STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505204	A. Building B. Wing	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Queen Anne Healthcare	2717 Dexter Avenue North Seattle, WA 98109

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298 Based on interview and record review, the facility failed to accurately assess 1 of 3 residents (Resident 1), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to accurately assess a surgical wound placed the resident at risk for unidentified and/or unmet care needs and a diminished quality of life. Findings included . According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.19.1, dated October 2024, showed, .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources . include the resident's medical record . The RAI manual further showed, if a pressure ulcer [or pressure injury-wounds that occur from prolonged pressure on the skin] is surgically closed with a flap or graft [a body tissue used to cover another body area], it should be coded as a surgical wound and not as a pressure ulcer. If the flap or graft fails, continue to code it as a surgical wound until [it is] healed. Review of a physician progress note dated 02/04/2025, showed Resident 1 had a pressure ulcer on their sacrum (tail bone) that had undergone a failed flap surgery in 2023. Further review of the physician progress note showed Resident 1 had one unstageable (loss of the deepest layers of the skin extending into the muscle in which the base of the ulcer is covered by slough [yellowish layer of dead tissue] or eschar [dead tissue that appears hard, dry, dark covering]) pressure ulcer on their left ischium (hip bone). Review of the hospital wound note dated 02/10/2025, showed Resident 1 had history of stage 4 (full thickness tissue loss with exposed bone, tendon or muscle) pressure ulcer on their sacrum. Further review of the hospital wound note showed that Resident 1 had failed flap surgery on their sacral pressure ulcer. Review of Resident 1's significant change MDS dated [DATE], showed Section M0300D (Number of Stage 4 Pressure Ulcer) was coded 1. Review of Resident 1's physician progress note dated 04/15/2025, showed that Resident 1 had a flap surgical wound on their sacrum and unstageable pressure ulcer to their left ischium that was debrided (the process of removing dead skin from a wound to promote healing) and was evaluated as a stage 4 pressure ulcer. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the discharge MDS dated [DATE], showed Resident 1 was discharged to the hospital. Further review of the discharge MDS showed Section M0300D was coded 2. In an interview and joint record review on 04/22/2025 at 11:12 AM, Staff B, MDS Nurse, stated that they followed the RAI manual in coding the MDS. A joint record review of Resident 1's significant change MDS dated [DATE] showed that Section M0300D was coded 1. Joint review of Resident 1's discharge MDS dated [DATE] showed Section M0300D was coded 2. Staff B stated that they coded Resident 1's sacral wound as a stage 4 pressure ulcer on Resident 1's significant change MDS and on their discharge MDS. Joint review of the RAI manual dated October 2024 showed that a pressure ulcer should be coded as a surgical wound and not as a pressure ulcer when it was surgically closed with a flap and would continue to code it as a surgical wound even if the flap failed. Staff B stated that they did not code Resident 1's MDS accurately and will correct them. In an interview on 04/22/2025 at 1:54 PM, Staff A, Director of Nursing, stated that Resident 1's sacral pressure ulcer was not coded correctly and that they expected Resident 1's MDS to be coded accurately. Reference: (WAC) 388-97-1000 (1)(b)