| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505290 | A. Building<br>B. Wing | 10/31/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Belmont Terrace | 560 Lebo Boulevard<br>Bremerton, WA 98310 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0553<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow resident to participate in the development and implementation of his or her person-centered plan of care.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40914<br><br>Based on observation, interview and record review, the facility failed to ensure care plan conferences were held with the resident for 1 of 3 sampled residents (Resident 2) reviewed for participation in care planning. This failure placed residents at risk of not being fully involved and informed of decisions about care and services and a diminished quality of life.<br><br>Findings included .<br><br>Resident 2 was admitted to the facility on [DATE] with diagnoses including heart failure and chronic kidney disease. The quarterly Minimum Data Set (MDS), an assessment tool, dated 8/13/2024, documented Resident 2 was cognitively intact and required substantial assistance from staff with activities of daily living.<br><br>The care plan, revised on 04/10/2024, documented Resident 1 wished to return to their apartment. Interventions included that the facility would evaluate/record abilities and strengths and determine gaps which effected discharge with an interdisciplinary team.<br><br>Review of Resident 2's electronic health record from 05/01/2024 to 10/31/2024 showed no care conference had been conducted or offered.<br><br>On 10/14/2024 at 3:25 PM, Resident 2 said they want to discharge home, but the staff has not discussed discharged plans. When asked about care conferences, Resident 2 said they do not know what a care conference is, and they did not recall ever having one.<br><br>On 10/31/2024 at 3:33 PM, Staff C, Social Services, said they were new to the role. Staff C said she understood the facility was behind with care conferences and did not see a recent care conference for the resident. Staff A, Administrator, said the facility had not consistently performed care conferences.<br><br>At 3:41 PM, Staff B, Registered Nurse and Director of Nursing, said the facility has not been completing care conferences consistently.<br><br>Reference WAC 388-97-1020 (2)(e)(f) |

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 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Plan the resident's discharge to meet the resident's goals and needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40914<br><br>Based on observation, interview and record review, the facility failed to develop a personalized discharge plan based on each residents' identified needs, goals, and preferences and implement it timely for 1 of 3 residents (Resident 2) reviewed for discharge planning. This failure placed residents at risk for delayed discharge, unmet care needs after discharge and a diminished quality of life.<br><br>Findings included .<br><br>Resident 2 was admitted to the facility on [DATE] with diagnoses including heart failure and chronic kidney disease. The quarterly Minimum Data Set (MDS), an assessment tool, dated 8/13/2024, documented Resident 2 was cognitively intact and required substantial assistance from staff with activities of daily living.<br><br>The care plan, revised on 04/10/2024, documented Resident 1 wished to return to their apartment. The facility would evaluate/record abilities and strengths and determine gaps which effected discharge with an interdisciplinary team.<br><br>On 10/14/2024 at 3:25 PM, Resident 2 said he wanted to discharge home. Resident 2 said nobody had discussed discharged plans with him and he did not know what was going on. Resident 2 said they had improved to the point where discharge was possible. The resident felt like they could manage well in the prior living situation. The resident said no staff had talked about whether the resident had improved enough to discharge or discussed if the resident was safe to discharge.<br><br>On 10/31/2024 at 3:33 PM, Staff C, social services, said they were new to the social service role. Staff C said she did not see discharge planning for Resident 2 when reviewing the resident's record. Staff A, Administrator, said she did not see discharge planning for resident 2.<br><br>At 3:41 PM, Staff B, Registered Nurse and Director of Nursing, said there had been turn over with social service staff and documentation could be in a different format. Requested discharge planning documentation if identified. No further information was provided.<br><br>Reference WAC 388-97-0080 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40914<br><br>Based on observation, interview and record review, the facility failed to accurately assess and determine appropriate treatments for a chronic skin condition for 1 of 3 sampled residents (Resident 1) reviewed for skin conditions, non-pressure. This failure placed all residents at risk for unmet needs, pain and discomfort, declining health, and decreased quality of life.<br><br>Findings included .<br><br>Resident 1 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus, peripheral vascular disease (the vessels of the heart become narrowed or blocks affecting the legs and feet), and peripheral angiopathy (a buildup of fat in the arteries of the legs and arms). The quarterly Minimum Data Set (MDS), an assessment tool, dated 8/27/2024, documented Resident 2 has moderate cognitive impairment and was dependent on staff for assistance with activities of daily living.<br><br>The care plan, revised 09/01/2024, documented Resident 1 had diabetes mellitus and was at risk for skin breakdown. The resident would have good fluid intake to keep skin hydrated. The resident's skin would be checked for any breakdown and staff would apply treatment as ordered by the medical provider.<br><br>The Wound Clinic notes, dated 08/28/2024, documented Resident 1 had hemosiderin staining (discoloration on the legs and/or ankles yellow, brown, black, or rusty in appearance due to the breakdown in red blood cells) to their legs. The resident was noted as having chronic skin issues. Staff should apply house emollient as needed for skin hydration.<br><br>The skin evaluation, dated 09/15/2024, made no note of skin on Resident 1's legs.<br><br>The skin evaluation, dated 09/22/2024, made no note of skin on Resident 1's legs.<br><br>The skin evaluation, dated 09/24/2024, noted Resident 1's shins were very dry. No notation of treatment was noted.<br><br>The Interdisciplinary Team Skin Review, dated 09/27/2024, made no note of skin on Resident 1's legs.<br><br>The skin evaluation, dated 10/01/2024, made no note of skin on Resident 1's legs.<br><br>The Interdisciplinary Team Skin Review, dated 10/03/2024, made no note of skin on Resident 1's legs.<br><br>The skin evaluation, dated 10/06/2024, showed the resident refused an assessment of their skin.<br><br>The Interdisciplinary Team Skin Review, dated 10/09/2024, made no note of skin on Resident 1's legs.<br><br>The skin evaluation, dated 10/13/2024, noted brownish discoloration to Resident 1's lower legs.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The skin evaluation, dated 10/20/2024, noted brownish discoloration to Resident 1's lower legs.<br><br>The skin evaluation, dated 10/27/2024, noted dry, flaky skin below the resident's knees. No notation of treatment noted.<br><br>On 10/14/2024 at 1:20 PM, Resident 1 was observed in lying in bed. Resident 1's legs were exposed. Both lower legs were observed to be ruddy (reddish tone with a blotchy appearance) with dried, flaky skin. Both lower legs had scattered scabs and evidence of healed skin impairment. The resident said there are ongoing issues with skin breakdown on their legs.<br><br>On 10/31/2024 at 1:45 PM, Resident 1 was observed lying in bed. The resident's left lower leg was ruddy with signs of healed skin impairment. Resident 1's right lower leg was covered in a large area of moist, flaky skin. The sheet underneath the resident's right lower leg was observed to be wet and discolored. Resident 1 did not know why their sheets were wet. Resident 1 said she continued to have scabbing and flaky skin on her shins. Resident 1 said she was not aware if she received a treatment to manage her skin impairment.<br><br>At 1:50 PM, Staff E, Nursing Assistant, said Resident 1's skin was impaired on her lower legs. Staff E said the dry, flaky skin was moist. Staff E said Resident 1 refused personal care often, so it made it difficult to keep her skin intact. Staff E said Resident 1's sheets were wet. Staff E said this could be because the resident refused incontinence care.<br><br>At 3:09 PM, Staff F, licensed practical nurse (LPN), said Resident 1's skin on the lower legs would heal and then flare up again. Staff F said it was a chronic condition and she did not know the cause of the skin breakdown. Staff F said they had tried many different treatments, but the impairment returned. She had tried may over the counter treatments as well. The resident was sensitive to feeling of creams/lotions on her legs. Staff F said there was a treatment with aluminum as an ingredient, but they did not have an order for this anymore. Staff F said there were no orders for the resident's lower legs at the time. Staff F said she was not sure if there was an assessment or documentation of the skin condition and treatment attempts available for staff to reference.<br><br>At 3:41 PM, Staff B, Registered Nurse and Director of Nursing, said Resident 1's skin impairment was chronic but she was unsure of the cause of the skin impairment. The resident's skin would heal then become dry and flaky. Staff B said there was no current treatment of the skin impairment. Staff B said they monitor the skin weekly. Staff B said she would do a further review of the record. No further information was provided.<br><br>Reference WAC 388-97-1060(1) |

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate foot care.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40914<br><br>Based on observation, interview and record review, the facility failed to provide necessary diabetic nail care and treatment in accordance with professional standards for 1 of 3 sampled residents (Residents 1) reviewed for foot care. This failure placed residents at risk for developing further medical complications, discomfort and a diminished quality of life.<br><br>Findings included .<br><br>Resident 1 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus, peripheral vascular disease (the vessels of the heart become narrowed or blocks affecting the legs and feet), and peripheral angiopathy (a buildup of fat in the arteries of the legs and arms). The quarterly Minimum Data Set (MDS), an assessment tool, dated 8/27/2024, documented Resident 2 had moderate cognitive impairment and was dependent on staff for assistance with activities of daily living.<br><br>The care plan, revised 09/01/2024, documented Resident 1 has diabetes mellitus. The resident required daily inspection of feet for sores, blisters, and redness.<br><br>The Treatment Administration Record (TAR), dated September and October 2024, documented staff provided diabetic nail care for the resident weekly.<br><br>A review of the medical record showed no discussion regarding podiatry services with the resident.<br><br>On 10/14/2024 at 1:20 PM, Resident 1 was observed in lying in bed. Resident 1's feet were exposed and the resident's toenails were observed to be long, thick and jagged. The resident said her toenails were long and would like someone to cut them for her.<br><br>On 10/31/2024 at 1:45 PM, Resident 1 was observed lying in bed. Resident 1's feet were exposed. The resident's toenails were observed to be long, thick and jagged. Resident 1 said the long toenails were uncomfortable and just wanted someone to cut them. The resident could not recall the last time their nails were cut. Resident 1 said they were willing to see podiatry to get their nails cut.<br><br>At 1:50 PM, Staff E, Nursing Assistant, said Resident 1's toenails were long and jagged. The resident did not always let staff cut their nails. Staff E could not recall the last time the resident had their nails cut.<br><br>At 3:09 PM, Staff F, licensed practical nurse (LPN), said she was going to try and tackle the resident's toenails that day. Staff F said the resident would refuse to let staff cut their toenails. Staff F said Resident 1's toenails did bother them due to the length. Staff F said sometimes, she would just try and clip the rough parts of the nail. Staff F said she did not know if podiatry comes to the facility and did not think the resident has seen a podiatrist. Staff F said she does sign off weekly nail care even if the resident refuses their toenails cut because she will often cut the resident's fingernails at that time. Staff F said she has not reported the refusal of nail care to her supervisor.<br><br>(continued on next page) |

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | At 3:25 PM, Staff A, Administrator, said the facility would follow up on Resident 2's need for podiatry services.<br><br>At 3:41 PM, Staff B, Registered Nurse and Director of Nursing, said the facility has mobile podiatry services and would follow up with the resident. During a discussion regarding the TARs signed off for nail care that was not provided, Staff B said she was not aware staff were signing it off without performing nail care. Staff B said she would do further review of the record and provide evidence of nail care, if found. No further information was provided.<br><br>Reference WAC 388-97 -1060 (3)(j)(viii) |