

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505400	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2026
NAME OF PROVIDER OR SUPPLIER Enumclaw Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2323 Jensen Street Enumclaw, WA 98022	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement pressure offloading interventions timely for resident's assessed to be at increased risk for skin breakdown to prevent the development of pressure injuries (PI) for 2 of 3 residents (Residents 1 & 2) investigated for development of new PI after admission. Resident 1 experienced harm when they developed two avoidable deep tissue pressure injuries (DTPI) after admission, one on each heel, that resulted in pain, affected their mobility and care routines, and delayed their rehabilitation and discharge goals. Resident 2 experienced harm when they developed a Stage 3 PI on their sacrum that resulted in pain, affected their ability to sleep, comfort, and decreased their bed mobility. These failures placed residents at risk for injury, infection, pain, and diminished quality of life. Findings included. The 2025 National Pressure Injury Advisory Panel (NPIAP), a leading expert in pressure injuries) defined PIs as localized damage to the skin and underlying soft tissues usually occurring over a bony prominence. The injury could present as intact skin or an open ulcer and may be painful. These injuries occurred from intense and/or prolonged pressure or pressure in combination with friction or shearing of skin tissues. The NPIAP defined a stage 3 PI as full thickness skin loss that extends below the top and middle layers of skin in which fat or connective tissue is visible in the ulcer. A Deep Tissue Pressure Injury (DTPI) was defined as intact or nonintact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration, or separation of multiple skin layers revealing a dark wound bed or blood-filled blister <Facility Policy> Review of the August 2009 policy for Skin Integrity, updated March 2026, showed residents who entered the facility without PI would not develop a PI, assessment of PI risk was completed at admission, a care plan would be established based on risk factors, and ongoing weekly skin assessments would be completed. The policy showed when a new PI was identified there would be an assessment, documentation, and implementation of interventions for PI treatment. <Resident 1> Review of the 04/01/2026 admission nursing assessment showed Resident 1 was admitted to the facility on [DATE], was dependent on staff for bed mobility, and required two staff to assist with movement in bed. Review of the 04/01/2026 admission skin assessment showed Resident 1 had no skin impairment on their heels at admission. Review of the 04/01/2026 Braden assessment for predicting pressure sore risk showed Resident 1 was at risk for PIs related to very limited mobility, unable to make body position changes independently, required assist by staff into a chair, risk of friction and shear to skin from sliding against sheets and surfaces in bed/chair. Review of the 04/02/2026 wound specialist progress note showed the facility made a referral for an at-risk skin consultation for treatment recommendations related to a risk assessment score placing Resident 1 at risk for skin related complications. The wound specialist note showed no skin impairment on the feet or heels, and muscle weakness to both feet. The specialist recommended change of position every two hours related to Resident 1 immobility, skin care with lotion to feet, and float heels off mattress using pillows or wedge. Review of the 04/08/2026 baseline care plan showed no care plan to prevent Resident 1 from developing PIs. The care plan did not show interventions to prevent skin breakdown identified in the Braden skin assessment or the wound specialists recommendations for PI prevention. Review of two late entry nursing progress notes for 04/09/2026 (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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F 0686 Level of Harm - Actual harm Residents Affected - Few	<p>showed Resident 1 had a DTPI on the right heel measuring 3.5 centimeters (cm) long by 4.5 cm wide, dark red/purple in color, worsening since last evaluation. The left heel had a DTPI measuring 2.5 cm long by 3.3 cm wide, dark red/purple color and worsening since last evaluation. Review of a 04/10/2026 nursing progress note showed Resident 1 had a follow up visit by the wound care specialist who assessed two new DTPIs, one on each heel. The note described the DTPIs as dark in color, non-blanching and tender when touched. The note showed the wound specialist recommended Resident 1's heels be floated to relieve pressure while in bed. The note showed the facility ordered an air mattress for Resident 1. Review of a 04/16/2026 wound specialist note showed Resident 1's right heel increased in size, measured 5 cm wide, 6.5 cm long, and was deteriorating by dimension and overall clinical impression. The note showed no changes to the left heel. The note showed recommendation was made to the facility, a second time, to implement a low air loss mattress for Resident 1's healing of both DTPIs. In an interview on 04/22/2026 at 4:39 PM, Resident 1's representative (RR) stated they visited Resident 1 daily and most days visited twice. The RR stated Resident 1 did not have any skin problems at home or in the hospital before coming to the facility on April 1, 2022. The RR stated they visited on April 3, 4, 5, 2026 and Resident 1 did not get out of bed for three days, there were no pillows in the bed, and the RR did not see Resident 1 be repositioned as was done in the hospital every couple of hours. The RR stated the staff just had Resident 1 lay on their back the whole time. The RR stated on April 6, 20026 the facility staff had Resident 1 in a wheelchair that did not have footrests that fit, so Resident 1's feet dragged on the floor when they were pushed in the wheelchair to and from the dining room. The RR stated they brought in Resident 1's personal wheelchair so they would have footrests. The RR stated facility staff informed them of the wounds on Resident 1's feet on April 9, 2026 and informed the RR that Resident 1 was not allowed to walk or put pressure on their heels and would use a wheelchair until the PIs healed. The RR stated when they looked at Resident 1's heels they were dark red and painful looking and Resident 1 winced and pulled away when the PI were touched. The RR stated Resident 1 was admitted to the facility to get stronger and walk so they could discharge home or to an adult home. The RR stated Resident 1 could use a walker and the toilet on admission but is now incontinent due to not walking to the bathroom. The RR stated Resident 1 had severe dementia and now the wounds on their feet had changed their mobility and care routines. The RR stated Resident 1 had significant setbacks to their rehab and discharge goals. In an observation and interview on 04/23/2026 at 8:50 AM, Resident 1 was sitting in a wheelchair in their room, was unable to answer questions, and had to rely on staff to hold their feet for the specialist to see the heels. The wound specialist removed Resident 1's socks and there was a piece of white foam on the right heel. The foam had dried red-brown drainage. The wound specialist stated they first observed the PIs on 04/09/2026 and saw them again on 04/16/2026 and the right heel was larger in size. The wound specialist assessed the heels and stated the right heel had started draining fluid from the dark purple wound. The wound specialist stated the right heel was not draining fluid the week prior. Observation of Resident 1's bed showed a standard mattress; there was not an air mattress on the bed. In an interview on 04/23/2026 at 1:11 PM, Staff B (Director of Nursing) stated Resident 1 was supposed to have an air mattress after the DTPIs were identified on 04/09/2026. Staff B reviewed Resident 1's medical record and stated there was no skin care or PI prevention care plan implemented on admission, when Resident 1 was assessed to be at risk for developing PIs. Staff B stated the 04/10/2026 progress note showed an air mattress was ordered and Resident 1 never received the air mattress. Staff B stated there was no follow up by staff to ensure the air mattress was ordered or implemented. <Resident 2> Review of a 03/20/2026 admission Braden assessment for predicting pressure sore risk showed Resident 2 was admitted on [DATE], was assessed at risk for developing PIs related to limited mobility, confined to bed, their skin had increased exposure to moisture, and was at risk of friction and sheer to skin from sliding against sheets in bed. Review of the 04/03/2026 nurse progress note showed Resident 2 reported to staff they had a sore on their buttocks. The nurse note described the wound as a friction tear to the skin. (continued on next page)</p>		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the 04/09/2026 wound specialist note showed Resident 2 had a facility acquired stage 3 PI measuring 4.7 cm wide, 5.6 cm long and 0.2 cm deep on their sacrum. The note showed the wound specialist recommended treatment with a low air loss mattress discussed with Resident 2 and caregivers. Review of a 04/09/2026 late entry nurse progress note showed Resident 2 presented with a stage 3 PI to the sacrum, the abrasion had deteriorated with redness surrounding the wound. The note showed an air mattress was ordered to help with healing. In an interview and observation on 04/23/2026 at 10:56 AM, Resident 2 was observed lying on a standard facility mattress with a sheet, feet on pillows and able to move independently to reposition. Resident 2 stated they had a bedsore on their buttocks that hurt and was not there when they admitted to the facility. Resident 2 stated they could not sleep well because of the bedsore and could not get comfortable in their bed. Resident 2 stated their mattress had a hole in it and was caved in from the previous person that used it. Resident 2 stated they told a staff person a couple weeks ago and was told they would get a new mattress but had not received it yet. In an interview on 04/23/2026 at 12:25 PM, Staff D (Admissions Coordinator) stated the facility owns air mattresses and when one needs to be rented, they (Staff D) were the person responsible for renting the air mattresses for residents who needed them. Staff D stated the rental air mattresses are usually delivered on the same day. Staff D stated rental air mattresses were not ordered or obtained for Resident 1 or Resident 2. In an interview on 04/23/2026 at 1:22 PM, Staff B and Staff C (Resident Care Manager) stated they recalled discussion amongst the team to provide an air mattress to Resident 2. Staff B and C reviewed team discussion on their computers and stated Staff A (Administrator) asked the team to obtain an air mattress for Resident 2 on 04/09/2026. Staff B stated Resident 2 should have an air mattress as recommended by the wound specialist, documented in the nurse notes, and as requested by Staff A. Staff B stated there was no staff follow-up to ensure the air mattress was ordered or implemented for Resident 2. REFERENCE: WAC 388-97-1060(3)(b).		