STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505344	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury House	502 29th Street Southeast Auburn, WA 98002

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 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** 44295 Based on observation, interview, and record review, the facility failed to ensure residents received the necessary care and services in accordance with professional standards of practice. The facility failed to ensure physician orders were followed, implemented timely, or were clarified as needed; Care Plans (CP) developed for 3 (Resident 2, 4, 3) of 3 residents reviewed; medications were not provided as ordered, for 1 (Resident 5) of 3 residents reviewed; and to monitor weights and bowels, act on, or implement their policies for 4 (Residents 3, 2, 1, 4) of 4 residents reviewed. These failures placed all residents at risk for unmet care needs, and decreased quality of life. Findings included . <Following, Implementation & Clarification of Physicians Orders & CP> <Resident 2> Review of an admission Minimum Data Set (MDS, an assessment tool) showed Resident 2 admitted to the facility on [DATE], was able to make their needs known, make their own decisions, and had behaviors of rejecting care four to six days out of a seven day look back. The MDS showed Resident 2 was dependent on staff for toileting hygiene, bathing, bed mobility, and transfers. The MDS showed Resident 2 had medically complex conditions, including surgical after care following intestinal perforation (a hole passing through) , acid reflux, and muscle weakness. The MDS showed Resident 2 had surgical wounds, received surgical wound care with the application of medications, and was not on a specialized diet. Review of a baseline CP, dated 07/24/2024, showed Resident 1 had a regular diet with regular textured food and thin liquids. Review of a Nutrition Hydration risk CP, dated 08/26/2024, implemented 32 days after Resident 2 admitted to the facility showed Resident 2 was at risk for nutritional issues related to diuretic (water pill, induces urination) use, inflammation of the large intestine with an abscess (collection of pus), obesity, and muscle weakness. The CP directed staff to provide diet as ordered by the physician, refer to the facility Registered Dietician (RD) as appropriate, and weights per the facility protocol. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a hospital after visit summary and hospital transfer orders, dated 07/24/2024, showed a physician order for Resident 2 to continue with a high protein diet. Review of a hospital Nutritional Assessment, dated 08/07/2024, showed Resident 2 had increased nutritional needs due to surgical wounds healing, unintended weight loss, and poor intake by mouth. The nutritional assessment showed Resident 2 was on a regular diet with high calories and high protein. On a subsequent re-admission to the facility on [DATE], no diet order was on the hospital transfer orders and facility staff did not identify or clarify Resident 2's diet. During an interview on 09/12/2024 at 1:10 PM, Staff F (Registered Dietician (RD)) stated Resident 2 was on a regular diet, acknowledged the 07/24/2024 hospital transfer orders showed a a high protein diet should be continued but Resident 2 was not on a high protein diet as ordered. Staff F stated residents nutritional status was assessed within the first fourteen days of admission, the fourteen day period would start over if the resident was readmitted to the facility. Staff F stated Resident 2 was not assessed by the RD or a CP developed until 08/23/2024, 29 days after Resident 2 admitted to the facility. In an interview on 09/12/2024 at 1:14 PM, Staff B (Director of Nursing) stated Resident 2 was not on the high protein diet per the hospital transfer orders. Staff B stated Resident 2 was not discussed or reviewed in the facility nutrition/hydration skin committee meetings. <Resident 4> Review of an admission MDS, dated [DATE], showed Resident 4 admitted to the facility on [DATE], was able to make their needs known, make their own decisions, and had behaviors of rejecting care one to three days of a seven day look back. The MDS showed Resident 4 required staff assistance with toileting hygiene, transfers, and ambulating. The MDS showed Resident 4 had medically complex conditions, including a gastrointestinal infection, high blood pressure, and anxiety. Review of an anxiety CP, dated 09/06/2024, showed Resident 4 had anxiety due to effects of the current disease processes and an unfamiliar environment. The CP directed staff to encourage family to visit, have the resident attend social activities, and encourage the resident to identify and express causes of anxiety. Review of a care conference evaluation, dated 09/03/2024, under section titled resident/resident representative issues and concerns showed, Resident 4 and the CC had concerns with Resident 4's anxiety and wanted a medication to treat the anxiety. The care conference evaluation showed on 09/03/2204, Resident 4 was referred to behavioral health services for anxiety, medication management, mood and behavior management. Resident 4 was not currently prescribed any medications for anxiety. Review of a psychiatric provider note, dated 09/04/2024, showed Resident 4 was seen by a provider for an anxiety disorder and depression. The note showed the provider assessed Resident 4 with difficulty falling asleep, sadness, fatigue, racing thoughts, difficulty relaxing, and restlessness. The provider recommended Resident 4 start two medications to manage their anxiety and depression. Review of Resident 4's physician orders , showed a physician orders, dated 09/10/2024 for Resident 4 to start an anti-anxiety medication, this was six days after the psychiatric provider made recommendations. An additional physician orders, dated 09/10/2024, showed an anti-depressant medication for Resident 4 ordered six days after recommendations were made. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/10/2024 at 1:45 PM, Resident 4's Collateral Contact (CC) stated the resident had increased anxiety that affected their eating, sleeping, and therapy progress. The resident was afraid to move at times when they had an indwelling catheter (tube that drains urine from the bladder). During an interview on 09/12/2024 at 2:45 PM, Staff B stated they were not sure why the psychiatric providers recommendations were implemented six days after but would expect staff to implement provider orders after they are written. <Resident 3> Review of an admission MDS, dated [DATE], showed Resident 3 admitted to the facility on [DATE], was able to make their needs known, had a decision maker, and had no behaviors. The MDS showed Resident 3 was dependent on staff for toileting, bed mobility, and transfers. The MDS showed Resident 3 had medically complex conditions, including surgical aftercare following blood vessel surgery, diabetes. pain, and carpal tunnel syndrome. Review of a baseline CP, dated 07/18/2024, showed interventions that directed staff to report verbal and physical signs of pain. The CP showed Resident 3 had chronic pain in their left leg. Review of Resident 3's comprehensive CP showed no specific CP for Resident 3's pain. Review of a pain evaluation, dated 07/18/2024, showed Resident 3 was assessed with pain that was aching, chronic and affected their activities and appetite. The evaluation showed Resident 3 was prescribed three different types of pain medications, and rest and medications improved their pain. Review of Resident 3's Medication Administration Record (MAR), dated 07/2024, showed a physician orders that directed staff to monitor Resident 3 for side effects of opioid use, such as delirium, over sedation, change in mental status, and reduced respirations. The physician orders directed staff when side effects were observed, document a y for yes and add a progress note. The MAR showed staff documented y for side effects for 12 days. Review of nursing progress notes, dated 07/18/2024-07/29/2024, showed no documentation on what side effects Resident 3 experienced, who or when they were notified, and what staff did to manage the side effects. A nursing progress note dated 07/29/2024, showed Staff D (Registered Nurse (RN)/Resident Care Manager (RCM)) documented they were informed by Resident 3's Collateral Contact (CC) that Resident 3 was very sleepy and would like their pain medication changed. Staff D contacted the physician and had the medication changed to a less stronger medication. In an interview on 08/16/2024 at 1:35 PM, Resident 3's CC stated Resident 4 had no tolerance for pain medications and was drowsy when they visited. The CC stated they informed numerous staff about Resident 4 being overly sleepy and not acting like their normal self. The CC stated they told Staff D on 07/29/2024, and Staff D contacted the physician who changed the pain medication to something not as strong. During an interview on 09/12/2024 at 2:55 PM, Staff B stated they were not sure what the side effects were that Resident 3 experienced. Staff B stated depending on what the side effect were observed would direct how staff should respond. Staff B stated they expected staff to follow the physician orders and when side effects were observed staff should notify the physician and document. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Medications Provided as Ordered> <Resident 5> Review of an annual MDS< dated 08/21/2024, showed Resident 5 admitted to the facility on [DATE], was able to make their needs known, own decisions, and had no behaviors. The MDS showed Resident 5 was dependent on staff for toileting, personal hygiene, bed mobility, and transfers. The MDS showed Resident 5 had medically complex conditions, including heart failure, diabetes, anxiety, and depression. Review of a diabetes CP, revised on 07/29/2024, showed the goal for Resident 5 was to have no complications related to their diabetes. The CP directed staff to administer diabetes medications as ordered by the physician, and monitor and report any signs of low or high blood sugar levels to the physician. Review of Resident 5's physician orders showed a physician orders, dated 08/31/2024, that directed staff to administer 44 units of insulin to Resident 5 twice daily. Review of Resident 5's September 2024 MAR, showed on 09/01/2024 day shift staff documented a 9, which indicated other, see progress note according to the MAR chart codes. On 09/06/2024 day shift, staff documented OO, which indicated the medication was on order from the pharmacy, and on 09/07/2024 day shift staff documented a 9. Review of Resident 5's nursing e-mar (electronic medication administration record) notes, dated 09/01/2024, showed Staff G (RN/RCM) documented that Resident 5 received 45 units of insulin, the insulin dose was clarified with the pharmacists, and the physician was notified regarding the dosage. The note did not indicate what the pharmacy or physician responded to the insulin dose of 45 units. Review of e-mar notes, dated 09/06/2024, showed no notes regarding Resident 5's insulin administration, if pharmacy was called to determine where medication was or to clarify with the physician on the missed insulin dose. Review of e-mar notes showed on 09/07/2024, Staff H (RN) documented order clarified with the pharmacist, who called on-call provider, insulin now increased to 45 units twice daily. Review of Resident 5's September 2024 MAR, showed facility staff updated Resident 5's insulin order on 09/07/2024, six days after insulin orders were clarified on 09/01/2024. During an interview on 09/10/2024 at 3:00 PM, Staff D stated the emergency medication kit had insulin available. Staff D stated when a resident ran out of insulin staff are expected to check the emergency medication kit, if none available there, the staff should call the pharmacy to have the medication sent right away. In an interview on 09/10/2024 at 3:25 PM, Resident 5 stated they missed four doses of insulin, their blood sugars had been low, and were told by staff there was no extra insulin in the emergency kit. Resident 5 stated they got upset when staff didn't inform them of running out of medications and was worried about their blood sugar levels and had staff check their blood sugar every few hours. During an interview on 09/12/2024 at 3:00 PM Staff B stated they facility had an emergency medication kit (Cubex) available. When the medication was not available in the Cubex, staff were expected to call the pharmacy to have the medication sent to the facility as soon as possible. Staff B stated staff should call and inform the physician of the medication not being available and implement any orders given for an alternative medication. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Monitoring & Implementation on Weight and Bowel changes> According to the facility policy, titled Weights, revised 07/30/2024, showed new admission residents were weighed on the day of admission, then weekly for one month. The policy showed for residents on dialysis, the facility used the weights from the dialysis center. The policy showed any weight with a five pound (lb) variance, the resident would be re-weighed in 24 hours. Once the re-weigh was completed the weight would be recorded in on the permanent weight record. When a significant weight variance was identified, staff were expected to document in the medical record, revise the CP, refer the resident to the nutrition hydration skin committee, and notify the physician and the resident representative. <Resident 3> Review of an admission MDS< dated 07/24/2024, showed Resident 3 admitted to the facility on [DATE], was able to make needs known, had a decision maker, and no behaviors. The MDS showed Resident 3 was dependent on staff for toileting, bed mobility, and transfers. The MDS showed Resident 3 had medically complex conditions, including surgical aftercare following blood vessel surgery, diabetes. pain, and carpal tunnel syndrome. The MDS showed Resident 3 had no or unknown weight loss or gain. Review of Resident 3's nutrition/hydration risk CP, dated 07/31/2024, showed Resident 3 was at risk for nutrition and hydration deficits related to their current medical condition, history of bariatric surgery, diabetes, pressure ulcer, and history of a kidney transplant. The CP goal was for Resident 3 to have no significant weight loss or gain, and directed staff to weigh Resident 3 per the facility policy. Review of Resident 3's weight record, showed on 071/19/2024, Resident 3 weighed 191.2 lbs. A second weight was completed on 07/29/2024, Resident 3 weighed 152.1 lbs., a loss of 39.1 lbs. No additional weights were observed in the record and no additional weight documents were provided when requested from Staff B. Review of a Nutritional Evaluation, dated 07/31/2024, showed Staff F (Registered Dietician (RD)) evaluated Resident 3 with a significant weight loss of 20.4% percent of their body weight in one month. Staff F requested a re-weigh to verify current weight. In an interview on 09/12/2024 at 1:30 PM, Staff B stated residents were weighed within the first 24 hours of admission. When asked to clarify the weight policy, Staff B stated residents should be weighed the day of admission to the facility and weekly thereafter. When asked where the weekly weight for 07/26/2024 was documented, Staff B stated Resident 3 refused, and it might be documented in a restorative binder, as the restorative aides weighed the residents. No additional weights were provided and Staff B stated we missed it. When asked about Resident 3's significant weight loss, Staff B stated the re-weigh would have been done on 08/01/2024 but the resident was discharged to the hospital with increased confusion. When asked when the significant weight loss was found on 07/29/2024 what actions did staff take, Staff B replied the re-weigh should have been done on 07/30/2024, and acknowledged no re-weigh was completed as recommended by the RD. <Resident 2> (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an admission MDS, dated [DATE], showed Resident 2 admitted to the facility on [DATE], was able to make needs their known, make their own decisions, and had behaviors of rejecting care four to six days of a seven day look back. The MDS showed Resident 2 was dependent on staff for toileting hygiene, bathing, dressing, bed mobility, and transfers. The MDS showed Resident 2 had medically complex conditions, including abdominal surgery, acid reflux, and muscle weakness, The MDS showed Resident 2 had no or unknown weight loss or gain. Review of Resident 2's nutrition/hydration CP, dated 08/26/2024, showed Resident 2 was at risk for nutrition and hydration deficits related to diuretic medication use, recent abdominal surgery, obesity, and difficulty walking. The CP directed staff to weight the resident per the facility policy and refer to the RD as appropriate. Review of Resident 2's weight record showed Resident 2's first weight was 426 lbs on 07/26/2024, two days after Resident 2 admitted to the facility. Resident 2 weighed 419.1 lbs on 08/01/2024, a loss of 6.9 lbs. The document showed no re-weight was obtained after the 6.9 lb loss. Review of Resident 2's weights showed on 08/10/2024 Resident 2 weighed 424.4 lbs, and the weight was completed a day after Resident 2 readmitted to the facility. The weight record showed no weight was obtained weekly on 08/17/2024 and a 08/25/2024 weight showed Resident 2 weighed 415 lbs, a loss of 9.4 lbs. Review of nursing progress notes, dated 07-24/2024-08/25/2024, showed no documentation that staff attempted to weigh Resident 2 on admission and re-admission to the facility. The documentation did not support staff informed the physician or Resident 2 about the 6.9 lb weight loss or the additional 9.4 lb weight loss. During an interview on 09/12/2024 at 1:45 PM, Staff B stated Resident 2 was not weighed on the date of admission and re-admission to the facility and expected weights to be completed on the day of admission. Staff B stated the weights should be in the residents record, re-weighs should be documented in the record within the next 24 hours, and the resident should be weighed weekly. When asked what the facility did about Resident 2's 9.4 lb weight loss, Staff B Stated Resident 2 should be re-weighed and acknowledged the weight was not in the record. <Resident 1> Review of Resident 1's admission MDS, dated [DATE], showed Resident 1 admitted to the facility on [DATE], was able to make their needs known and required assistance with decision making. The MDS showed Resident 1 was always incontinent of bowels, had no behaviors of rejecting care and required maximum assistance from staff for toileting hygiene, bed mobility, and transfers. The MDS showed Resident 1 had medically complex conditions, including respiratory failure, end stage renal disease requiring dialysis (removing excess water, solutes and toxins from the blood when kidneys no longer work), anxiety, and muscle weakness. The MDS showed Resident 1 had no or unknown weight loss or gain. Review of Resident 1's nutrition/hydration CP, dated 07/25/2024 showed Resident 1 was on a 2 liter daily fluid restriction. The CP directed staff to monitor Resident 1's weights per the facility policy and refer to the facility RD as appropriate. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 1's weight record, showed on 07/26/2024, a day after admission, Resident 2 weighed 136.7 lbs. The weight record showed a day later on 07/27/2024, Resident 2 weighed 141.8 lbs, a weight gain of 5.1 lbs in one day. Two additional weights were documented on the weight record and showed on 07/30/2024 Resident 2 weighed 141.3 and on 08/02/2024 Resident 2 weighed 139.8 lbs. No additional weights were observed in Resident 2's record. In an interview on 09/12/2024 at 1:55 PM, Staff B stated when a resident was receiving dialysis the facility used the weights obtained at the dialysis center. Staff B stated Resident 1 attended dialysis three times a week, weights should be sent back with the resident and if not, the nurse was expected to call the dialysis center to obtain the weight information. Staff B acknowledged dialysis weight records were not in Resident 1's record but should be. Staff B stated Resident 1 was not weighed on the day of admission or re-admission to the facility on [DATE]. <Resident 4> Review of an admission MDS, dated [DATE], showed Resident 4 admitted to the facility on [DATE], was able to make needs known, own decisions, and had behaviors of rejecting care one to three days of a seven day look back. The MDS showed Resident 4 required staff assistance with toileting hygiene, transfers, and ambulating. The MDS showed Resident 4 had medically complex conditions, including clostridium difficile (c. diff, a contagious gastrointestinal infection causing diarrhea), high blood pressure, and anxiety. Review of a nursing progress note, dated 08/22/2024, showed Resident 4 admitted to the facility following a gastrointestinal infection, required antibiotics, and therapy for weakness. The nursing progress note showed Resident 4 had a formed stool on 08/22/2024. Review of Resident 4's bowel monitoring, dated 09/04/2024-09/09/2024, showed on 09/04/2024 Resident 4 had multiple loose stools on day, evening, and night shift. The bowel monitoring showed Resident 4 continued to have loose stools on 09/05/2024, on day, evening, and night shift. The bowel monitor showed Resident 4 continued to have loose stools on 09/06/2024, 09/07/2024, 09/08/2024, and four loose stools on 09/09/2024. Review of a 09/10/2024, lab result for stool testing, showed Resident 4 was positive for c.diff. Review of a 09/10/2024 infection control note showed, Staff C (Infection Preventionist) documented Resident 4 continued on contact precautions (intended to prevent the transmission of infectious agents). In an interview on 09/10/2024 at 1:45 PM, Resident 4's CC stated the resident continued to have a lot of diarrhea, The CC stated they informed staff but had to tell the staff multiple times about the diarrhea and eventually asked the facility to re-test Resident 4 for c.diff, as the resident recently completed antibiotics for their c.diff infection. The CC expressed concern that the infection was not resolved after completing the antibiotics. In an observation and interview on 09/10/2024 at 4:15 PM, Resident 4 was observed in their bed resting. Resident 4's room was observed with a contact precautions sign that directed staff to put on a gown and gloves upon entering the room. Resident 4 stated they continued to have diarrhea, their tail bone was very sore, and had difficulties sleeping. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/10/2024 at 4:40 PM, Staff I (Registered Nurse) stated when a resident had multiple loose stools the nurse should assess the resident and check bowel tones and stool for consistency and smell. The nurse should take vital signs, check for signs of dehydration, determine a potential cause of the diarrhea, notify the physician and implement any orders. In an interview on 09/12/2024 at 2:00 PM, Staff C stated bowel monitors were reviewed in the morning meetings and the protocol for c.diff was three or more loose stools in a 24 hour period. Staff C stated all staff should know the protocol and initiate contact isolation if c.diff was suspected. Staff C reviewed Resident 4's bowel monitoring and stated Resident 4 should have been put on contact isolation on 09/04/2024, when the resident had multiple loose stools and met the criteria for contact isolation. Staff C stated no other residents were positive for c.diff and Resident 4 would remain in a private room on contact isolation. REFERENCE: WAC 388-97-1060(3)(h)(k)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44295 Based on observation, interview and record review the facility failed to ensure 3 of 3 (Residents 3, 4, 1) residents reviewed for Pressure Ulcers (PU, injury to the skin and underlying tissue due to prolonged pressure), received necessary care and services, consistent with professional standards of practice, to promote healing, and prevent new ulcers from developing. Failure to timely monitor, assess, implement wound provider recommendations, and preventative skin measures placed all resident's at risk for deterioration in skin condition(s), pain, and diminished quality of life. Findings included . Review of the facility policy titled, Skin Integrity, updated 10/2022, showed to maintain the resident's skin integrity and promote healing of skin ulcers/PU's/wounds the facility would use a systematic approach and monitoring process to evaluate and document skin integrity. When a resident admitted to the facility with or developed a skin ulcer/PU/wound the facility would provide care to treat, heal, and prevent, when possible the further development of skin ulcers/PU's/wounds. The policy showed when a resident was identified with a skin impairment upon admission the Licensed Nurse (LN) would document the skin impairment that included measurements, color, presence of odor, drainage, and pain in the nursing notes and complete a weekly wound evaluation. The LN would notify the resident or resident's responsible party and physician, obtain, and implement a treatment order, evaluate and identify and implement interventions to promote wound healing, and document on the residents Care Plan (CP). <Resident 3> Review of the admission Minimum Data Set (MDS, an assessment tool), dated 07/24/2024, showed Resident 3 admitted to the facility on [DATE], was able to make their needs known, and required assistance with decision making. The MDS showed Resident 3 had no behaviors of rejecting care, was frequently incontinent of their bowels, had impairments to one side of their upper extremities, and was dependent on staff for toileting hygiene, bed mobility, and transfers. The MDS showed Resident 3 had medically complex conditions, including surgical aftercare, peripheral vascular disease (progressive disorder of blood vessels, causing narrowing or blockage affecting the legs and feet), diabetes, history of bariatric surgery, and a kidney transplant. The MDS showed Resident 3 was at risk for developing PU's, had one unhealed stage 4 PU (skin injury that extends down to the muscle, bone or tendons), had one venous or arterial ulcer (result of irregular blood flow), and had surgical wounds. The MDS showed Resident 3 received PU and surgical wound care that required the application of medications. Review of an admission skin assessment, dated 07/18/2024, showed Resident 3 had non-blanchable (oxygen does not perfuse to skin tissue) redness to their tailbone, a skin tear above their tailbone, a stage 1 PU (intact skin that may be painful and red) to the left heel, a surgical incision to their lower abdomen and left thigh. Review of Resident 3's CP, imitated 07/18/2024, showed no CP developed for Resident 3's skin impairments. The CP showed no interventions that directed staff how to manage, heal and prevent further worsening of Resident 3's skin impairments. (continued on next page)

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(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 - Minimal harm or potential for actual harm Residents Affected - Some	Review of an outside wound provider note, date 07/25/2024, showed Resident 3 was assessed with a surgical wounds to the left thigh, left groin, left lower leg, an arterial wound to the left lower leg, a stage 2 PU (a shallow open ulcer with a red wound bed) to the left heel, and a stage 4 PU to their tailbone. The wound provider ordered a treatment for the left heel and tailbone PU's. Review of Resident 3's physician orders, dated 07/31/2024, directed staff to provide a treatment for Resident 3's tailbone PU. A second physician order, dated 08/01/2024, directed staff to provide a treatment to Resident 3's left heel PU. Review of the July 2024 Treatment Administration Record (TAR, documentation of treatment orders and staff signatures of completion), showed staff did not implement the wound providers recommendations on 07/25/2024 when treatments were ordered until seven days later. Review of Resident 3's Activities of Daily Living (ADL) bed mobility documentation, dated 07/18/2024-07/31/2024, showed on multiple occasions staff documented NA (not applicable) in response to assisting Resident 3 with rolling from side to side in the bed. Staff documented NA on 07/19/2024 night shift, 07/21/2024 day and night shift, 07/24/2024, 07/25/2024, 07/27/2024, 07/29/2024, and 07/30/2024 night shift. During an interview on 08/16/2024 at 1:35 PM, Resident 3's Collateral Contact (CC), stated when they visited Resident 3 they were swimming in their own stool, was worried about the stool soiling the surgical incisions, and staff would tell Resident 3 we will let you finish before changing the resident. The CC stated Resident 3 had no history of PU's, and the one on their bottom got really bad from just laying there. The CC stated that Resident 1 would make comments that staff ignored them and would not reposition them in the bed. The CC stated Resident 3 was seen by the wound provider on 08/01/2024, was very confused, and the facility sent Resident 3 to the hospital to be evaluated. In an interview on 09/12/2024 at 1:30 PM, Staff B (Director of Nursing Services) stated Resident 3 admitted to the facility following a surgery and needed care for wounds and antibiotic therapy. When asked what skin prevention measures were in place when Resident 3 admitted , Staff B replied the facility implemented wound care orders. Staff A (Administrator) stated all the resident beds at the facility were graded for pressure relief up to a stage 2 PU. Staff B stated Resident 3 should have a CP for their pressure and surgical wounds with interventions, and was not sure why it took six days to implement the would care providers recommendations but would expect staff to implement recommendations as soon as possible. Staff B stated they expect staff to turn and reposition residents every two hours and as needed on all shifts when the resident was in bed, and acknowledged seven of 14 days staff documented NA for bed mobility. Staff B stated they were not sure how Resident 3's tailbone PU went from a Stage 1 to a Stage 4 in one week. <Resident 4> Review of an admission MDS, dated [DATE], showed Resident 4 admitted to the facility on [DATE], was able to make their own decisions, and had behaviors of rejecting care one to three days of a seven day look back period. The MDS showed Resident 4 was occasionally incontinent of bowels, required staff supervision and assistance with toileting hygiene, bed mobility, and moderate assistance with transfers. The MDS showed Resident 4 had medically complex conditions, including clostridum difficile (c.diff, an infectious bacteria causing abdominal discomfort and diarrhea), anxiety, muscle weakness, and difficulty in walking. The MDS showed Resident 4 had no PU's, was at risk for developing PU's, and had an application of a non-surgical dressing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505344	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an admission assessment, dated 08/22/2024, showed Resident 4 was assessed with blanchable (oxygen perfuse to skin tissue when pressure applied with finger tip) redness to their tailbone. Review of Resident 4's CP, imitated 08/22/2024, showed no CP developed for Resident 4's risk for skin impairments. The CP showed no interventions that directed staff how to manage and prevent skin impairments for Resident 4. Review of a Nursing Progress Note (NPN), dated 08/22/2024, showed Staff D (Registered Nurse, Resident Care Manager (RCM)) documented Resident 4 was alert, oriented, able to answer questions appropriately, and complained of discomfort to their tail bone. Staff D documented Resident 4 was repositioned on their side, which helped with the pain. Review of Resident 4's physician orders, dated 08/22/2024, showed a physician order that directed staff to apply a foam dressing to resident 4's tail bone every seven days and as needed. Review of Resident 4's August 2024 TAR, showed on 08/23/2024 staff documented a dressing was applied to Resident 4's tail bone. The TAR showed on 08/30/2024, staff documented 1, according to the TAR chart codes, indicated the resident was absent from home without meds. Review of Resident 4's NPN's, dated 08/30/2024, showed Resident 4 was out of the facility for an appointment . The NPN did not address Resident 4 missing their dressing change to their tail bone. Review of NPN, dated 09/03/2024, showed Resident 4 was seen by a urologist, the NPN did not address the new wound found on Resident 4's tail bone at the urology appointment. Review of a wound provider note, dated 9/5/2024, showed Resident 4 was assessed with a Stage 2 PU to their tailbone and ordered a treatment for the PU. During an interview on 09/10/2024 at 1:45 PM, Resident 4's CC stated they were present at a doctors appointment on 09/03/2024, when a wound was discovered on Resident 4's tail bone. The CC stated the doctor's nurse measured the wound at five inches in length and three inches in width. The CC was not aware Resident 4 had the wound. The CC stated Resident 4 complained multiple times to staff of their tail bone hurting. The CC stated Resident 4 couldn't move well by themselves, needed more help, and had a lot of diarrhea lately since being sick. During an interview on 09/12/2024 at 1:40 PM, Staff B stated it was not very common to have a dressing be changed every 7 days, and it should be changed when the dressing was soiled or after a shower. Staff B stated they would expect staff to report to the next shift or re-schedule the dressing change when the resident was out of the facility for a doctors appointment. Staff B stated the facility had knowledge of the wound on 09/03/2024. Staff B stated Resident 4 was referred to the wound provider. Staff B stated Resident 4 did not have a CP with interventions to manage the Stage 2 PU and would expect there to be a CP developed. <Resident 1> (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 1's admission MDS, dated [DATE], showed Resident 1 admitted to the facility on [DATE], was able to make their needs known and required assistance with decision making. The MDS showed Resident 1 was always incontinent of bowels, had no behaviors of rejecting care and required maximum assistance from staff for toileting hygiene, bed mobility, and transfers. The MDS showed Resident 1 had medically complex conditions, including respiratory failure, end stage renal disease, anxiety, and muscle weakness. The MDS showed Resident 1 had one unhealed Stage 1 PU, was at risk for PU, received PU care, and applications of dressings. Review of Resident 1's skin integrity CP, dated 07/25/2024, showed Resident 1 had an actual impairment to the skin integrity but did not identify what type of wound, wound characteristics or wound location. The CP directed staff to follow facility protocols for treatment of injury, monitor/document the location, size, and treatment of the skin injury, and directed staff to report any abnormalities to the physician. The CP directed staff to monitor the wound weekly and document the wound characteristics. Review of hospital transfer PO's, dated 07/25/2024, showed Resident 1 had PO that directed staff to provide wound care and a referral to wound care for their stage 2 PU. Review of a NPN, dated 07/25/2024, showed Staff E (Licensed Practical Nurse, RCM) documented Resident 1 admitted to the facility with a Stage 2 PU to their tail bone. The NPN showed Resident 1's wound measured four centimeters (cm) in length, three cm in width, and 0.1 cm in depth. Review of Resident 1's medical record showed no documentation of weekly wound assessments for Resident 1's stage 2 PU after the first assessment was completed on admission. Resident 1's stage 2 PU was not assessed on 08/01/2024 or 08/08/2024. During an interview on 09/12/2024 at 1:30 PM, Staff B stated Resident 1 should have a CP that identified the type and location of the wound. Staff B stated Resident 1's weekly wound assessments were missed and they would expect wounds to be assessed weekly with documentation. Staff B stated resident's with a stage 2 or higher PU were referred to a wound provider and Resident 1 was not referred to a wound provider as they would expect. REFERENCE: WAC 388-97-1060(3)(b) .