STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505255	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Othello Nursing & Rehab	495 North Thirteenth Street Othello, WA 99344

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 0687 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38527 Based on interview and record review, the facility failed to ensure a physician ordered foot care referral for a podiatrist was followed up on, and a change in foot wound condition was reported to the medical provider for 1 of 3 sampled residents (Resident 1), reviewed for wound care. Resident 1 experienced harm when they required additional surgery and amputations to their foot. These failures constituted Past Non-Compliance (the facility was not in compliance at the time the situations occurred; however, there was sufficient evidence that the facility corrected the non-compliance after they were identified) at harm level. The facility immediately implemented and completed a plan of correction which was verified by surveyors. The plan of correction included a review of the previous 72 hours of progress notes to identify any residents with a change of condition and reporting any identified changes to the medical provider, a skin sweep of the entire facility resident population to ensure wounds were accurately documented and appropriate referrals and/or wound care orders were implemented, education to licensed nurses on completion of skin and wound assessments and reporting changes of condition to the appropriate medical provider, and audits to ensure solutions were sustained. Findings included . Review of the facility policy titled, Documentation-Skin Conditions, dated 02/24/2024 showed licensed nurses would perform weekly skin and wound assessments, identified skin conditions would be referred to the wound consultant if available, staff would document the wound assessments including measurements and recommendations for treatment, and assessments would be communicated to the medical provider. Review of the admission assessment dated [DATE] showed Resident 1 admitted with diabetic foot ulcers (one to the left heel and one to the left 5th toe) which required dressing changes from staff, was mildly cognitively impaired, and rejected care one to three days of the assessment period. Review of the 03/11/2024 Skilled Nursing Facility Transfer Orders showed Resident 1 was to have follow-up appointments with wound care, vascular surgery, and podiatry. The facility was to follow the recommendations of the wound team for treatment of their diabetic foot wounds. (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 0687 Level of Harm - Actual harm Residents Affected - Few	Review of a wound care provider note dated 03/18/2024 showed Resident 1's foot wounds were measured, biofilm (a slimy layer of microorganisms) over the wound was removed, and a wound culture (laboratory test to diagnose and treat bacterial infections) was performed. Per the note, the resident had last been seen by a podiatrist prior to their admission to the facility and a follow-up with podiatry was recommended. No additional wound care provider notes were found in the resident's record after 03/18/2024. Review of the March 2024 Medication Administration Record showed the resident received an antibiotic from 03/21/2024 to 03/31/2024 due to a positive wound culture. Review of a facility Weekly Skin Evaluation form dated 04/01/2024 showed the resident's foot wounds were measured again and the left toe wound had increased in size and had black/dead tissue covering the wound. Per the form, the physician was not notified of the change. No additional evaluations of the resident's wounds were found in the resident's record after 04/01/2024. Review of the March and April 2024 progress notes showed Resident 1's follow-up appointment with their vascular surgeon was rescheduled from 03/25/2024 to 05/06/2024. No documentation related to a podiatry follow-up was found in the progress notes. Additionally, the notes showed no notification to the wound care team, the vascular surgeon, and/or a podiatrist about the decline in the resident's wound on or after 04/01/2024. Per the progress notes the resident was hospitalized on [DATE] related to significant changes to the resident's left toe wound and a decrease in blood flow to the foot. Review of the hospital records dated 04/11/2024 showed the resident admitted to the hospital with sepsis (a potentially life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs) and gangrene to the left foot. Per the hospital record, the resident required intensive monitoring, intravenous antibiotics, and additional surgeries to treat their condition. In an interview on 04/25/2024 at 12:57 PM, Staff B, Podiatrist, stated Resident 1 was not referred to their services while the resident was in the facility. Staff B stated their last scheduled visit in the facility was prior to the resident's admission, and they did not do emergency appointments, so the facility would have needed to schedule the resident with a local podiatrist, per their admission orders. In an interview at 1:31 PM the same day, Staff C, Registered Nurse (RN), confirmed Resident 1 was not seen by the wound care provider one to two weeks after their appointment on 03/18/2024, as recommended. Staff C stated they were not aware if a provider was notified of the decline to the resident's wound identified on 04/01/2024. In an interview at 2:08 PM, Staff D, RN, stated Resident 1 was cooperative with wound care and was anxious about the healing of their wounds. Staff D stated they assessed the resident's wound on 04/01/2024 and noted the wound was larger and had darker tissue in the wound bed after they were no longer receiving antibiotics, which should have been reported. Staff D stated they did not know if the resident had any follow-up appointments with wound care, vascular surgery, and/or a podiatrist. (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	In an interview at 2:25 PM, a representative for Resident 1 stated after the resident was transferred to the hospital on 04/10/2024, they required two surgeries and amputation of a portion of the left foot due to the infection (gangrene). Per the representative, the resident had just transferred out of the hospital and was still suffering from post-operative delirium (a state of serious confusion, disorientation and inattention that may result in hallucinations, delusions, difficulty communicating and/or understanding of what is occurring). In an interview on 04/25/2024 at 4:08 PM, Staff A, Director of Nursing, stated when a resident completed an antibiotic, they should be evaluated to determine if it was effective. Staff A stated they reviewed Resident 1's medical record on 04/01/2024 and did not see any notes that would indicate the antibiotic was not effective as Staff D's assessment of the wound was completed later in the day. Staff A stated they were unaware of the order to refer the resident to podiatry upon admission and did not have additional information regarding notification of a medical provider of the decline to the resident's wound. At 5:04 PM the same day, Staff A stated the facility had completed an investigation after Resident 1's hospital admission on 04/10/2024 and identified failures related to documentation of wound care, completion and documentation of routine wound assessments, notification of changes in resident conditions to the medical provider, and follow-up with ordered referrals. Staff A stated the facility had implemented a plan of correction that included a review of the previous 72 hours of progress notes to identify any residents with a change of condition and reporting any identified changes to the medical provider, a skin sweep of the entire facility resident population to ensure wounds were accurately documented and appropriate referrals and/or wound care orders were implemented, education to licensed nurses on completion of skin and wound assessments and reporting changes of condition to the appropriate medical provider, and audits to ensure solutions were sustained. This was Past Non-Compliance at harm level and is no longer outstanding. The deficiency was corrected on 04/22/2024. Reference WAC 388-97 -1060 (3)(j)(viii)