STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505230	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fir Lane Health & Rehabilitation Center	2430 North 13th Street Shelton, WA 98584

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068 Based on observation, interview and record review, the facility failed to implement care plan interventions for 2 of 3 residents (Resident 2 and 3) reviewed for quality of care. This failure placed residents at risk for poor hygiene, clinical complications, and a diminished quality of life. Findings included . <Resident 2> Resident 2 was admitted to the facility on [DATE] with diagnoses including dementia and depression. The Minimum Data Set (MDS), an assessment tool, dated 11/20/2024, showed Resident 2 was dependent on staff for transfers, bed mobility, dressing, hygiene and had cognitive impairment. Resident 2's self-care deficit care plan, revised on 07/20/2021, showed the resident had hearing aids. Staff were to ensure the resident had them on in the am and out at night. The care plan showed the resident was to set up at the sink and encouraged to assist with hygiene. Resident 2's ADL [activity of daily living] care plan, revised on 08/16/2024, showed the resident was to have TED hose (compression socks that help to prevent blood clots in the legs) on in am and off at HS [bedtime] and was dependent on staff for transfers and dressing. On 02/07/2025 at 12:51 PM and 02/12/2025 11:21 AM, Resident 2 was observed lying in bed wearing a hospital gown and was not wearing hearing aids. On 2/10/2025 at 12:34 PM, Collateral Contact 1 (CC 1), said the staff did not get the resident out of bed unless CC 1 became upset. CC 1 said they would like the resident to get up to their wheelchair and go out into the hallway and get out of their room. CC 1 said staff told them the resident refuses. CC 1 said they had told the staff to contact them if the resident refused to get out of bed so they could speak with the resident and CC 1 also gave the staff approaches to utilize due to Resident 1's dementia. CC 1 said when they visited, they often found the resident had not been cleaned. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/12/2025 at 11:34 AM, Staff F, Certified Nursing Assistant (CNA), said they were assigned to Resident 2 and had worked at the facility for approximately a month. Staff F said they had never seen Resident 2 out of bed. Staff F said when they were trained on the unit the staff told them Resident 2 was bed bound so they had not asked and/or encouraged the resident to get out of bed. Staff F said Resident 2 did not wear hearing aids and they just talked loud to them. When asked if Resident 2 was wearing TED hose, Staff F said the resident was not and they were not aware they wore them. On 02/21/2025 at 11:37 AM, Resident 2 was observed lying in bed wearing a hospital gown, no TED hose on their legs and was not wearing hearing aids. On 02/21/2025 at 11:48 AM, Staff F, CNA, said they had to prioritize the care they gave and had not had time to provide dressing and/or hygiene assistance to Resident 2 that morning. Staff F said they had changed the resident's brief but had to prioritize other resident's care and now had to assist in the dining room. Staff F said they did not ask Resident 2 if they wanted to get out of bed, he doesn't get up and had not dressed the resident yet and/or changed their hospital gown. Staff F said they weren't aware Resident 2 wore hearing aides but said it would be lovely if they did because it would make for better communication with the resident. On 02/21/2025 at 1:59 PM, Staff C, Unit Manager, said Resident 2 did occasionally get out of bed and wore TED hose. Staff C said they knew nothing about the hearing aids. <Resident 3> Resident 3 was admitted [DATE]. The MDS, dated [DATE], showed the resident was cognitively intact and required assistance with bathing. On 02/10/2025 at 3:25 PM, Resident 3 said they were supposed to get a shower on Mondays and Thursdays. Resident 3 said they were admitted on a Monday and did not receive a shower but thought it was because they were just admitted but they did not get a shower for the rest of the week and did not receive a bed bath, the only time I was wiped down was when I wet the bed. Resident 3's care plan, revised 02/02/2025, showed the resident required one person assistance with bathing/showering frequently and as necessary. The care plan showed Resident 3 required moderate assistance with personal hygiene. Resident 3's task report for bathing, dated 01/27/2025 through 02/02/2025, showed no showers documented. On 02/21/2025 at 1:59 PM, Staff C, Unit Manager, reviewed Resident 3's medical record and said they did not see any reason the resident had not received a shower. <Final Interview> On 02/21/2025 at 2:39 PM, Staff E, Director of Nursing, said Resident 2 and Resident 3's care plans were not consistently implemented by facility staff, and they were working on their care plan system. Reference WAC 388-97-1020 (3)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068 Based on interview and record review, the facility failed to accurately assess and take timely action to prevent the development of pressure ulcers (injury to skin and underlying tissue resulting from prolonged pressure) experienced by 1 of 1 closed record Resident reviewed for wound care. Resident 1 experienced actual harm when they developed pressure ulcers to both heels which required hospitalization for surgical intervention, intravenous (administered through the vein) antibiotics and below the knee amputation (BKA) of their right lower extremity (RLE). These failures placed residents at risk for pressure ulcer development, deterioration of existing pressure ulcers, pain, and a decreased quality of life. Findings included . Review of the facility's policy titled, Wound Prevention and Treatment, revised 02/03/2023, showed that wounds including pressure injuries and significant skin tears would be monitored weekly and documentation of size, color, odor, healing progression, notifications and other pertinent information related to the skin conditions would be documented in the electronic medical record. Physician notification and resident/resident representative notification would be completed as needed. Resident 1 was admitted on [DATE] with diagnoses including developmental delay, diabetes and morbid obesity. The Minimum Data Set, an assessment tool, dated 01/27/2025, showed the resident was cognitively intact, at risk for pressure ulcers and required staff assistance for bed mobility and was dependent for out of bed transfers. Review of Electronic Health Record (EHR) showed Resident 1 had long standing orders since admission for weekly diabetic foot checks. The EHR showed Resident 1 had a history of pressure ulcers, the most recent to their left lateral foot that was documented as resolved 12/03/2024 by wound consultant team. Resident 1's skin evaluation, dated 01/13/2025, showed no skin impairments on the resident's feet and/or heels. Resident 1's skin evaluation, dated 01/20/2025, showed the resident's left heel was reddened with a 6.0 centimeters (cm) by 2.0 cm scabbed area. Resident 1's physician order, dated 01/26/2025, showed an order for staff to monitor bilateral heel wounds and apply dressings every Tuesday, Thursday and Friday. Resident 1's medical provider notes, from date of service of 01/27/2025, showed resident was seen by an Advanced Registered Nurse Practitioner (ARNP) and Resident 1's skin was noted to be warm, dry, pink, intact other than rash to the posterior of the left lower extremity and it was healing and no drainage on sheet noted. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident 1's progress notes, dated 01/28/2025, documented a nursing assistant had noticed a small amount of blood on Resident 1's right heel and the skin looked pulled back, when nurse went to assess she noted an area around the resident's right heel wound that looked macerated (skin condition that occurs when skin softens and breaks down due to prolonged exposure to moisture) as if resident had been picking at it and they had pulled back a large layer of skin, presenting as a 5x4 area of skin tear. Resident was placed on alert and their care plan was updated. The progress note documented the resident would sit cross legged/duck style and lean their upper body over the lower body thereby applying pressure to the heels and was encouraged to reposition and staff placed pillows to help with pressure relief. Review of the EHR showed the following: On 01/29/2025, there were no notes found regarding Resident 1's feet. On 01/30/2025 at 1:24 AM, a note was made showing, dressings to feet are intact, foam booties in place. On 01/31/2025, there were no notes found regarding Resident 1's feet. The three times a week dressing changes on the January 2025 Treatment Administration Record (TAR) were checked off as having been completed throughout January. On 02/01/2025 at 1:37 AM, a note was made showing, dressings to feet are intact, foam booties in place. Resident 1's care plan, revised 02/02/2025, showed the resident had a pressure area on left foot at the lateral aspect (outside edge) of the 5th toe (pinky toe) with a goal the pressure ulcer would show signs of healing and remain free from infection. The care plan showed an intervention of assess/record/monitor wound healing weekly and prn [as needed] and measure length, width, and depth where possible, assess and document status of wound perimeter, wound bed and healing progress and report improvement and declines to the Medical Doctor (MD). The care plan showed the resident had a skin tear on the right heel, with a goal the skin tear would heal with no s/s [signs and symptoms] of infection and interventions to monitor/document location, size and treatment of skin tear, report abnormalities, failure to heal, signs and symptoms of infection, maceration to MD. On 02/02/2025 and 02/03/2025, there were no notes found regarding Resident 1's feet. The next formally documented skin evaluation (last was 01/20/2024), dated 02/04/2025, showed the bottom of the resident's right heel with a skin tear 5 x 4 and ongoing treatment of the resident's left heel that showed it was reddened with a 6.0 cm x 2.0 cm scabbed area. A physician order dated 02/05/2025, showed an order for wound consultant to evaluate and treat as indicated and a dressing to the right heel to be changed daily. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident 1's progress notes, dated 02/05/2025, showed new orders were received for wound consultant to evaluate and treat. The note showed the LN [licensed nurse] asked the wound team consultant to look at the wound and wanted the resident to be on their rounds the next week. The wound consult was submitted and new treatment orders were received from the provider for cleansing and dressing daily. Review of Resident 1's progress notes, dated 02/06/2025 through 02/10/2025, showed no documentation of assessment or monitoring of Resident 1's skin which was ordered for daily monitoring and dressing changes during this time. Resident 1's wound consultant report, dated 02/11/2025, showed an assessment of large ulcers to the resident's bilateral feet with maceration and erythema (redness of the skin) with a concern for underlying osteomyelitis (infection in the bone), risk of amputation and the resident needed to be sent to the ED [emergency department] for evaluation. Resident 1's hospital records, with date of admission as 02/11/2025, showed when the resident presented to the hospital emergency room where the medical provider's assessment showed chronic, very foul-smelling decubitus (damage to an area of the skin caused by constant pressure on the area for a long time) ulcerations (open wounds) in the bilateral calcaneal (heel bone) areas. Resident 1's hospital records showed a podiatrist (medical doctor that specializes in feet and lower leg issues) consult, dated 02/12/2025, documented decubitus ulcer of heel bilateral, a right heel 6.0 x 6.0 centimeters (cm) full-thickness ulceration with necrotic tissue (dead tissue) with purulence (presence of pus) with the ability to probe deep to the bone, a left lateral heel with 4.0 cm x 4.0 cm area of necrotic purulent tissue with inability to probe deep to bone and a full thickness ulceration about the plantar left fifth metatarsal head (the long bone on the outside of the foot) with inability to probe deep to bone. The consult showed the right side with necrotic infected tissue and the left side had significant necrotic infected tissue loss. The consult showed the podiatrist did not think the right lower extremity was salvageable and they hoped the left lower extremity could be salvaged with aggressive tissue debridement (removal of damaged tissue from a wound), and long term intravenous (medication administered in the vein) antibiotic (medication for infection) therapy. On 02/20/2025, the hospital record showed the resident had a right BKA [below the knee amputation] on 02/19/2025 and received intravenous antibiotics. On 02/12/2025 at 12:03 PM, Staff A, Registered Nurse (RN)/Staff Nurse, said they worked the day shift, three days on and then three days off on a rotating schedule with Staff D, Licensed Practical Nurse (LPN)/Staff Nurse and were assigned to Resident 1. Staff A said Resident 1 would sit up in bed on their legs. Staff A said they reported it to the medical provider on 01/26/2025 when they found the resident's right heel with blood on it, and it had appeared that the resident had peeled the skin off the heel. Staff A said the left heel had scabs on it and it looked like it was forming a deep tissue injury (a type of pressure injury that occurs when prolonged pressure damages the underlying soft tissues). Staff A said the medical provider said to put pillows under the resident's legs so the resident could not sit on their legs and the medical provider was aware staff had asked the wound consultant to see the resident. Staff A said the wounds on both heels were soaking through the dressings. Staff A said after 01/27/2025, the wounds on both heels got worse and were deep tissue wounds and the previous week (week of 02/03/2025) both heels were draining and open wounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 02/12/2025 at 12:49 PM, Staff B, Unit Manager/LPN, said they would expect to see a wound assessment when wounds were discovered on a resident. Staff B said they had obtained the physician order for the wound consultant to see Resident 1 on 02/05/2025, for the wound on the right heel. Staff B said they were not aware the wounds had escalated and thought the wound consultant and/or Staff C would see the Resident, I thought the resident was on the weekly caseload with the wound consultant. On 02/12/2025 at 1:54 PM, Staff C, Unit Manager/RN, said they were assigned to accompany the wound consultants when they rounded on residents. Staff C said Resident 1 had a pressure wound on their left lateral foot that the wound consultants had resolved back in December of 2024. Staff C said they knew nothing about wounds on Resident 1's feet until the previous week (week of 02/03/2025) so they had mentioned to the wound consultant they needed to see the resident. Staff C said Resident 1 had COVID (had tested positive 01/24/2025) and the wound consultants would not see residents when they were on isolation. Staff C said they did not know Resident 1 had new wounds and did not assess the wounds until 02/11/2025 with the wound consultant. Staff C stated, I didn't now he had new wounds. I never saw them until yesterday. I did not go and assess; I had no idea they looked that bad. If I would have known, I didn't know it was to that extent. On 02/21/2025 at 11:04 AM, Staff D, said they were assigned to Resident 1 approximately three days per week and were very familiar with the resident's care. Staff D said they were completing dressing changes to the resident's left and right heel three times per week and then the right heel dressing was changed to daily on 02/05/2025. Staff D said on 02/04/2025, they were concerned that the resident's heels were getting worse. Staff D said they were darker in color with drainage and becoming larger in size. Staff D said that was why on 02/04/2025 they stopped the wound consultant in the hallway to ensure they had Resident 1 on their list to see. Staff D said the wound consultant confirmed they would see the resident the following week. Staff D acknowledged their only documentation of the wounds was signing the treatment administration record when they completed the dressing changes. On 02/21/2025 at 2:39 PM, Staff E, Director of Nursing Services/RN said Resident 1's skin assessments and documentation had not captured the resident's skin condition, stating, there were inaccuracies. Staff E said the nursing staff had not communicated the condition of Resident 1's wounds effectively to the interdisciplinary team to help the resident in a timely manner. WAC Reference 388-97-1060 (3)(b)