

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Hallmark Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 32300 First Avenue South Federal Way, WA 98003	

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)
<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>29644</p> <p>Based on interview, and record review, the facility failed to provide the necessary treatment and services to prevent the occurrence of an avoidable pressure ulcer/pressure injury (PU/PI) for 1 of 4 sampled residents (Resident 1). Resident 1 experienced harm when they developed an unstageable (a pressure injury that is a full thickness skin and tissue loss to which the extent of the tissue damage cannot be seen) wound to their right foot requiring hospital treatment and amputation.</p> <p>Findings included .</p> <p><Resident 1></p> <p>Review of the 02/21/2024 Quarterly Minimum Data Set (MDS - an assessment tool) showed Resident 1 had no pressure ulcers, was dependent on staff to put on/take off footwear, required substantial/maximal assistance with bed mobility, and was assessed as at risk of developing PU/PIs.</p> <p>Review of the Braden Scale (an assessment for predicting pressure sore risk) dated 05/06/2024 showed Resident 1 was assessed at a severe risk of developing pressure sores. According to the assessment, Resident 1 was confined to bed, had very limited ability to change and control body position, and required maximum assistance in moving.</p> <p>Review of the at risk for break in skin integrity Care Plan dated 12/29/2023 showed Resident 1 was admitted with a hard cast to their right lower extremity (RLE) due to a surgically repaired ankle fracture. Interventions included directions to staff to check skin integrity around the hard cast on RLE every shift (added 03/07/2024), and the hard cast was padded around the edges to prevent friction against the skin (added 03/09/2024).</p> <p>Review of the May 2024 Treatment Administration Record (TAR) showed an 02/28/2024 order to check circulation, movement, and sensation on right leg every shift and report abnormalities to Medical Doctor/Nurse Practitioner. The order was discontinued on 05/14/2024.</p> <p>Review of the Orthopedic Aftercare notes dated 04/22/2024 showed the cast was removed, the resident's RLE Range of Motion (ROM) was assessed as supple and pain free. The documented plan included Resident 1 may transition gradually to WBAT (Weight Bearing as Tolerated). Recommend use of a lace-up brace, especially during Physical Therapy (PT). Specific instructions included okay for WBAT to right lower extremity, in a lace up ankle brace (if resident tolerated). Continue working with PT to gain strength to the extremity. No orders were written.</p> <p>(continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Physical Therapy Evaluation dated 04/24/2024 showed the brace prevented testing of Resident 1's ROM. Right ankle in lace up ankle brace; no instructions provided for ROM in the orders. The resident was assessed as not appropriate for skilled therapy services and recommended Restorative Nursing Program (RNP) to maintain ROM in BLE (Bilateral Lower Extremities) if resident tolerated it.</p> <p>Review of the Restorative Nursing Communication Tool dated 04/24/2024 showed directives for LE Passive ROM with instructions to not perform ROM on the right ankle as the right ankle was immobilized in lace up ankle brace.</p> <p>Review of the Wound Observation Tool (WOT) dated 05/14/2024 showed that Resident 1 was noted with a facility acquired Deep Tissue Injury (DTI) and open area to their right lateral (side) foot and 5th toe. The wound measurements were 3.0 centimeter (cm) long, 5.0 cm wide and 0.6 cm deep. The wound on the right lateral foot and right 5th toe were clustered as one because of the proximity to each other. The toe presented with a DTI, the lateral foot wound had parts of it open with surrounding DTI. The wounds were attributed to the result of pressure from Resident 1's preference of lying on the right side. The physician was notified and treatment orders obtained.</p> <p>Review of a 05/20/2024 facility Investigation Report of the right lateral foot wound showed the Resident wears an immobilizer to the RLE related to fracture repair and revision. Review of Nursing Assistant Witness Statements showed that after the cast was removed, Resident 1 always had a bandage/ace wrap/wraps on their leg when the nursing assistants provided care. According to the provider, the wounds were unavoidable related to the immobilizer in place and comorbidities present.</p> <p>Review of Wound Healing provider notes showed on 05/21/2024 the resident's right lateral foot wound was evaluated. The Right Lateral Foot was assessed with a full thickness wound, measuring 5 cm by 13 cm by 0.5 cms, with exposed bone. There was moderate wound drainage and the area surrounding the wound was acutely inflamed. Initial assessment showed concerns for gangrene (death of body tissue due to lack of blood supply), bone was present at the wound base.</p> <p>Review of a 05/21/2024 Nursing Skin/Wound Note showed the wound was bigger in size, malodorous (smelling very unpleasant), with necrosis (death of body tissues due to injury) and bone exposure. Resident 1 was transferred to a local emergency room (ER).</p> <p>Review of Hospital Inpatient records dated 05/21/2024 showed Resident 1 had a cast in place which was removed on 04/22/2024 and was recommended a soft brace to be placed during therapy. Apparently the brace was in place for two weeks and once the brace was removed the resident was noted to have an ulcer on right foot lateral aspect. During evaluation in the ER, Resident 1's right foot showed deep necrotic ulcer with exposed fifth metatarsal (long bones of the foot, located between the heel/ankle and toes) head with warm erythematous (abnormal redness) surrounding foot. The resident was started on antibiotics and admitted to the hospital.</p> <p>During an interview on 05/29/2024 at 10:00 AM, Resident 1's representative stated that after the 04/22/2024 Orthopedic Aftercare appointment they gave the facility the after visit summary and told them the splint was to be worn during therapy. Resident 1's representative stated if the facility staff had taken the boot off, they would have seen the wound earlier. Resident 1 was sent to the ER with clearly exposed bone, admitted to the hospital and scheduled for an above the knee amputation on 05/30/2024.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/12/2024 at 1:26 PM, Staff C, Restorative Nursing Assistant, stated they did ROM on Resident 1's UEs, and Left LE, but did not do ROM on the affected (Right) LE. Staff C stated Resident 1 always had the right leg wrapped.</p> <p>During an interview on 06/12/2024 at 2:02 PM, Staff D, Licensed Practical Nurse, stated they checked the circulation in the resident's toes. Staff D stated the splint was on all day and they did not take it off when they worked.</p> <p>During an interview on 06/12/2024 at 12:34 PM, Staff B, Director of Nursing, stated the facility staff should have clarified with the orthopedic provider when the splint was to be worn and if ROM exercises to the RLE should be performed. Staff B acknowledged the care plan was not revised after the cast was removed to include removal of the brace for skin checks.</p> <p>REFERENCE: WAC 388-97-1060(3)(b)</p>		