STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505346	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheney Care Center	2219 North 6th Street Cheney, WA 99004

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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 27590 Based on observation, interview, and record review, the facility failed to assess, monitor, and notify the physician of a non-pressure related skin condition for 1 of 3 sampled residents (Resident 1), reviewed for skin integrity. This failure placed the residents at risk for potential worsening skin conditions and a decreased quality of life. Findings included . Review of the facility policy titled Wound and Skin, dated 07/23/2013, showed the facility policy was to identify all wound and skin issues upon admission, on an ongoing basis, and on the routine weekly skin check day using the skin assessment tool. Once a wound or skin issue was identified, the Licensed Nurse (LN) was to document the characteristics of the issue i.e. size, depth, color, drainage, and location in the chart and on an incident report. This information must be documented in the skin assessment on a weekly basis. The findings were to be reported to the MD and fax MD with plan for treatment. Staff were to record this on the electronic Medication Administration Record (eMAR) under treatments and was to be followed up on by the LN's. The Director of Nursing (DNS) was to be notified for all skin issues. According to a facility assessment, dated 03/02/2025, showed Resident 1 had a history of a stroke, anxiety and depression. The resident had some difficulty making their needs known. Resident 1 required substantial to maximal assistance with most Activities of Daily Living (ADL's). Review of a skin assessment, dated 04/26/2025, showed Resident 1 had 2 boils: 1 on the left bottom side of the scrotum and 1 on the right side. They measured 2 centimeter (cm) x 2 cm, and had hard lumps under the wounds. The left inner thigh had a blister that measured 2 cm x 2 cm and the blister was described as popped. Staff noted they covered all areas with barrier cream. Review of the resident's eMAR for April 2025 through May 3, 2025 showed no treatment in place related to the resident's skin issues. Review of progress notes showed no documentation on 04/26/2025 about the new skin issue or that the physician had been notified. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/01/2025 a progress note by Staff B, Infection Preventionist (IPC), showed a Nursing Assistant (CNA) reported Resident 1 had blood on their brief. Staff B assessed the resident's groin and found a small amount of blood from an excoriated (raw and irritated) area to the right side of the scrotum. On 05/03/2025 Staff C, Registered Nurse (RN) documented Resident 1 complained their pain had increased from their boils. The resident was no longer able to sit in their chair and wanted to lay down. Warm compresses where applied to the boils and the resident stated it only helped a little. The resident requested to go to the hospital and the on call provider agreed due to the increased pain and discharge from the resident's boils. Review of hospital records, dated 05/03/2025, showed the resident had scrotal cellulitis (a bacterial skin infection affecting the deeper layers of the skin and underlying tissue, often causing localized redness, swelling, warmth, and pain) and abscesses (a swollen area within body tissue, containing an accumulation of pus). The abscesses were drained and cultures taken which showed Methicillin-resistant Staphylococcus aureus (MRSA, a bacteria that is resistant to many antibiotics and highly contagious by skin to skin contact or contact and by contaminated surfaces). During an interview on 05/16/2025 at 11:03 AM, Staff D, Licensed Practical Nurse (LPN), stated if a new wound was identified, nurses would complete an incident report, notify Staff B, Infection Preventionist, and call the physician if a treatment was needed. When asked about Resident 1, Staff D stated they had taken care of the resident the evening before the resident went to the hospital. Staff D stated a nursing assistant asked them to look at the resident. The resident had boils - 1 on the inner thigh, the other on the side of their testicle, which looked ready to pop. The area was open, oozing and swollen. Staff D stated they didn't complete an incident report because the boils had been reported to them a couple of days prior and assumed it had already been done. Staff D stated they notified the physician in the provider book. During an interview on 05/21/2025 at 12:27 PM, Staff E, RN, stated they had completed the skin assessment on 04/26/2025 after a nursing assistant had notified them the resident had pain in their scrotal area. The resident had a popped blister on their left inner thigh and the resident's scrotum was swollen. Staff E assumed since the blister had popped, another nurse had identified the area, so didn't investigate further to see if a incident report had been done. On 05/21/2025 at 3:00 PM, Staff F, CNA, had noticed the skin issues for Resident 1 on the day the resident was sent out to the hospital. Staff F stated they went and told the nurse so they could assess it. On 05/22/2025 at 9:37 AM, Resident 1 was laying in bed. The resident stated they had boils on their scrotum and went to the hospital to have them drained. Resident 1 said they now had dressing changes and was told by staff the areas were healing. Resident 1 gave the surveyor permission to observe the dressing changes. At 10:21 AM, Staff A, RN, donned their gloves and removed the resident's brief. The wounds were without dressings and open to air. Staff A cleansed the resident's wound on the underside of the right testicle. Their was a small area open area which appeared to be healing. Staff A stated the resident had orders for the area to be packed but the wound had closed enough that packing wasn't needed. The area was cleansed, gauze was placed, and a border dressing was applied. The left inner thigh had a pink/red, closed area. The area was cleansed and a border dressing was placed. The resident tolerated the dressing change well. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/2025 at 11:23 AM, Staff C, RN, was contacted by telephone. Staff C stated the first they knew about the resident's boils was on the day the resident was sent to the hospital. The resident had been in their wheel chair and complained of increased pain so was put in bed. Staff C offered a warm compress and commented they were not sure what had been done for treatment prior to that. Later in the shift, Staff C was told by a CNA the resident had some blood and drainage. Staff C described the wounds as opened with a nickel size pus plug. The surrounding area was hard, like the size of an apple or orange. The other areas were harder to visualize. The resident was sent to the hospital. On 05/22/2025 at 11:50 AM, Staff B, IPC, stated the were not aware there was skin issues with Resident 1. When Staff E had identified the boils, they should have completed an incident report, placed the resident on alert, contacted the physician and Administration, and documented on a progress note. On 05/01/2025 a CNA told Staff B the resident had blood on their brief. When Staff B assessed the area, they found an excoriated area to the right of the resident's scrotum. Staff B stated the boils were under Resident 1's scrotum and were not visable at that time. Staff B stated the nurses should have followed the process for a new skin issue, which had not been done. In addition, Staff D, LPN, had notified the physician in the provider book but since it was a Friday evening, the provider should have been contacted directly. Reference: WAC 388-97-1060(1)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 27590 Based on observation, interview, and record review, the facility failed to ensure staff followed Contact Precautions, when indicated, for 1 of 1 sampled resident (Resident 1), during wound care. This failure placed the residents at risk for spread of infection, illnesses, and unintended health consequences. Findings included . Per the Center for Disease Control (CDC) guidelines, staff should wear a gown and gloves for residents on Contact Precautions. Additionally, if there is a chance for splashes or sprays of body fluid eye precaution and mask may be needed. According to a facility assessment, dated 03/02/2025, Resident 1 had a history of a stroke, anxiety and depression. The resident had some difficulty making their needs known. Review of a hospital discharge orders, dated 05/12/2025, showed the resident had abscesses that had been drained and tested positive for Methicillin-resistant Staphylococcus aureus (MRSA, a bacteria that is resistant to many antibiotics and highly contagious by skin to skin contact or contact with contaminated surfaces). Dressing changes were to be daily and Contact Precautions followed. During an observation on 05/22/2025 at 10:21 AM, Staff A, Registered Nurse (RN), and surveyor entered Resident 1's room for a dressing change. There was no signage on the door to show the resident was on contact precautions and no cart outside the room with Personal Protective Equipment (PPE's). When entering the room, a sign was seen on the resident's wall that showed they were on contact precautions and a tote was below. The sign was difficult to see due to the lighting in the room. Staff A donned their gloves, cleansed the wounds, and covered them with dressings. Staff A washed her hands in between putting on new gloves. The wounds appeared to be healing. Staff A did not place a gown on during the procedure. Staff A was interviewed at 11:12 AM and asked if Resident 1 was on contact precautions. Staff A looked at their work sheet and stated they should be, Resident 1 had MRSA. Staff A stated a gown should have been worn but they did not see a sign or cart to show they were on contact precautions. Staff A and the surveyor went into the room where the sign and tote were located. During an interview on 05/22/2025 at 11:50 AM, Staff B, Infection Preventionist, stated they had not been in the facility when Resident 1 returned from the hospital. Staff B stated the signage for residents on contact precautions, especially with MRSA, should have been on the outside of the door and the PPE cart so staff could don prior to entering the room. Staff B confirmed Staff A should have worn a gown at the time of the dressing change. Reference: WAC 388-90-1320(2)((B)