STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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** 44296 Based on interview and record review the facility failed to implement interventions to protect resident's skin from injury, accurately identify, assess, document, and report changes in skin integrity for 1 of 3 residents (Resident 1) reviewed for Pressure Ulcer/Pressure Injury (PU/PI). Resident 1 experienced harm when they developed five new PU/PIs and pain. This failed practice placed residents at risk for skin injuries, PUs/PIs, and diminished quality of life. Findings included . The National Institutes of Health (NIH) website showed a Pressure Injury (PI) was localized damage to the skin and underlying soft tissues usually over a bony prominence or related to a medical or other device. The injury could present as intact skin or an open ulcer and may be painful. The injury occurred from intense and/or prolonged pressure or pressure in combination with friction or shearing of skin tissues. The NIH website showed it was essential to use the intended staging or classification system for each type of injury to ensure appropriate treatment. Stage 1 PI: intact skin with a localized area of non-blanching tissue, redness that does not disappear when pressure is applied to the area. Stage 2 PI: partial thickness loss of skin with exposed middle layers of skin. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Stage 3 PI: full thickness skin loss that extends below the top and middle layers of skin in which fat or connective tissue is visible in the ulcer. Stage 4 PI: full thickness skin and tissue loss with exposed connective tissue, muscle, tendon, ligament, and bone is visible in the ulcer. Unstageable PI: full thickness skin and tissue loss in which the extent of the tissue damage within the ulcer cannot be confirmed because the deepest part of the ulcer is obscured by dead skin or tissue. Deep Tissue PI (DTPI): intact or nonintact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration, or separation of multiple skin layers reveling a dark wound bed or blood filled blister (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	Review of the facility policy titles Pressure Ulcers (PU) and Skin Breakdown, dated April 2018, showed nursing staff would recognize, assess, and document a resident's significant risk factors for developing PUs. The nurse staff would describe and document a full assessment of the PU including the stage, size, drainage and presence of dead tissue, pain assessment, mobility status, diagnoses, support surfaces, and skin treatments. The physician would assist staff to identify cause, evaluate, and provide treatment for PUs. The policy showed monitoring and care planning would occur for PUs. Review of a 07/17/2024 PU risk assessment showed Resident 1 had very limited sensory perception, risk for moist skin, was bedfast, had very limited mobility, had inadequate nutrition, and was at risk for skin friction and shearing injuries (layers of skin move in opposite directions and damage is caused to the deep skin tissues). Resident 1 was assessed at high risk of developing PU/PIs. The 07/22/2024 Admission Minimum Data Set (MDS, an assessment tool) showed Resident 1 was admitted to the facility on [DATE] for rehabilitation with diagnoses including a brain disorder, dementia, neurological disorder, mobility disorder, obesity, and diabetes. Resident 1 was assessed to be dependent on staff for all personal care and required two staff for all mobility. The MDS showed Resident 1 weighed over 200 pounds, was assessed at risk of developing PU/PIs, and did not have any PU/PIs on admission. The 07/26/2024 Care Area Assessment (CAA, a tool used to create the resident care plan) showed Resident 1 had risk factors leading to increased risk of developing PU/PIs, including incontinence of bowel, use of a urinary catheter, altered mental status, cognitive loss, and poor nutrition. The CAA showed Resident 1 required a special mattress and wheelchair seat cushion to relieve pressure to skin, total staff assistance for transfer out of bed, rolling in bed, repositioning in bed, sitting and lying in bed, good skin hygiene, weekly skin checks by the nurse, protective skin protocol, protection to heels, and treatments to the heels to prevent PU/PIs. The 07/20/2024 Care Plan (CP) showed Resident 1 had actual impairment to their skin with left heel redness. The CP showed the goal was to maintain Resident 1's skin integrity with interventions of offloading pressure from the heels while in bed and wheelchair, weekly skin assessments, and report new skin impairments. The CP showed two staff were required to turn and reposition Resident 1 every two hours while in bed and in wheelchair, used a mechanical lift for transfers, used a tilt in space wheelchair due to Resident 1's inability to independently shift their weight. There were no interventions shown on Resident 1's CP how to prevent friction and shearing of Resident 1's skin, as assessed on the PU risk assessment. Review of Resident 1's weekly nurse skin assessments showed they were completed on 07/17/2024, 07/23/2024 and 07/30/2024. Even though Resident 1 was assessed to have left heel redness on the 07/20/2024 CP, the skin assessments showed Resident 1 had no skin impairments. A review of the 07/2024 nursing assistant's documentation of care from 07/17/2024 to 07/31/2024 showed bed mobility was provided by one staff person on 11 shifts, when the MDS showed Resident 1 was assessed to require two staff to assist with bed mobility. The nursing assistant documentation showed seven shifts were left blank with incomplete documentation for staff assistance provided with bed mobility. There was no documentation by staff on 07/30/2024 night shift (the shift before the PU/PI was discovered) that bed mobility assistance was provided to Resident 1. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the 07/31/2024 discharge nursing progress note showed no documentation of the Resident 1's medical condition on discharge, no documentation of any impaired skin issues, no documentation of communication with the physician, Resident 1's Representative (RR), or the provider of the community home where Resident 1 was discharged . The last nursing progress note in the record was dated 07/30/2024 at 3:29 PM. Review of the 08/02/2024 nurse assessment, completed at the community home where Resident 1 was discharged , showed Resident 1 was admitted on [DATE] with a right side coccyx PU/PI which measured 6 centimeters (cm) wide by 6 cm long, and had dry, firm, black, dead tissue that measured 3 cm by 4 cm, the surrounding skin around the PU/PI was pink/red, the PU/PI had a foul odor, red bloody drainage, and was classified as an unstageable PU/PI. The assessment showed a second PU/PI on the left side buttock which measured 3 cm by 2 cm and classified as a stage two PU/PI. The assessment showed a third PU/PI on the left outer ankle measuring 1 cm by 0.5 cm and classified as a stage two PU/PI. A fourth PU/PI on the left heel measuring 2 cm by 2 cm, was not staged by the nurse assessor. A fifth PU/PI on the right heel described as a black dry scab measured 4 cm by 3.5 cm, was not staged by the nurse assessor. Review of the 08/03/2024 home health nurse progress notes showed the wound specialist determined both heels were classified as DTPIs and the sacrum was an unstageable PU/PI. The wound care specialist notes showed the heel DTPIs would require surgical removal of dead tissues and a long time to heal. The progress note showed Resident 1 had a level eight out of ten pain demonstrated through guarding, immobility, anxiety, and resistant behaviors. The progress note showed Resident 1's pain effected their sleep and day-to-day activities. Review of the 08/06/2024 Nurse Practitioner history and physical assessment showed diagnoses including an unstageable DTPI to the right buttock, stage two or three PU/PI on right buttock, and DTPIs to both heels present on admission to the community home. The document showed the PU/PIs and DTPIs were several days old, present on admission to the community home, and developed at the skilled nursing facility. In an interview on 08/22/2024 at 8:46 AM, a Collateral Contact (CC) stated Resident 1 arrived at the community home on 07/31/2024 around lunch time. The CC stated Resident 1 had a large bandage on their buttocks that was clean and intact. The CC stated the community nurse assessor saw Resident 1 in the facility the week prior to discharge and there were no skin issues. The CC stated the skilled nursing facility did not inform the CC of any skin injuries. The CC stated they were told by the RR that Resident 1 had a wound on their buttocks found by the nurse on 07/31/2024 befroe discharge, the facility sent dressing supplies, and arranged a home health nurse to do wound care. The CC stated when a skin check was completed at admission to the community home, two large black PU/PIs were discovered on Resident 1's buttocks and dark purple PU/PIs were found on both heels. The CC stated the facility did not inform the RR or the CC about the severity of the two buttock PU/PIs, the two heel PU/PIs, or the ankle PU/PI. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 08/22/2024 at 10:38 AM, Staff A (Director of Nursing) stated Resident 1's PU/PIs on the buttocks were identified on the day of discharge, 07/31/2024. Staff A reviewed Resident 1's CP and stated the CP did not identify the individualized risk factors for PU/PIs or DTPIs. Staff A stated the CP did not have specific interventions to protect Resident 1's skin from friction and sheer type DTPIs. Staff A stated the PU/PIs should have been, and were not, assessed for cause of injury. Staff A stated the nursing staff should have, but did not, accurately identify, assess, and document Resident 1's PU in the medical record. Staff A stated the nursing staff should have, but did not, document the notification of Resident 1's PU/PIs to the practitioner and the RR. Staff A stated the facility systems to maintain skin integrity, prevent PU/PIs and DTPIs, identify, assess, and report PU/PIs needed improvement. REFERENCE: WAC 388-97-1060(3)(b).