STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505417	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Anne Nursing and Rehabilitation Center	3540 Northeast 110th Street Seattle, WA 98125

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35787 Based on interview and record review, the facility failed to provide timely treatment of pressure injuries/pressure ulcers (wounds that occur due to prolonged pressure on the skin) for 1 of 3 residents (Resident 1), reviewed for pressure ulcers. The failure to provide timely treatments for pressure ulcers placed the resident at risk of further decrease in skin integrity, wound infection, and related complications. Findings Included . Review of the admission Minimum Data Set assessment (MDS - an assessment tool) dated 04/08/2024, showed Resident 1 was admitted to the facility on [DATE] with a diagnosis of hemiplegia (weakness or inability to move one side of the body) after a stroke. The MDS also showed Resident 1 required assistance with mobility and was at risk for pressure ulcers. Review of the admission screen form dated 04/02/2024, showed Resident 1 had redness to toes. On 05/23/2024 at 1:56 PM, Staff C, Registered Nurse (RN), stated they completed the admission screen for Resident 1 on 04/02/2024, and observed redness to both big toes that did not go away [non-blanchable - superficial reddening of the skin (red, blue, or purple hues in darkly pigmented skin) that when pressed does not turn white. If the cause of the injury is not relieved, these will progress and form pressure ulcers]. Staff C further stated that Resident 1 was seen by the wound care team for the redness to both big toes. Review of a wound care note dated 04/11/2024, showed Resident 1 had a non-blanchable deep tissue injury (DTI - is a type of pressure ulcer that occurs when pressure or shear damage the soft tissue beneath the skin occurs) on the right great toe measuring 0.5 centimeters (cm, a unit of measurement] by 0.6 cm with no measurable depth, and a non-blanchable DTI to the left great toe with persistent deep red/maroon/purple discoloration measuring 1.0 cm by 1.8 cm with no measurable depth. Further review of the wound care note showed Resident 1 had treatment orders to cleanse the right and left great toe with wound cleanser and apply a bordered foam dressing every other day. Review of the April 2024 Treatment Administration Record (TAR), and physician's order dated 04/15/2024, showed to cleanse [the] right and left great toe with wound wash. Pat dry and cover with small foam padding. Change every other day on day shift. Further review of the TAR showed the start date of the treatment was on 04/16/2024, five days after (04/11/2024) the wound consult order was written. (continued on next page)

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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(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 - Few	On 05/23/2024 at 3:56 PM, Staff D, Registered Nurse (RN), stated they would notify the doctor immediately after the skin was assessed and a skin problem was identified to get a treatment order for the skin problem. On 05/23/2024 at 4:00 PM, Staff E, RN, stated, I would call the doctor right after the skin was assessed and get the order started to treat the skin condition. On 05/23/2024 at 4:05 PM, Staff B, Director of Nursing Services, stated it was the responsibility of the nurse that was assigned to the resident to receive and carry out treatment orders for the residents they were assigned to provide care for. Staff B stated the treatment order was dated 04/11/2024 but was not started until 04/16/2024 because the treatment order from the wound consult was sent to the computer of a staff member that was not at work on 04/11/2024, and other staff members did not have access to that computer. On 05/23/2024 at 4:33 PM, Staff A, Administrator, stated there was a delay of care when the treatment order dated O4/11/2024 was not started until 04/16/2024. Reference: (WAC) 388-97-1060(3)(b)