STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505254	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roo Lan Health & Rehab	1505 Carpenter Road SE Lacey, WA 98503

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 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** 49451 Based on observation, interview and record review, the facility failed to ensure adequate care and services were provided to promote wound healing and prevent pressure ulcers from developing or worsening by implementing and following care interventions timely for 4 of 7 sampled residents (Residents 1, 2, 5 and 6) reviewed for pressure ulcers. Resident 1 experienced harm when the resident's skin was not assessed, and they developed an unstageable pressure ulcer to the left heel with no treatment initiated for 12 days. These failures placed residents at risk for worsening pressure ulcers, infection, medical complications and diminished quality of life. Findings included . <Facility Policy> Review of the facility policy, titled, Skin Assessment, undated showed a full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury. The policy showed documentation of the skin assessment would show the type of wound, describing the wound's measurements, color, type of tissue in the wound bed, and presence of drainage, odor and pain. <Resident 1> Resident 1 was admitted to the facility on [DATE] with diagnoses including palliative care (specialized medical care for people living with serious illness), dementia, malnutrition and a pressure ulcer to the sacrum (pelvis area). The admission Minimum Data Set (MDS), an assessment tool, dated 12/09/2024, documented Resident 1 was cognitively impaired, had impairment to their upper and lower extremities and was frequently incontinent of bladder and bowel. The Admission Assessment, dated 12/04/2024, showed coccyx [tailbone] pressure. The assessment did not indicate the size or description of the pressure injury/wound. A Skin Assessment, dated 12/06/2024, documented a deep tissue injury (DTI/damage is below the skin's surface, the extend of damage is unknown, these injuries are often caused by sustained pressure or trauma) to the sacral/coccyx with description of deep purple red. (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 0686 Level of Harm - Actual harm Residents Affected - Few	Resident 1's medical record showed no skin assessments were documented from 12/07/2024-01/15/2025 (39 days). Review of hospice documentation, dated 01/15/2025, noted the following: -Sacrum initial assessment 12/02/2024, pressure injury, Stage 3. -Bilateral Buttocks Stage 2 wounds -Left heel Stage 2, scabbed heel, apply betadine (antiseptic) and leave open to the air and float heels. New pressure injury noted. Reviewed skin care and updated skin care orders for nursing. An Administration note, dated 01/18/2025, documented blue boots to relieve pressure to bilateral heels. On at all times while in bed. Resident 1's Skin Assessment, dated 01/24/2025, documented an unstageable pressure injury to the sacrum which measured 2 centimeters (cm) length x 2 cm width x 2 cm depth. Resident 1's Electronic Medication Administration Record (EMAR) dated 01/2025 showed a Physician's order, dated 01/27/2025, for betadine [used to dry out the wound] to the left heel and to leave open to the air. Hospice noted a pressure injury to the left heel on 01/15/2025 and no treatment was initiated until 01/27/2025 (12 days later). On 02/03/2025 at 1:21 PM, Resident 1 was observed lying in bed on his right side. The resident did not have protective boots on his feet at the time. The boots were observed on the floor beside the bed. On 02/03/2025 at 2:30 PM, Resident 1's room was observed with Staff C, Licensed Practical Nurse (LPN). The resident did not have protective boots on his feet at the time. Resident 1's left heel was observed with as an unstageable pressure ulcer. Staff C applied the heel protector boots to Resident 1's feet. On 02/04/2025 at 9:35 AM, Resident 1 was observed sleeping in bed. The resident did not have protective boots on his feet at that time. Resident 1 was observed lying on his right side. Resident 1's heels were not floated on pillows. At 10:24 AM, Resident 1 was observed sleeping in bed. The resident did not have protective boots on his feet at the time. Resident 1 was lying on his right side. Resident 1's heels were not floated on pillows. <Resident 2> Resident 2 was admitted to the facility on [DATE] with diagnoses including paraplegia (partial or complete paralysis of the lower half of the body with involvement of both legs) and fracture to the right femur. The admission MDS, dated [DATE], documented Resident 2 was cognitively intact, had impairment to bilateral lower extremities. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident 2's care plan, dated 11/14/2024, showed a stage 2 pressure injury (wound caused by pressure that has broken through the top layer of the skin and part of the layer below) to the coccyx. Interventions included to monitor and document location, size and treatment of skin injury. Weekly treatment documentation to include measurement of each area of skin breakdowns and width, length, depth, type of tissue and exudate (drainage). Review of a provider note, dated 11/24/2024, documented to use enabler bars and air mattresses and refer to wound consultant if worsens. Review of Resident 2 skin assessments showed the following: Skin assessment, dated 11/14/2024, showed a Stage 2 pressure ulcer to the spine 1.5 cm length x 0.6 cm width. Skin assessment, dated 11/21/2024, showed a Stage 2 pressure ulcer to the spine 1.7 cm x 0.2 cm. Skin assessment, dated 11/27/2024, showed a Stage 2 pressure ulcer measured 0.3 width x 6.1 cm length. No skin assessments documented from 11/28/2024-12/16/2024 (18 days). Skin assessment, dated 12/17/2024, showed a Stage 1 wound on sacrum. There was no description or measurement of wound. No skin assessments documented from 12/18/24 - 01/07/2025 (21 days). On 01/03/2025 at 12:54 PM, during a telephone interview Resident 2 said she had been a paraplegic for [AGE] years and the facility was supposed to supply an air mattress, and the resident said she did not have one yet. On 01/06/2025 at 1:45 PM, observation of Resident 2's pressure ulcer with Staff C, showed an intact dressing, dated 01/05/2024, and with a pressure ulcer to the left buttocks with slough (dying cells/debris that hinders wound healing and can increase risk of infection) in the wound bed. Staff C acknowledged she was not aware of what stage the resident's pressure ulcer was and there was not an air mattress on Resident 2's bed at that time. Skin assessment, dated 01/08/2025, showed a Stage 2 pressure ulcer to the spine and measured 0.9 cm length x 0.6 width x 0.3 depth. Review of a Wound Consultant's assessment, dated 01/08/2025, showed a healing Stage 3 pressure ulcer (wound under second layer of skin and into the fat tissue) that measured 0.9 x 0.5 x 0.3. Wound debridement (removal of dead or infected tissue to promote healing) was completed. Review of a Physician's Order dated 01/10/2025 (59 days after admission to the facility) documented, Wound # 3 sacrum pressure with treatment recommendations. -Cleanse wound vigorously to patient tolerance with house wound cleanser and gauze (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Treat periwound with emollient to dry skin areas daily. -Pack with calcium alginate (wound dressing) -Cover with bordered dressing -Change: Every other day and as needed for accidental removal, saturation and/or soiling. <Resident 5> Resident 5 was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction (blood flow to brain was interrupted, causing brain cells to die), Hemiplegia and Hemiparesis (muscle weakness or partial paralysis to one side of the body), Chronic Pain and Failure to Thrive. The Significant Change MDS, dated [DATE], documented Resident 5 was cognitively intact, was at risk for developing pressure ulcers and was frequently incontinent of bladder and bowel. Resident 5's Care Plan, revised 11/29/2024, showed the resident was at risk for pressure injury and had a lesion to the spine which was resolved. No skin assessments documented from 11/29/2024 - 01/01/2025 (34 days). Skin assessments, dated 01/06/2025 - 01/13/2025 showed a healing scar to the vertebrae. Skin assessments, dated 01/21/2025, showed a skin tear to the upper back. On 01/23/2025 at 1:09 PM, observation of Resident 5's wound on her back with Staff F, Certified Nursing Assistant (CNA), and Staff G, Registered Nurse (RN), showed a dressing covered the wound. Staff G, RN, said the wound was from a skin tear. Staff F, CNA, said the wound was from a few weeks prior from tucking a sling under the resident and a fingernail snagged her back. The resident's wound had drainage on the dressing and the site appeared to be reddened. On 01/29/2025 at 10:15 AM, observation of Resident 5's wound with Staff E, LPN showed an undated wound dressing was intact to the resident's spine. Staff E removed the dressing and noted a small wound with yellow slough to the wound bed. Staff C, RCM, said she was unsure if there were orders for Resident 5's wound and would review the orders and notify the provider. Staff C said the wound measured 0.6 cm width x 1 cm length. Review of wound consultation documentation and subsequent physicians order, dated 01/29/2025 after discussion with Staff C, showed Resident 5 had an unstageable pressure ulcer to the thoracic spine that measured 0.9 cm by 0.7 cm by 0 cm with orders to clean the wound with wound cleanser, apply Medi honey (a wound treatment) to wound base and apply a bordered dressing every other day. On 01/29/2025 at 10:50 AM, Staff C, RCM, acknowledged there were incomplete skin assessments for Resident 5 in December 2024 and skin assessments were to be completed weekly. Staff C said she was notified yesterday that the wound had opened up again and there were no current treatment orders for this wound. <Resident 6> (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident 6 was admitted to the facility on [DATE] with diagnoses including Cerebral Palsy (group of neurological disorders that appear in early life and permanently affect body movement and muscle coordination) and Polyneuropathy (peripheral nerve disorder). The Quarterly MDS, dated [DATE], documented Resident 6 was at risk for developing pressure ulcers and was frequently incontinent of bladder and bowel. Resident 6's Admission Assessment, dated 09/10/2024, showed a skin tear to the groin, and MASD to the sacrum. Resident 6's care plan, dated 09/10/2024, showed the resident had an alteration in skin integrity related to skin tears to the testicles and a closed blister to the right buttocks. Resident 6's progress note, dated 01/16/2025, showed the resident was discharged from the facility. Resident 6's record showed no skin assessments were completed after the initial assessment throughout the resident's admission (128 days). On 02/06/2025 at 3:15 PM Staff B, Director of Nursing and Registered Nurse, acknowledged skin assessments were not completed weekly for Residents 1, 2, 5 and 6 and should have been completed weekly by nursing. Staff B said the facility did have a wound nurse that was coming into the facility to assess wounds and also worked remotely. The wound nurse stopped working at the facility in December 2024 and skin assessments were not being completed after that time. Staff B acknowledged Resident 1 developed second pressure ulcer after admission, skin assessments were not completed weekly and there was a delay in treatment of the pressure ulcer for Resident 1. Reference WAC 388-97-1060 (3)(b)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49451 Based on observation, interview and record review, the facility failed to assess gastrostomy tube (surgically placed tube through the abdominal wall into the stomach to provide nutrition) placement prior to initiating an enteral feeding (feeding through tube) and failed to follow the prescribed orders for hydration for 1 of 2 residents (Resident 7) reviewed for tube feeding management. This failure placed residents at risk for alteration in nutrition and decreased quality of life. Findings included . Review of the facility policy, titled, Verifying Placement of Feeding Tube, undated, showed before beginning a feeding, flushing the tube, or administering a medication via the feeding tube, proper placement and functioning will be verified. The policy then went on to describe the various methods of confirming proper placement. <Resident 7> Resident 7 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (serious condition that occurs when blood flow to the brain is disrupted), hemiplegia (muscle weakness or partial paralysis on one side of the body), dysphagia (swallowing difficulties) and severe protein malnutrition. The Admission Minimum Data Set, an assessment tool, dated 12/09/2024, documented Resident 7 had a feeding tube on admission to the facility. Resident 7's admission summary, dated 12/05/2024, showed a gastrostomy tube to the resident's mid abdomen was in place. A physician's order, dated 12/26/2024, showed enteral feeding every six hours related to dysphagia following cerebral infarction. Bolus (large amount at once) Iso source 1.5, give 250 milliliters (ml) via G-tube (gastrostomy tube) every six hours. Flush with 100 ml of water before and after feeding. On 01/21/2025 at 12:30 PM, Staff E, Licensed Practical Nurse was observed completing the enteral feeding for Resident 7 in the resident's room. Staff E did not check for placement of the gastrostomy tube prior to instilling 50 ml of water into the tube. Staff E instilled 250 ml of the prescribed enteral feeding through the gastrostomy tube. Staff E flushed the tube with 50 mls of water after the enteral feeding was completed. At 12:45 PM, Staff E acknowledged she did not check the position or placement of the gastrostomy tube prior to the enteral feeding for Resident 7 and acknowledged she flushed the gastrostomy tube with 50 mls of water and not the prescribed 100 mls of water. Reference WAC 388-97-1060 (3)(f)