p> <p>During an interview on 04/23/2024 at 1:45 PM, Staff B denied receiving a skin incident report for Resident 3's toe and confirmed the resident was not followed by the wound care team.</p> <p>&lt;Resident 4&gt;</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Review of the 03/08/2024 significant change in status MDS showed Resident 4 was dependent on staff for all mobility and ADLs and was assessed with no skin impairments.</p> <p>Review of the potential for impairment to skin integrity CP showed a rash to Resident 4's left underbreast was added to the CP on 04/22/2024. Interventions included a treatment order in place for the rash.</p> <p>Review of the April 2024 TAR showed a PO to conduct a weekly skin check. No new skin skin impairments were noted on the weekly skin checks dated 04/02/2024, 04/03/2024, 04/09/2024, 04/10/2024, 04/16/2024, and 04/17/2024.</p> <p>Review of the April 2024 Medication Administration Record (MAR) showed a 04/17/2024 to apply medicated cream under left breast two times a day for 14 days for a rash.</p> <p>Review of progress notes showed the Resident was noted with redness under left breast on 04/16/2024. A 04/17/2024 note showed receipt of a PO to apply medicated cream under the left breast with a plan for documented monitoring for any worsening of the skin rash. A 04/19/2024 and 04/20/2024 note showed the nurses applied the cream under the breast and left underarm for a rash without documented MD notification that the rash spread.</p> <p>On 04/23/2024 at 12:03 PM, Staff H (LPN) was observed to apply the cream under Resident 4's left breast. No rash was observed to the resident's left underarm. During an interview at that time Staff H stated the left armpit rash resolved and the rash under the breast was improving.</p> <p>During an interview on 04/23/2024 at 2:18 PM, Staff B stated the facility recently identified concerns regarding skin care and were in the process of implementing changes in procedures and staff education.</p> <p>REFERENCE: WAC 388-97-1060(1).</p> |   |  |