STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505217	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Ridgemont	2051 Pottery Avenue Port Orchard, WA 98366

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068 Based on interview and record review, the facility failed to obtain clarification for treatment and assess timely for prompt intervention, a surgical incision under the dressing for 1 of 3 residents (Resident 1) reviewed for wound care. Resident 1 experienced harm when their surgical incision dehisced (opened back up), became necrotic (dead/devitalized tissue) and showed signs of infection after 19 days without observation of the incision below the dressing assessment. This failure placed residents at risk for medical complications and a decreased quality of life. Findings included . Resident 1 was admitted on [DATE] with diagnoses including diabetes, heart and kidney disease. The Minimum Data Set, an assessment tool, dated [DATE], showed the resident required assistance with their activities of daily living. Resident 1's progress note, dated [DATE], showed Resident 1 was scheduled for a L [left] toe amputation (surgical procedure to remove a body part) on [DATE] related to necrosis and several unsuccessful rounds of antibiotic treatments and wound care. Resident 1's After Visit Summary, dated [DATE], showed post-operative discharge instructions that included to remove the dressing after 72 hours and redress with light gauze dressing at least every other day. The after-visit summary showed they were to call the medical provider if they had redness, tenderness or signs of infection around the surgical site. Facility designated physician order, for Resident 1, dated [DATE], showed orders to leave the dressing to left great toe in place until follow-up appointment on [DATE]. The order expired/was discontinued on [DATE], leaving no remaining treatment orders in place. Resident 1's surgeon's office visit note, dated [DATE], showed staff removed the bandage from the left amputation site, sutures were intact, no drainage, warmth or erythema (redness) at the site. The note showed sterile gauze was applied to the site and wrapped with kerlix (type of bandage) and the patient was instructed to call for any signs of infection or concerns. Review of Resident 1's Treatment Administration Record from [DATE] through [DATE], showed no documentation of a dressing change to the left great toe and/or monitoring/assessment of the left great toe surgical site. (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 1's progress notes from [DATE] thru [DATE], showed no dressing changes to the left great toe and/or monitoring/assessment of the left great toe surgical site. Review of Resident 1's physician orders from [DATE] through [DATE], showed no orders for dressing changes to the left great toe and/or orders to keep dressing in place. Resident 1's weekly skin assessments, dated [DATE] and [DATE], showed the left great toe amputation dressing was intact, and the dressing was to remain in place until follow up appointment with the surgeon (dressing change orders ended [DATE] after which new orders should have been obtained). The skin assessments did not document the dressing on the surgical incisions was removed or any visualization of the incision site occurred. Review of Resident 1's surgeon's office visit note, dated [DATE], retrieved from EPIC (an electronic record system outside of Resident 1's facility medical record), by Staff A, Resident Care Manager (RCM) on [DATE], showed the left great toe amputation site with residual cellulitis (skin infection) and an order for Keflex (antibiotic). Resident 1's weekly skin assessment, dated [DATE], showed the left great toe amputation dressing was intact but there was no assessment of the surgical incision beneath the dressing. Resident 1's progress note, dated [DATE] (9 days after surgeon's visit) and the first time documentation showed facility staff assessed the resident's incision since the amputation on [DATE], documented the resident's wound/incision to their left dorsal hallux (great big toe), had a scant amount of drainage with a slight foul odor. Resident 1's facility medical provider notes, dated [DATE], showed the provider examined Resident 1's surgical site on the left great toe and it was necrotic, foul smelling, with purulent (thick, milky fluid) drainage and wound dehiscence (a partial or total separation of an incision). The notes showed the provider advised the resident they needed to go the hospital for intravenous (administered into the vein) antibiotics and wound debridement (medical procedure to remove dead and infected tissue) but the resident declined to go and chose to remain at the facility and stay comfortable. On [DATE] at 1:48 PM, Staff A said they entered the order on [DATE] for the dressing to remain in place until the follow up appointment with the surgeon and expected there would be new dressing orders at the [DATE] follow up appointment. Staff A said Resident 1 went to their follow up appointment with the surgeon on [DATE] and returned with no paperwork. Staff A said they expected when residents returned from appointments without paperwork, the expectation was to call the doctor's office to ensure there were no new orders and/or instructions. Staff A said there was no documentation in the medical record that this took place. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 3:24 PM, Staff B, Director of Nursing, said the system for monitoring and assessment of wounds was during dressing changes, documenting in the progress note and weekly during skin assessments. Staff B said they reviewed Resident 1's medical record and saw documentation the resident had a dressing on the left great toe, but no documentation of a physician's order for a dressing after [DATE], no monitoring and/or assessment of the surgical site and no documentation the staff changed the left toe dressing between the surgeon's follow up appointments. Staff B said they expected that during Resident 1's weekly skin assessment that staff should have assessed the resident's skin to include the left great toe surgical incision, and a surgical incision should be followed by the RCM until healed. Staff B said the staff should have contacted the physician for clarification of the wound care. Staff B said that did not happen. WAC Reference [DATE] (1)