STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505326	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood Extended Healthcare	1649 East 72nd Tacoma, WA 98404

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to coordinate podiatrist services for 3 of 3 residents (Residents 1, 2, and 3) reviewed for foot care. This failure placed residents at risk of infection, pain, discomfort, and a diminished quality of life.Findings included. Resident 1Resident 1 admitted to the facility on [DATE] with diagnoses to include left-side hemiplegia/hemiparesis (weakness or inability to move one side of the body) following a stoke, lung cancer, and diabetes. Resident 1 required moderate to maximum assistance from staff for activities of daily living (ADLs - dressing, bathing, eating, toileting, grooming, etc.). In an interview on [DATE] at 2:30 PM a collateral contact (CC1) stated that Resident 1 had needed podiatrist care for long, thick, ingrown toenails the entire time they were a resident in the facility, and they did not think nurses provided toenail care. CC1 further stated that Resident 1 was complaining of discomfort and had sores on their feet. CC1 stated that the last time they checked with the facility staff about Resident 1's podiatrist visit, they were told that they would be seen on [DATE]. CC1 stated that Resident 1 passed away on [DATE] without ever being seen by a podiatrist. Review of Resident 1's medical record showed a physician's order, dated [DATE], which read, May have medical consult and TX [treatment] as indicated. (Dental, Podiatry, Eye, Hearing, Psych and Wound Care, Cardio, Renal, Physiatry), and another order, dated [DATE], which read, Referral to podiatry for foot care. Review of Resident 1's care plan, initiated [DATE], showed, Refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails. Review of Resident 1's electronic health record (EHR) on [DATE] showed no documentation that Resident 1 had been seen by a podiatrist during his stay. In an interview on [DATE] at 12:20 PM, Staff B, Assistant Director of Nursing (ADON), stated they could not find any documentation to show that Resident 1 had been seen by a podiatrist during their stay. Resident 2Resident 2 admitted to the facility on [DATE] with diagnoses to include quadriplegia (a form of paralysis that causes loss of movement and sensory function in all four limbs and the torso) and required total assistance from staff for all ADLs. In an interview on [DATE] at 12:27 PM Resident 2 stated, My toes are bad. I need to see a podiatrist. An observation at the same time showed Resident 2's left and right feet with long, yellowing, flaking, thick toenails. Review of the medical record on [DATE] showed that Resident 2 had nothing documented on the nursing admission assessment noting fungal issues with nails, no order for podiatry as needed, no care planning related to fungal toenails/fingernails, and no progress notes about fungal toenails/fingernails. In an interview on [DATE] at 12:30 PM, Staff D, Shower Aide, stated that during showers, they would clean and trim nails, but the nurses were responsible for nail care in diabetic residents. Staff D further stated that if a resident's toenails were very thick and not easily trimmed, they would tell the nurse, and the nurse could put them on the list for a podiatry referral. In an interview on [DATE] at 12:32 PM, Staff C, Appointment & Transportation Scheduler, stated that Resident 2 was not on the list for podiatry referral. In an interview on [DATE] at 1:40 PM Staff B, ADON, stated that if a resident admitted with long, thick, fungal toenails, it should be documented in a progress note because the nursing admission assessment did not have a place to document the condition of the nails. Staff B, ADON, further stated that if issues were identified with a resident's toenails, the nurse should communicate with the (continued on next page)

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

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medical provider and request and order for referral to podiatry, and the problem should be care planned. Resident 3Resident 3 admitted to the facility on [DATE] with diagnoses to include diabetes, obesity, heart failure, and need for assistance with personal care. In an interview on [DATE] at 12:13 PM, Resident 3 stated that they had asked to see a podiatrist and thought that the doctor had wanted them to see a podiatrist, but the facility never set up an appointment for them to be seen by one. Resident 3 stated, I just gave up on it. Observation at the same time showed Resident 3's toenails were long, big toenails were thickened, and the skin of feet and toes were dry and flaky. Review of Resident 3's medical record showed a physician's order, dated [DATE], which read, May see podiatrist PRN [as needed] for foot related issues. Review of Resident 3's progress notes showed a Social Services note, dated [DATE], documenting that Resident 3 had accepted referrals for vision, hearing, dental, and podiatry. Further review of Resident 3's progress notes showed this physician note, Toenails fungal infection in both feet, repeatedly documented on the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Review of Resident 3's EHR showed no documentation that a podiatry visit had ever taken place. In an interview on [DATE] at 12:32 PM, Staff C, Appointment & Transportation Scheduler, stated that Resident 3 was not on the list for podiatry referral. In an interview on [DATE] at 12:20 PM Staff B, ADON, stated that there was a new podiatry practice that the facility had just contracted with and there was a brief time in with there was not a podiatrist seeing residents on-site. In addition, Staff B, ADON, stated that the person who had done the appointment scheduling had recently left the position, things were disorganized, and the new scheduler was trying to get a handle on everything. Staff B, ADON, further stated that the expectation was that podiatry referrals were to be written on an electronic communication board in the facility's EHR system, and the scheduler would then see the notes and would place the named residents on the list to be seen by a podiatrist. In an interview on [DATE] at 12:42 PM, Staff C, Appointment & Transportation Scheduler, stated that the process for staff to communicate residents' podiatry needs was verbal communication, use of the electronic communication board in the EHR, and/or written requests for follow-up from previous podiatrist appointments. Staff C further stated that the electronic communication board messages could be problematic because they expired after a set time, so there was a possibility of those messages being lost before they could be addressed. In an interview on [DATE] at 2:00 PM, Staff A, Administrator, stated that they were aware of deficiencies in the facility's process for podiatry referrals and care in the facility, and were working on them. Reference WAC 388-97-1060(3)(j)(viii).