STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505211	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Puyallup Nursing and Rehabilitation Center	516 23rd Ave SE Puyallup, WA 98372

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46472 Based on interview and record review the facility failed to ensure residents were provided a complete and accurate discharge summary that included a recapitulation (overview) of the residents' stay, a final summary of the resident's status (including skin condition), a reconciliation of all pre-discharge medications with the resident's post-discharge medications (prescriptions, over-the-counter medications, and treatments), scheduled appointments and contact information for Primary Care Provider (PCP), medical specialists, blood thinner clinic follow ups, and a post-discharge plan of care that included Physician Ordered (PO) Home Health (HH) services for 6 of 6 residents (Residents 3, 9, 8, 7, 10, & 11) reviewed for discharge summary. These failures placed residents at risk of post-discharge complications, delayed treatment, and decline in their overall condition by not having the necessary information and services established to ensure continuity of care for a successful discharged to the community. Findings included . <Resident 3> Review of the 06/09/2024 Significant Change in Assessment Minimum Data Set (MDS-assessment tool) showed Resident 3 had no cognitive impairments and diagnoses included history of urinary tract infection, enlarged prostate, and Parkinson's disease. Resident 3 had a chronic indwelling foley catheter and was incontinent of stool. In an interview on 08/6/2024 at 10:39 AM, Resident 3's Collateral Contact (R3CC) stated Resident 3 was discharged home from the facility on 08/05/2024 with three Pressure Ulcer/Pressure Injuries (PU/PIs) on their right buttock, no directions for wound care treatment orders on the discharge summary, and no orders for HH nursing services. Review of Resident 3's August 2024 Medication Administration Record (MAR) showed they receieved a zinc based moisture barrier ointment three times daily for the treatment of a wound on their right buttock and required foley catheter care three times a day. (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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Discharge Summary & Orders (DSO), signed 08/05/2024, showed the summary was incomplete. The medication reconciliation did not show a quantity for dispense or indication (reason) for taking the medication. The skin condition section was incomplete and did not describe Resident 3's skin condition at the time of discharge, and no wound care treatments. The discharge summary did not address the care required for the foley catheter maintenance, when it was last changed, the size and type of product, or prescription to obtain foley catheter supplies. In an interview on 08/13/2024 at 3:20 PM, Staff C, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM), stated they initiated the DSO but the nurse on the floor did the actual discharge teaching and DSO review with the Resident and/or Responsible Party. Staff C stated they looked at Resident 3's skin before they discharged but did not see, or was aware, they had a PU/PI on their right buttock. Staff C stated they did not put the treatment for the right buttock on the medication reconciliation because there was nothing there. Review of the Nurse Progress Note, dated 08/05/2024 at 2:36PM, read discharged . In an interview on 08/13/2024 at 4:00 PM, Staff G, LPN/RCM, stated when residents discharged all the medications, treatments, and medical device care provided at the facilty were required to be on the medication reconciliation and DSO but were not. Staff G stated their expectation was that when resident's discharged , the discharging nurse documented their final evaluation of the resident (including skin condition), their patient teaching, medication reconciliation, a reconciliation of their personal belongings, who they reviewed the discharge instructions with, the time the resident left the facility, and how they left, at a minimum. Staff G stated the discharge note was not acceptable. <Resident 9> Review of the ARNP Discharge Summary Note dated 08/09/2024 at 10:01 AM showed Resident 9's discharge plan included: HH referral for continued therapy and nursing care to meet discharge needs for a safe transition to home and community, follow up with PCP in one week, follow up with orthopedics as scheduled, and continue current medications/treatments. Review of Resident 9's August 2024 MAR/TARs showed they were on a blood thinner that required periodic monitoring of blood levels to ensure proper dosing of the medication. Review of the NPN dated 08/09/2024 at 10:21 AM showed Resident 9 discharged home and was educated to follow up with their PCP regarding blood thinner management. The note did not provide information of scheduled appointments and contact information for their PCP, the blood thinner management clinic, or orthopedics. Review of Resident 9's DSO dated 08/07/2024 showed the discharge instructions were incomplete, inaccurate, did not contain scheduled future appointments for blood thinner clinic, PCP, orthopedics, or Home Health. The DSO showed: >An anticipated discharge date of [DATE] - going home with family. >The recapitulation of stay did not address the therapies Resident 9 received at the facility. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	>The Social Service Summary showed Resident 9 was discharging to an Adult Family Home (AFH) and HH would be ordered for both physical and occupational therapy (the documentation did not address HH nursing services). >The most recent vital signs were documented from 08/07/2024 at 07:12 (two days prior to their discharge). >The skin condition section was incomplete. >The Equipment and Services section showed a HH referral was sent to Home Health Agency 1 (HHA1). >The Discharge Summary Instructions section to validate the DSO was reviewed and understood, then signed the Resident and/or Resident Representative was incomplete and did not have a signature of who received the discharge instructions or signature of receipt of the documents. In an interview on 08/22/2024 at 11:15 AM, the HHA1 Intake Coordinator stated a referral for Resident 9 was never received and Resident 9 was not on their caseload. In an interview on 08/27/2024 at 10:45 AM, Resident 9's Collateral Contact (R3CC) stated they were present on the day of Resident 9's discharge from the facility. R3CC stated the nurse doing the discharge did not say anything about blood thinner management and did not provide any scheduled appointment for the blood thinner clinic, PCP follow up, or HH services. R3CC stated the provider at the AFH helped re-establish Resident 9 with the blood thinner clinic and PCP follow up. Resident 9 still has not had HH services. <Resident 8> Review of the ARNP Discharge Summary Note dated 08/05/2024 at 12:45 PM showed Resident 8 was medically stable to discharge. The discharge plan included HH therapy and nursing services for a safe transition to home and community, follow up with oncology (cancer specialist), follow up with their PCP in one week, and continue current medications/treatments. Review of the DSO dated 08/02/2024 showed: >The Discharge Plan was incomplete and did not provide the reason for discharge, the discharge destination, transportation arrangements, or pharmacy contact information. >The Nursing, Social Services, and Activities Summaries were incomplete and did not provide therapies provided, psycho-social and cognitive status, facility progress, or discharge potential. >The most recent weight measured 2,142 pounds on 08/01/2024. Review of the clinical weight record showed they weighed 214.4 pounds on 07/30/2024, indicating a weight variance or error in documentation. >The most recent vital signs were measured on 08/02/2024 at 7:15 AM. Review of the clinical vital signs record showed the most recent vital signs were measured on 08/05/2024 at 7:15 AM. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	>The medication reconciliation of pre-discharge medications with post-discharge medication orders were reconciled on 08/02/2024, three days before discharge. The reconciliation did not include the indications for each medication or quantity to dispense. >The skin condition section was incomplete and did not describe their skin status on discharge. >The DSO did not provide documentation to show HH referrals were sent, who the HH agency was, and their contact information. >The future appointments section did not provide scheduled appointments with contact information for oncology or their PCP within one week. Review of NPN dated 08/05/2024 at 2:36 PM read discharged . In an interview on 08/12/2024 at 4:10 PM, Staff G stated the DSO should have been complete with the pharmacy information, HH information, scheduled appointments and contact information, and a complete and accurate medication reconciliation but was not. In an interview on 08/13/2024 at 9:00 AM, Resident 8 stated they did not have a PCP appointment scheduled and their prescriptions were a bit of a mess when they discharged but their pharmacist was working to fix the problems. Resident 8 stated the facility provided what medications they had left which was not going to last long. Resident 8 stated the facility did not schedule their oncology appointment, they were contacted by the oncology office because an appointment had not been scheduled, and they now have an upcoming appointment. Resident 8 stated they received calls from a couple different HH companies but had not been seen yet. <Resident 7> Review of the ARNP Discharge Summary Note dated 07/29/2024 at 2:48 PM showed Resident 7 was medically stable to discharge on 08/01/2024. The discharge plan included follow up with cardiology (heart specialist), follow up with their Primary Care Provider (PCP) in one week, and continue current medications/treatments. Review of the August 2024 Medication and Treatment Administration Records (MAR/TARs) showed Resident 7 was ordered medications for the heart failure and high blood pressure with hold parameters for low blood pressure. Resident 7 was also ordered daily weight measurements in the morning and to notify the provider if a weight gain was identified of 3 pounds in 24-hours or 5 pounds in one week. The TAR showed Resident 7 had a skin problem on their right lower leg, right wrist, and a surgical incision. Review of the DSO dated 07/31/2024 showed: >The most recent weight measured 10.2 pounds on 07/29/2024 at 11:44 AM. Review of the clinical weight record showed Resident 7 measured 110.4 pounds on 07/20/2024, indicating a weight variance and/or inconsistency. The DSO did not provide direction to measure their weight daily. >The most recent vital signs were measured on 07/31/2024 at 7:03 AM. Review of the clinical vital signs record showed the most recent vitals signs were measured on 08/01/2024 at 6:54 AM. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	>The medication reconciliation of pre-discharge medications with post-discharge medication orders were reconciled on 07/31/2024, one day before discharge. The reconciliation did not include the indications for each medication or any vital sign parameters to check prior to administration for their high blood pressure medication. >The skin condition section was incomplete and did not indicate the status of their skin condition at discharge. >The future appointments section did not provide a scheduled appointment with contact information for cardiology or their PCP within one week. >The DSO did not indicate who received the discharge instructions or the time reviewed and provided. Review of Nurse Progress Note (NPN) dated 08/01/2024 at 3:58 read discharged . <Resident 10> Review of a NPN dated 07/12/2024 at 12:34 AM showed Resident 10 discharged home with all medications, treatments, and belongings. Resident 10 discharged with an invasive irrigation drain tube system. Review of the clinical record did not show a DSO that included where or how to was reviewed and signed by the discharging nurse, physician, Resident, and/or Resident Representative. In an interview on 08/12/2024 at 4:20 PM, Staff G stated all the documents that were reviewed with Resident 10 and their representative should have been copied and placed in the clinical record but were unable to be located. <Resident 11> Review of a NPN dated 08/06/2024 at 3:17 PM read discharged . Review of Resident 11's DSO dated 08/02/2024 showed sections that were incomplete, vital signs that were from four days before their discharge date , and no signature from the nurse who reviewed the discharge instructions with Resident 11. REFERENCE WAC: 388-97-0080(7)(a)(b)(c).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46472 Based on observation, interview, and record review the facility failed to provide necessary care and services to prevent the occurrence and/or worsening of avoidable pressure ulcer/pressure injury (PU/PIs) for 4 of 5 residents (Residents 3, 1, 4, & 6) reviewed for PU/PIs. The failure to develop a system to timely and accurately evaluate newly identified PU/PIs and perform weekly wound evaluations placed the residents at risk for worsening PU/PIs, unmet care needs, and diminished quality of care/quality of life. Findings included Review of the facility's Skin at Risk Program: skin integrity, wound care policy, undated, showed when a new wound was identified, an appropriate treatment order would be obtained, and a Weekly Skin Measurement Tool (WSMT) would be initiated for each PU/PI identified. PU/PIs would be evaluated weekly, documented on the WSMT, and would include the wound characteristics: length, width, depth, undermining, tunneling, pain, drainage, condition of the wound bed and edges. <Resident 3> Review of the 06/09/2024 Medicare/Significant Change Minimum Data Set (MDS-assessment tool) showed Resident 3 readmitted to the facility on [DATE], no problems with cognition, required staff assistance for bed mobility and transfers, and was incontinent of bowel. Resident 3 diagnoses included a cervical (neck) spine problem, Parkinson's disease, and obstructive sleep apnea. Resident 3 had no unhealed PU/PIs and was assessed to be at risk for the development of PU/PI. Review of the Skin CP, revised 07/11/2024, showed an intervention, dated 07/09/2024, that read Non-Blanchable Area Right Buttock, which would indicate Stage 1 PU/PI. The CP did not show the facility implemented new interventions for the new PU/PI on 07/09/2024. Review of the Skin Grid for Pressure, Venous, Arterial, & Diabetic Ulcers form showed Resident 3 had a Stage 2 PU/PI on the right buttock, identified on 07/09/2024, that was not present on admission to the facility and the probable cause was marked Pressure. The wound measured 7 centimeters (cm) x 7 cm, no depth measurement was documented. The Stage 2 PU/PI did not have drainage, the wound bed was pink, and there was no other documented characteristics. The Skin Grid did not show any other subsequent wound evaluations after 07/09/2024. Further review of the clinical record did not show Resident 3's responsible party, or the physician were notified. Review of the Nurse Progress Notes and Weekly Wound Assessment evaluations, between 07/09/2024 and 07/22/2024 showed no wound measurements, evaluations, or monitoring of the wound. Review of the Wound Specialist (WS) initial evaluation, dated 07/22/2024, showed Resident 3 had a wound on the right buttock (labeled Wound #1), the result of pressure, moisture, and friction and the primary cause was Moisture Associated Skin Damage (MASD- skin inflammation and erosion that occurs when skin is exposed to moisture for a long time). The evaluation showed Resident 3 had chronic discoloration likely due to tissue injury from sitting on their sacral area and MASD flare with partial thickness opening on the right buttock. The evaluation did not provide wound measurements. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Weekly Wound Assessment (WWA-formerly called WSMT), dated 07/22/2024, showed Resident 3's right buttock wound measured 3.0cm x 2.4cm x 0.1cm and was a moisture lesion (redness or partial thickness skin loss involving the epidermis, dermis, or both caused by excessive moisture to the skin from urine, feces, or sweat). Review of the WWA and the WS subsequent evaluation, both dated 07/29/2024, showed Wound #1 measured 0.5cm x 0.6cm x 0.1 cm with a small amount of drainage. Review of the clinical record did not show a WWA or a WS evaluation was completed on 08/05/2024. Additionally, the record showed that when the WS was not at the facility for wound rounds, the WWA was not completed, and wounds were not evaluated. Review of the Discharge Summary & Orders, dated 08/05/2024, showed Resident 3 discharged home. The documentation did not provide an evaluation of Resident 3's skin condition, the PU/PI on the right buttock, or the treatment the facility used to treat the PU/PI. In an interview on 08/06/2024 at 09:30 AM, Resident 3's Collateral Contact (R3CC) stated Resident 3 was discharged from the facility on 08/05/2024 with three PU/PIs, was not provided instructions or treatment orders for the care of the PU/PIs at home, nor was Resident 3 ordered home health nursing services. R3CC stated they were not notified by the facility of the PU/PIs and was unsure when they developed but became aware of them on 08/02/2024. In an interview on 08/07/2024 at 3:30 PM, Staff F, Certified Nursing Assistant, stated they last cared for Resident 3 on 08/02/2024 (the Friday before they discharged) and Resident 3 had three open areas on their right buttock. Staff F stated Resident 3 preferred to have their head of bed elevated to watch tv but would slide down in the bed so Staff F would have another staff member help them boost Resident 3 up in bed. In an interview on 08/07/2024 at 3:00 PM, Wound Specialist (WS), Physician's Assistant, stated they first observed the wound on the right buttock on 07/22/2024. WS stated they observed a few scattered open areas on the right buttock, surrounded by chronic discoloration and old scarring from previous open areas. The WS called the wounds MASD and was not aware that a nurse had already evaluated the wound to be a Stage 2 PU/PI on 07/09/2024 (13 days prior). WS pulled up an electronic photo of the wound that showed a linear, well defined open wound, with rounded red wound edges, and a white wound bed, but no measurements of the wound. The next and last time WS saw the wound was on 07/29/2024, when the wound measured 0.5cm x 0.6 cm x 0.1 cm and was noted to be improved. WS electronic photo of the wound on 07/29/2024 showed a smaller wound than on 07/22/2024, however just above and to the right of the wound were two linear deep purple areas that appeared to be deep tissue injuries. WS stated they were unsure why they did not evaluate the deep purple areas to see if they blanched (pressing down on the skin to see if there is blood flow to the area) or measure and document them in their progress note for monitoring. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/07/2024 at 3:15 PM, Staff D, Licensed Practical Nurse (LPN), stated they were wound care certified and oversaw the wound care program. Staff D stated the facility's process once a new open area was identified was to assess the wound, notify the physician and obtain treatment orders, update the CP, and notify the responsible party. Staff D stated they would also made a referral to the Wound Specialist who came to the facility weekly. Staff D stated if the wound was determined to be a PU/PI, the nurse would also initiate a facility investigation report. Staff D stated they were notified Resident 3's wound sometime after it was first identified but did not go and evaluate the wound. Staff D stated Staff H, LPN, evaluated the wound and reported to Staff D it was MASD. Staff D did not evaluate the wound until 07/22/2024 on wound rounds with WS. Staff D stated the continued monitoring and evaluation of the wound should occur at least weekly from the time the wound was identified until it was resolved. Staff D stated they completed the WWA on wound round days. Staff D stated the Resident Care Managers were responsible for the completion of the WWAs if WS was not at the facility for wound rounds. In an interview on 08/07/2024 at 5:00 PM, Staff B, Director of Nursing, stated they were not provided a facility investigation for the Stage 2 PU/PI that was identified on 07/09/2024 but should have. Staff B stated they expected the wound certified nurse to evaluate all PU/PIs in the facility to ensure accurate evaluation and identification of the wounds, ensure appropriate treatments were in place, and ensure weekly monitoring of the wounds occurred. <Resident 1> Review of the 06/07/2024 Admission MDS showed Resident 1 admitted to the facility on [DATE] with diagnoses including a PU/PI of the tailbone. Resident 1 was assessed to have one Stage 3 PU/PI on admission. Review of the 06/18/2024 Stage 3 PU/PI CP directed staff to refer to the Wound Specialty Group for weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue, and exudate. The CP directed nurses to assess/record/monitor wound healing weekly, obtain wound measurements where possible, assess and document the wound perimeter, wound bed and healing progress. Review of the clinical record showed no WWA or WS progress note for the week of 06/24/2024. In an interview on 08/12/2024 at 4:00 PM, Staff G, LPN/RCM, stated there should be weekly documentation of a wound evaluation, including the week of 06/24/2024 but was not. <Resident 4> Review of the Admit and Quarterly Assessment, dated 06/21/2024 showed Resident 4 had non-blanchable redness on the tailbone but did provide measurements of the area. Review of the 06/24/2024 Admission MDS showed Resident 4 admitted to the facility on [DATE] with diagnoses including cancer, malnutrition, and failure to thrive. Resident 4 was assessed to be at risk for PU/PI and had one Stage 1 PU/PI. Review of the Skin Integrity CP, revised 07/10/2024, directed nurses to evaluate the wound weekly and document the measurements and wound characteristics. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record did not provide documentation to show a WWA or WS evaluation was conducted of the Stage 1 on the tailbone for 06/28/2024 or 07/05/2024. Review of a WS Initial evaluation, dated 07/08/2024, showed Resident 4 had a wound left of the tailbone, partial thickness, and measured 1.8cm x 1.6 cm x 0.1 cm, the wound bed had up to 25% slough (dead fat tissue), and a small amount of drainage, and was improving (but did not provide the reference used to gauge improvement). This WS evaluation provided the first measurement of the wound identified on admission. Review of subsequent WWA and WS evaluations showed no evaluations conducted on 07/22/2024 or 08/05/2024 (an evaluation was conducted on 08/07/2024, 9 days after the last evaluation). In an interview on 08/13/2024 at 4:00 PM, Staff G stated WWA should have been completed for the wounds weekly, including the weeks WS did not evaluate the wound, but did not. <Resident 6> Review of the 08/02/2024 Quarterly MDS showed Resident 6 readmitted to the facility 11/03/2020 and had one unhealed Stage 3 PU/PI. Review of the clinical record showed when WS was not able to attend weekly wound rounds, the facility did not evaluate, measure, or document the status of the wounds by completing the WWAs. REFERENCE: WAC 388-97-1060(3)(b).