STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505289	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birch Creek Post Acute & Rehabilitation	5601 S Orchard Street Tacoma, WA 98409

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46244 Based on interview and record review, the facility failed to identify, report to administrator and investigate an allegation of neglect for 1 of 3 sampled residents (Resident 1) reviewed for abuse and neglect. Failure to report alleged abuse and neglect placed the residents at risk for unidentified abuse, mistreatment, and a diminished quality of life. Findings included . Facility policy, Abuse Investigation and Reporting, dated 10/01/2001, documented all reports of abuse or neglect would be reported and thoroughly nvestigatigated by facility management. Resident 1 was admitted to the facility on [DATE] with multiple diagnoses to include a sacral pressure injury (bedsore on tailbone) and osteomyelitis (bone infection) of the sacrococcygeal region (portion of spine between lower back and tailbone). During an interview on 6/12/2024 at 11:34 AM, Collateral Contact 1 (CC 1) stated that on 2/10/2024, Resident 1 was found in bed with urine-soaked briefs and bedsheets. CC-1 indicated concern that Resident 1 had been lying in a wet bed overlong. CC 1 said they took a photo and carried it to the nurse in charge. On 06/18/2024 at 2:15 PM, Staff C, Registered Nurse (RN) and Nursing Supervisor, stated that on 2/10/2024 CC-1 had shown a photograph taken of Resident 1 lying in wet bed. Staff C said CC1 was very upset but did not allege neglect. Staff C said CC 1 just seemed to want help changing Resident 1 so Staff C immediately changed Resident 1's briefs and bedding. Staff C stated that Resident 1 frequently urinated and it did not appear to be old, dried urine. Review of facility incident logs for 2024 showed there were no reports of CC 1 finding Resident 1 in urine-soaked briefs and bedding. During an interview on 06/24/2024 at 1:27 PM, Staff B, RN, Director of Nursing Services (DNS), stated they were not aware of any report or investigations involving CC 1's complaint that Resident 1 was lying in wet briefs and bedding. Staff B indicated that this complaint should have been identified as an allegation of neglect and the staff should report to the DNS, administrator and State Agency and begin the investigation when there was an allegation. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-0640(6)(c)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40226 Based on observation, interviews and record review, facility failed to provide care and treatment according to professional standards to prevent development or deterioration of pressure injuries for 2 of 5 residents (Residents 1 & 2) reviewed for pressure injury prevention when it did not develop, revise and implement individualized care planned interventions for incontinence care, positioning and behaviors. This failure placed residents at risk for new or worsening pressure injuries and a diminished quality of life. Findings included . The 2019 National Pressure Injury Advisory Panel (NPIAP) guidance, Prevention and Treatment of Pressure Ulcers/Injuries: Quick Reference Guide, documented wounds should be protected from contamination by urine by cleansing the skin promptly after each episode of incontinence. Facility Policy, Pressure Injury Prevention and Management, dated 10/01/2021, documented that a resident-centered (individualized) care plan would be developed and implemented by the interdisciplinary team including provider, nurse, nursing assistant, and dietary/nutritional representative to address the resident's risk for development of a pressure injury and promote healing if the resident had an existing injury. The Policy stated that interventions to promote healing the pressure injury and prevent deterioration will be incorporated into the care plan. The Policy noted preventive measures included assistance with turning and repositioning and incontinence care. < Resident 1 > Resident 1 was admitted to the facility on [DATE] with multiple diagnoses to include a sacral pressure injury (bedsore on tailbone), osteomyelitis (bone infection) of the sacrococcygeal region (portion of spine between lower back and tailbone), kidney failure, severe protein calorie malnutrition and adult failure to thrive. Minimum Data Set (MDS), an assessment, dated 11/25/2023, documented Resident 1 was always incontinent of bowel and bladder, needed substantial to maximal assistance rolling from side to side and was dependent on staff assistance with activities of daily living. Admission Nursing Assessment, dated 11/20/2023, documented Resident 1 was admitted with a pressure injury of the coccyx (tailbone). Bladder Incontinence Care Plan, initiated 11/20/2023, documented the goal was to prevent complications to skin due to incontinence and brief use. The interventions included that Resident 1's incontinence briefs should be checked and changed frequently with cleansing after each episode. An individualized plan for Resident 1's incontinence episodes was not identified. The Care Plan did not indicate the expected frequency for this care or who was responsible for these actions for Resident 1. Skin Integrity Care Plan, initiated 11/29/2023, documented the goal for Resident 1 was to prevent complications of the pressure wound at the coccyx and promote healing. The Care Plan did not identify turning and repositioning Resident 1 as an intervention to prevent prolonged pressure to vulnerable areas. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wound Care Provider Note, dated 2/08/2024, documented the wound at Resident 1's coccyx was healing but had delayed wound closure complicated by risk factors of multiple medical conditions. Wound Provider recommended repositioning and offloading Resident 1. Resident 1's Skin Integrity Care Plan was not revised to include the wound care provider's recommendations. Wound Care Provider Note, dated 3/07/2024, documented Resident 1's coccyx wound was resolved and no longer required medical intervention. Nursing Readmission Evaluation, dated 3/22/2024, documented Resident 1 returned to the facility after a 12 day hospital stay for hip surgery and was found with a 7 pound weight loss and Stage II pressure injury to the coccyx. Skin Integrity Care Plan for Resident 1 was not updated to reflect the newly opened wound. Progress Notes, dated 3/23/2024, documented Resident 1 was admitted to hospice. Wound Care Provider Note, dated 04/04/2024, documented Resident 1's wound at coccyx had deteriorated with severe exacerbation and noted that failure to thrive and terminal skin failure was evident. Progress Notes, dated 4/04/2024, documented Resident 1's family revoked hospice services in order to send the resident to the hospital for interventional wound care. During an interview on 6/12/2024 at 11:34 AM, Collateral Contact 1 (CC-1) stated that on 2/10/2024, Resident 1 was found in bed with urine-soaked briefs and bedsheets. CC 1 said they took a photo and carried it to the nurse in charge. On 6/12/2024 at 12:16 PM, a photograph identified by CC-1 as Resident 1, was reviewed. The photograph showed Resident 1 lying in wet sheets. The ring of moisture under the resident had dried yellow edges. Resident 1's briefs were shown in photo, saturated with moisture. On 6/24/2024 at 2:40 PM, Staff D, Registered Nurse, said that Resident 1 had urinary frequency and would be wet again 10 minutes after being changed. Staff D stated that Resident 1 drank a lot of fluid and was taking laxatives. Resident 1's Bladder Incontinence Care Plan did not identify this urinary pattern and risk factors and address them with individualized interventions. When asked how frequently Resident 1 was changed, Staff D stated, couple times a shift whenever it was needed. Staff D said they saw CC-1 taking photographs of Resident 1. Staff D said Resident 1's behavior presented risk for infection as the resident would put hands in feces, vagina, mouth and eyes. These behaviors that placed Resident 1 at risk for infection were not addressed in the care plan. < Resident 4 > Resident 4 was admitted [DATE] with diagnoses including diabetes and spinal stenosis (condition of spine that can put pressure on the bowel and bladder). The MDS, dated [DATE], showed Resident 4 was always incontinent. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Skin Integrity Care Plan, revised 3/10/2024, documented Resident 4 should be encouraged to reposition as needed. Urinary Incontinence Care plan, dated 9/22/2022, documented staff should identify Resident 4's voiding pattern and provide assistance as needed. On 7/10/2024 at 1:45 PM, Resident 4 was observed being transferred from chair to bed with the assistance of two staff. Repositioning Resident 4 in bed to provide incontinent care required the assistance of two staff. At 1:50 PM, Staff E was observed removing Resident 4's pants and said, Those are really wet. When staff exposed Resident 4's buttocks during incontinent care, a reddened area on the right buttocks was observed. At 4:30 PM, Staff G, Unit Manager, was observed assessing Resident 4's sacrum/coccyx and buttocks. Staff G stated that an area at Resident G's coccyx was open again and there was a recurring area of MASD on the right buttocks. < Resident 3 > Resident 3 was admitted [DATE] with history of a stroke. The MDS, dated [DATE], documented Resident 3 was occasionally incontinent of urine and dependent on staff for toileting hygiene. On 6/06/2024 at 3:15 PM, Resident 3 said, I went all day without being changed .I think it was Monday. On 7/10/2024 at 12:04 PM, Staff G, Licensed Practical Nurse and Unit Manager, stated that a standard would be to check and change a resident every two hours. Staff G explained that repositioning dependent residents every 2 - 3 hours would meet a standard of care but that when understanding individual needs, the care plan may change. Staff G stated that when a resident was admitted the baseline care plan was created and then edited in the days that followed as the staff came to know the resident and was able to make the care plans individualized. Staff G indicated the facility did not define or delineate the frequency of nursing actions for incontinent care or repositioning in the care plan. On 7/10/2024 at 5:15 PM, Staff B, Director of Nursing Services, indicated the expectation that facility practices follow policy, regulations and professional standards for prevention and treatment of pressure injuries. Reference WAC 388-97-1060(3)(b).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46244 Based on observations, interviews and record reviews, the facility failed to ensure physician orders were clarified and treatment was provided according to physician orders for 3 of 5 sampled residents (Residents 1, 4 & 7) reviewed for wound care. This failure placed residents at risk for delayed healing or deterioration of wounds and a diminished quality of life. Findings included . < Resident 4 > Resident 4 was admitted [DATE] with diagnoses including diabetes and spinal stenosis (condition of spine that can put pressure on the bowel and bladder). The Minimum Data Set (MDS), an assessment, dated 06/09/2024, showed Resident 4 was always incontinent. MASD (Moisture Associated Skin Damage) Care Plan, dated 12/27/2022, documented licensed nurses were responsible to carry out physician orders for treatment of the MASD. Physicians Order, dated 03/8/2024, documented Resident 4 was to have Moisture Associated Skin Damage (MASD) at the sacrococcygeal region (portion of spine between lower back and tailbone), cleansed with normal saline before application of a moisture barrier ointment (A&D) to the coccyx (tailbone) once daily. Treatment Administration Record (TAR) for July 2024 showed Resident 4's order for treatment to the sacrococcygeal region was completed by licensed nurses daily through 07/10/2024. Physicians Order, dated 03/30/2024, documented Resident 4 was to have an antifungal powder applied under the left breast twice daily until redness/moisture was resolved. July 2024 TAR showed Resident 4's treatment with antifungal powder under the left breast was documented as completed by licensed nurses twice daily through 07/10/2024. A second order for application of antifungal powder, dated 06/2/2024, documented the same reddened area under Resident 4's left breast should be cleansed and antifungal powder applied three times daily. The July 2024 TAR documented licensed nurses followed this order through 07/10/2024, three times daily, making a total of 5 applications of antifungal powder per day under Resident 4's left breast. On 07/10/2024 at 1:45 PM, Resident 4 was observed lying in bed on the left side while Staff E, Certified Nursing Assistant, applied zinc oxide to Resident 4's buttocks and coccyx and then applied an antifungal powder under Resident 4's left breast. When asked how they knew they were to provide these treatments for Resident 4, Staff E said the nurses told them to do it. Resident 4 stated it was nursing assistants and not nurses who applied both the zinc and antifungal powder. At 2:56 PM, Staff F was asked if treatments to Resident 4's left breast and sacrococcygeal region had been done that shift. Staff F said these were not done but were signed as completed beforehand. Staff F said that the orders were actually for nurses to make sure aides applied the powder and ointment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 4:45 PM, Staff G indicated that orders for Resident 4's skin treatments were to be completed by licensed nurses. Staff G indicated that when the nurse signed the TAR it idicated the treatment was completed. Staff G indicated that signing that a treatment was done in advance of actually doing it did not meet professional standards. < Resident 7 > Resident 7 was admitted [DATE] with diagnoses including diabetes and wounds on the left lower leg and foot. Physician Orders, dated 06/15/2024, documented Resident 7 was to have a dressing change to the left lower leg and foot every other day. On 06/24/2024 at 6:39 PM, Resident 7 was observed lying in bed and the left leg was wrapped in a gauze dressing that had serosanguinous drainage (pink drainage; a sign that wound was healing) soaking through the bandage. Resident 7 stated that the dressing had not been changed in a week. Review of the TAR for June 2024 showed the dressing orders were not followed as written and two treatments had been missed, 06/17/2024 and 06/21/2024. < Resident 1 > Resident 1 was admitted to the facility on [DATE] with multiple diagnoses to include a sacral pressure injury (bedsore on tailbone), osteomyelitis (bone infection) of the sacrococcygeal region (portion of spine between lower back and tailbone), kidney failure, severe protein calorie malnutrition and adult failure to thrive. Physicians Orders, dated 03/22/2024, documented nurses were to apply a topical steroid cream to an unnamed body part. The TAR for March 2024 showed nurses signed that they had carried out the order although the body part had not been identified. Physicians Order, dated 03/22/2024, documented nurses were to apply an antifungal powder to an unnamed body part. The TAR for March 2024 showed nurses signed that they had carried out the order although the body part had not been identified. At 6:50 PM, Staff B, Director of Nursing Services, indicated the expectation that nurses clarify and follow physician orders and professional standards of care. Reference WAC 388-97-1620 (2)(b)(ii) (6)(b)(i)