STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505296	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Healthcare - Bellingham	3121 Squalicum Parkway Bellingham, WA 98225

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** 43954 Based on interviews and record reviews, the facility failed to consistently reposition, assess and monitor skin integrity timely & implement pressure offloading interventions to prevent the occurrences of avoidable pressure ulcers (PU) for 1 of 3 residents (Resident 1) reviewed for pressure ulcers. Resident 1 experienced harm when they developed unstageable PU (later diagnosed as Stage 4 pressure ulcer) to their sacrum that became infected and required hospitalization . Findings included . The National Pressure Ulcer Advisory Panel (NPUAP) Pressure Injury (Ulcer) states a pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present itself as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Further definitions include but not limited to: - Stage 4 Pressure Injury: Full-thickness skin and tissue loss. Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. - Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. - Deep Tissue Pressure Injury (DTI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. Review of facility policy titled Skin Integrity, dated ,d+[DATE] documented the facility, based on a resident's comprehensive assessment, will provide care, consistent with professional standards of practice, to prevent pressure ulcers and promote healing, prevent infection and prevent new ulcers from developing unless the resident's clinical condition demonstrates that they were unavoidable. Guidelines include but not limited to: (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	10. Resident's care plan will reflect the preventive strategies for residents identified as at risk for developing PU/PI. 15. Prevention and treatment plans will be individualized and consistently provided. 22. Repositioning or relieving constant pressure is an effective intervention for treatment or prevention of PU/PIs. Repositioning plans will be addressed in the resident's comprehensive care plan. 30. The IDT will develop a relevant care plan that includes measurable goals and interventions for prevention and management of PU/PIs. Identified interventions will be implemented. 34. Daily monitoring of PU/PI will include: a. Evaluation of the PU/PI, if no dressing is present; b. Evaluation of the status of the dressing, is present; c. Status of the area surrounding the PU/PI (without removing existing dressing); d. Presence of possible complications; e. If pain is present, is it being controlled. 35. A weekly evaluation of the PU/PI will be documented, to include: a. Location and staging; b. Measurements, including the depth and any undermining or tunneling; c. Exudate, if present (type, color, odor, amount); d. Wound bed status; e. Description of wound edges and surrounding tissue. Resident 1 was admitted to the facility on [DATE] with diagnoses to include right hip fracture, major depressive disorder, muscle weakness, spina bifida (birth defect that affects the spinal cord and nerves, potentially leading to paralysis, and sensory loss), chronic pain, and need for assistance with personal care. Review of Resident 1's Admission Minimum Data Set (MDS-an assessment tool) Care Area Assessment (CAA), dated [DATE], documented they were at risk for developing PU's, currently had no PU's, had a surgical wound, and required substantial/maximal assistance from staff for rolling in bed. Review of Resident 1's quarterly MDS assessment dated [DATE], documented through a clinical assessment the resident was at risk of developing PUs, currently had no PU's or other skin conditions and required pressure reducing devices for their chair and bed, and they were cognitively intact. Review of Resident 1's BRADEN scale (scale for predicting PU risk) assessment dated [DATE] documented a score of 16 indicating the resident was considered to be at risk for the development of PUs. Review of Resident 1's care plan documented: - Focus area ADL (Activities of Daily Living) self-care performance deficit, initiated on [DATE], revised on [DATE]. Interventions included Resident requires 2 staff max assist to turn and reposition in bed, initiated [DATE], revised [DATE]. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Focus area Skin integrity and the resident was at risk for pressure ulcer development related to decreased mobility secondary to hip fracture and chronic deficits related to spina bifida with impaired sensation, initiated on [DATE]. The care plan was revised on [DATE], and documented the resident had an unstageable pressure ulcer to the coccyx/sacrum area. The care plan was then updated again on [DATE], and documented the unstageable PU was surgically debrided (surgically remove dead, damaged tissue or infected tissue from a wound or area) and was now a Stage 4 pressure ulcer, and a Stage 2 on their left heel and a DTI to the right heel. The goal documented on the care plan was that Resident 1 would not develop any further avoidable skin breakdown, initiated on [DATE]. Interventions included: o Follow facility policies/protocols for the prevention/treatment of skin breakdown (initiated/revised on [DATE]). o Monitor skin for any changes or impairments (initiated/revised on [DATE]). o Reposition Resident 1 with rounds and cares (initiated on [DATE], revised on [DATE]). o Low air loss mattress in place to relieve pressure (initiated [DATE]). o Resident requires pressure relieving/reducing device on bed/chair (initiated [DATE], revised [DATE]). - Focus Area Resistive to care/interventions, initiated [DATE]. Review of Resident 1's Kardex (care plan directive for nursing assistants) documented: - As of [DATE]- Resident required one person staff assist to turn and reposition in bed. There were no other skin/pressure prevention interventions documented. - As of [DATE]- The resident requires one staff assist stand by to turn and reposition in bed. - As of [DATE]- Resident requires pressure relieving/reducing device on bed/chair; they require one person staff set-up to stand by assist to turn and repositioning in bed. There were no care information/directives related to Resident 1's current PU's. - As of [DATE]- Resident requires pressure relieving/reducing device on bed/chair; they require two staff max assist to turn and reposition in bed and two persons assist with offloading (relieve pressure). There were no care information/directives related to Resident 1's current PU's. Review of Resident 1's Documentation Survey Report v2 Nursing Assistant Certified (NAC documentation) for January, February and [DATE] showed the resident had no refusals documented for the task of rolling right and left in bed. Review of Resident 1's progress note, dated [DATE] at 4:37 PM, documented the resident was noted to have a 9 centimeter(cm) by 9 cm sore to their sacrum area. Review of Resident 1's physician progress note, dated [DATE], documented the resident had an unstageable sacral ulcer that had been found a few days prior. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 1's progress note dated [DATE] at 11:01 AM documented that they had been seen by wound care in the facility and their pressure area to sacrum had been debrided (surgical removal of dead or damaged skin/tissue from a wound). Review of a wound care note, dated [DATE], documented Resident 1 had an unstageable sacral wound that measured 10.7 cm x 8.8 cm, with tunneling of 2 cm. Review of Resident 1's progress note, dated [DATE] at 3:00 PM, documented that the resident was lethargic, with low blood pressures (BP- normal range ,d+[DATE]) of ,d+[DATE] and ,d+[DATE], and low oxygen readings (normal ,d+[DATE]%) from 67% to 92%. The facility provider was notified and called 911 for the resident to be transferred to the hospital. Review of Resident 1's hospital records dated [DATE] to [DATE] documented the resident was diagnosed with septic shock, (life-threatening condition that is the most severe stage of sepsis), urinary tract infection or osteomyelitis (bone infection, usually caused by bacteria) related, and a Stage 4 sacral pressure ulcer. Review of the facility investigation dated [DATE], completed by Staff A, Registered Nurse (RN)/Director of Nursing Services (DNS) documented interventions in place prior to sacral ulcer were Activities of Daily Living (ADL) assist for turn/reposition as indicated. Staff A documented the unstageable pressure injury to Resident 1's sacrum was identified on [DATE]. Staff A documented that based on measures identified, care planned and implemented, interventions that were in place upon admission and prior to skin impairment should have been sufficient and reasonable to prevent the formation of pressure ulcers. Staff A documented that upon review of the resident clinical picture, the pressure ulcer suspected to be unavoidable related to previous decrease in frequency of repositioning, decrease in sensation with spina bifida, recent refusals of care and history of pressure injuries In an interview on [DATE] at 2:05 PM, Resident 1 stated that they had never had any pressure ulcers before and that they can't believe that this happened. Resident 1 stated that they are unable to feel in the sacrum area due to their spina bifida. Resident 1 stated when their insurance ran out and therapy was finished, the staff just let them lay in the bed. Resident 1 stated that no staff came to change their position or turn them in bed, and no staff came to remind them to do it independently, they had no idea about repositioning until after this pressure ulcer was found. Resident 1 stated they need help and that is why they were in the facility. The resident stated that the staff did not know that this was happening to their skin, and they could have died from the infection. In an interview on [DATE] at 4:43 PM, Resident 1 family member (CC1) stated after Resident 1's insurance ran out or they were discharged from physical therapy that the facility was not providing any therapy services or assisting the resident. CC1 stated that they were notified by the surgeon that the infection had gone into their bones from the PU and that the healing process may affect the rest of their life. CC1 stated Resident 1 does not have sensation and can't feel the area of their body where the PU is located, and they have never had any previous PU's. CC1 stated that the facility was not providing the care that Resident 1 required or deserved. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on [DATE] at 1:11 PM, Staff B, Nurse Aide Certified (NAC), stated that they follow the Kardex to know what level of assistance a resident requires. Staff B stated they alert the licensed nurse if the resident refuses any care, and it can be documented in the resident's electronic medical record (EMR) related to the task that was refused. Staff B stated that one person assist, or one person stand by assist with bed mobility, rolling left and right, meant it required one staff to partially assist resident to complete the task and set up for whatever they need to accomplish. Staff B stated that residents who have skin issues or are at risk for skin issues have interventions for floating the area, reposition, and change their position. In an interview on [DATE] at 1:22 PM, Staff C, NAC, stated they review the care plan or Kardex to know what care is required for a resident. Residents who have skin issues or are at risk for skin issues usually have interventions to float the affected area, special mattress, and frequent turning and repositioning. Staff C stated that all resident care tasks have an option to document for a resident refusal of care. Staff C stated they report to the licensed nurse if the resident refused care. Staff C stated that one person assist or standby assist for bed mobility requires one staff to assist the resident to reposition and stated they were not sure what a standby assist for bed mobility was. Staff C stated that Resident 1 had not refused care from them. In an interview on [DATE] at 1:33 PM, Staff D, Registered Nurse (RN), stated they review the care plan to know what assistance the resident requires. Staff D stated that interventions for residents who have skin issues are that staff complete frequent checks, provide reposition care every two hours, and offload the pressure areas of concern. Staff E stated if a resident refused care, they would attempt three times and then complete notifications to the resident power of attorney (POA) or responsible party, notify the provider, and complete a progress note with the refused care and complete teaching with resident of risks and benefits of the care they have refused. Staff D stated that if a resident required one person assist for bed mobility, then one staff should assist with that care. In an interview on [DATE] at 2:52 PM, Staff E, RN/Resident Care Manager (RCM), stated they were aware Resident 1 had refused to get out of bed for meals, unsure about bed mobility or to be repositioned. Staff E stated that Resident 1 had never been considered independent with their bed mobility, repositioning or care needs and that they were aware that the resident had previously refused to get out of bed and sit up for meals. Staff E stated that they did not recall knowing that the resident had refused being repositioned. Staff E stated that a one person or one person stand by assist for bed mobility and repositioning would be one staff member to assist or be there to see what assist the resident required and then stated that a standby assist for bed mobility does not really make sense. Staff E stated that if a resident had refused care or is known to refuse frequently, it should be documented by NAC's and Licensed Nurses (LN), and they were unsure of where it would be documented. Staff E stated that Resident 1's care plan should have been updated related to refusals of care and assessed to see why Resident 1 had refused care. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on [DATE] at 4:34 PM, Staff A stated that if a resident had a skin issue or was at risk to develop a skin issue, the expectation is that there are interventions in the care plan and those interventions should be implemented. Staff A stated that Resident 1 had stated that they previously had some skin issues or a wound in the same area, although their clinical record did not indicate that in their history when I reviewed it. Staff A stated that Resident 1 was identified at risk related to immobility due to the hip fracture and sensation loss related to spina bifida. Residents who are at risk or have skin integrity care plans should be turned and repositioned on staff rounds and with care provided by NAC's. If a resident has refused care, it should be documented by NAC's and LNs in the EMR, it should also be documented in their EMR that staff review risks and benefits related to refused care. Staff A stated their expectations for care plans are that they are updated when there is a change. Requested additional information related to documentation of resident refusal of bed mobility, being repositioned or care plan updates, no further information was provided. Reference WAC: [DATE] (3)(b)