

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505401	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Medical Resort of Parkside		STREET ADDRESS, CITY, STATE, ZIP CODE 308 West Emma Union Gap, WA 98903	

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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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(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 - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide thorough skin assessments to develop pressure offloading interventions and notify the provider timely of change in skin condition for treatment to prevent the worsening of pressure injuries (PI, localized damage to the skin and underlying soft tissue usually over a bony prominence) for 1 of 3 residents (Resident 1) reviewed for pressure injuries. Resident 1 experienced harm when their coccyx (tailbone) had a Stage 1 PI (intact skin with localized area of non-blanchable redness [red color does not change when area pressed]) present on admission that worsened to a Stage 3 PI (full-thickness loss of skin, in which fat is visible in the wound) and progressed to an unstageable PI (wound bed not visible with full-thickness skin and tissue loss) requiring wound debridement (removal of dead skin and tissue) by a wound care specialist and hospital evaluation. This failure placed the resident at risk for additional PIs and wound infection. Findings included. Review of The National Pressure Ulcer Advisory Panel (NPUAP) April 2016, showed PI Stages as follows: Stage 1 PI is intact skin with a localized area of non-blanchable redness (when the redness of the skin temporarily disappears when pressure is applied to the area). Stage 2 PI is partial-thickness skin loss with exposed dermis (middle layer of skin). The wound bed is viable, pink or red, and moist. These injuries commonly result from pressure and an adverse microclimate such as moisture associated skin damage (MASD, a term used to describe skin inflammation or erosion caused by prolonged exposure to moisture such as urine or feces.) Stage 3 PI is full-thickness loss of skin, in which fat is visible in the ulcer wound Stage 4 PI is full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage or bone in the wound Unstageable PI is obscured full-thickness skin and tissue loss in which the extent of tissue damage within the wound cannot be confirmed because it is obscured by slough (dead skin tissue that appears yellow or white and can cover parts or the entire wound bed) or eschar (dead tissue that falls off healthy skin). If slough or eschar is removed, a Stage 3 or Stage 4 PI will be revealed. Resident 1 Record review showed Resident 1 admitted to the facility on [DATE] with diagnoses to include rheumatoid arthritis (a chronic autoimmune disorder that primarily affects the joints causing pain), heart failure (a progressive heart disease that affects pumping action of the heart muscles) and a urinary tract infection. Record review of a 09/10/2025 nursing admission assessment showed Resident 1 was at risk for PI and the 09/10/2025 skin check showed Resident 1's coccyx had blanchable redness (the redness temporarily disappears when the area was pressed) and a barrier cream was applied. Review of Resident 1's 09/10/2025 care plan showed the interventions to maintain clean and intact skin as follows: Avoid scratching and keep fingernails short, Encourage good nutrition and hydration, Keep skin clean and dry. Use lotion on dry skin, No further interventions were added to the care plan prior to their discharge on [DATE]. Review of a 09/15/2025, 9:09 PM progress note showed Resident 1 had an open wound on their coccyx. The wound was cleaned, and a dressing was applied. (no measurements, description or staging of the wound were documented) Review of the 09/16/2025 comprehensive assessment showed Resident 1 was cognitively intact and required extensive assistance from staff for their activities of daily living (ADL) such as hygiene, toileting and dressing. Resident 1 required extensive assistance from two staff to change position in bed and transfer between bed and wheelchair. Review of the skin assessment worksheet showed Resident 1 was at risk for developing PIs due to urine/bowel incontinence, dependence on staff to reposition in bed and presence of one Stage 1 PI observed on their 09/10/2025 admission. Review of a 09/17/2025, 1:21 PM progress note showed Resident 1 was seen by the facility physician (MD) to follow up on their admission. The MD's narrative showed that nursing staff and Resident 1 voiced no new concerns. Review of a 09/17/2025, 1:27 PM progress note showed Resident 1 and their representative attended a care conference with members of the interdisciplinary team and nursing reported no new concerns. Review of a 09/18/2025 Nutrition at Risk (NAR) meeting progress note showed Resident 1's diet order was low salt, regular consistence and thin liquids. There were no nutritional supplements to increase protein intake. The meeting was attended by Staff B, Director of Nurses (DON), Staff C, Licensed Practical Nurse/Resident Care Manager (LPN/RCM) and Staff D, Registered Dietitian (RD). Review of the meeting notes also showed there were no current skin issues (three days after an open wound had been observed). Review of Resident 1's September 2025 Treatment Administration Record showed a 09/19/2025 physician order to cleanse the coccyx wound with normal saline, apply an ointment and dressing once daily. Further record review showed no progress note or skin assessment with measurements or wound staging on 09/19/2025 (four days after</p>		