| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505485 | A. Building<br>B. Wing | 05/21/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Linden Grove Health Care Center | 400 - 29th Street Northeast<br>Puyallup, WA 98373 |

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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 6 of 6 residents (Residents 4, 5, 6, 7, 8, and 9) reviewed for insurance disenrollment were informed of the risks/benefits, options, and alternative changes in their insurance, in ways that were easy for the residents and/or the residents' representative to understand. The facility failed to develop written policies and procedures regarding the process of assisting beneficiaries with changing their health care coverage, including the need to obtain a document signed by the beneficiary or representative that acknowledges that the specific information regarding the impact of a change in coverage was provided to them orally and in writing, and that they understood the information. Failure of the facility placed residents at risk of non-coverage, increased cost out of pocket, and caused undue stress to residents and/or resident representatives and placed Managed Medicare residents at risk of the facility disenrolling them without their request, consent knowledge, or complete understanding.Findings included.Review of the Skilled Nursing Facility admission Agreement showed that the facility was an in-network provider for some Medicare Advantage Plans. If a Resident's care was covered by a Medicare Advantage Plan (Managed Medicare), Resident's skilled nursing care was managed through the insurance company. The needs and services were authorized and managed by the insurance provider's case managers and physicians. The facility participated in the Medicare program. If eligible, Medicare would pay 100% of Resident's costs in a semi-private room for the first twenty (20) days. The next eighty (80) days were known as coinsurance days, which meant the Resident was responsible for paying coinsurance on day 21 forward. According to the admission Agreement, the facility assured Residents all the rights in the Resident's [NAME] of Rights.The Centers for Medicare and Medicaid Services Memo to Long Term Care facilities on Medicare Health Plan Enrollment, dated October 2021 documented Only a Medicare beneficiary, the beneficiary's authorized or designated representative, or the party authorized to act on behalf of the beneficiary under state law can request enrollment in or voluntary disenrollment from a Medicare health or drug plan. It further explains the facility's responsibility as the following: Explain orally and in writing the impact to the beneficiary if they change coverage (e.g., to a stand-alone prescription drug plan (PDP) and Original Medicare, or to a different Medicare health plan). Develop written policies and procedures regarding the process of assisting beneficiaries with changing their health care coverage.<RESIDENT 4>Resident 4 was admitted to the facility on [DATE] with multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (weakness or paralysis to the left side of the body following tissue death in the brain caused by a blocked or severely restricted blood supply). The Quarterly Minimum Data Set, (MDS-an assessment tool), dated 04/27/2026, documented Resident 4 as cognitively intact. Review of Resident 4's record showed they were originally admitted to the facility on [DATE] on Medicaid. Resident 4 was sent to the emergency room on [DATE] and re-admitted to the facility on [DATE] under a managed Medicare plan and transferred to Traditional Medicare effective 05/01/2026. Further reviews showed no documentation to support the resident or POA was explained orally and in writing the impact to the beneficiary if they changed coverage.On 05/19/2026 at 1:09 PM, Resident 4 said she does not handle any of her finances and to call her daughter who is her Power of Attorney (POA).<br>(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 |
|---|---|---|---|
| | 505485 | A. Building<br>B. Wing | 05/21/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Linden Grove Health Care Center | 400 - 29th Street Northeast<br>Puyallup, WA 98373 |

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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident 4 denied receiving anything in writing about the change in insurance.At 2:48 PM POA was interviewed. POA said she had not been aware that Resident 4's insurance had been changed to Medicare A but she is OK with it if Resident 4 is getting the care and services she needs. POA said this was not a good time to talk as she was on vacation and would reach out to the facility upon her return. <RESIDENT 5>Resident 5 was admitted to the facility on [DATE] with multiple diagnoses including unspecified fracture of upper end of right humerus (right upper arm fracture). The admission MDS, dated [DATE], documented Resident 5 as cognitively intact.Review of Resident 5's record showed they were admitted to the facility on [DATE] on a Medicare Advantage plan and transferred to Traditional Medicare effective 05/01/2026. Further review showed no documentation to support the resident or POA was explained orally and in writing the impact to the beneficiary if they changed coverage.Progress note date 04/29/2026 at 4:27 PM, documented Social Services met with Resident 5 to discuss insurance coverage options. Resident 5 in agreement to enroll in traditional Medicare A and B benefits and disenroll from Medicare Advantage plan.On 05/19/2026 at 3:17 PM, Resident 5 said she knows about the insurance change that took place at the beginning of the month. Resident 5 said she feels that it was a better option for her. Resident 5 said it was explained to her that she would receive more therapy allowing her to get home faster. Resident 5 said she is now having a hard time making an appointment with her normal doctor because of the insurance change. Resident 5 said instead of getting in right away she will have to wait almost a month. Resident 5 said she had not received anything in writing about the insurance change. <RESIDENT 6>Resident 6 was admitted to the facility on [DATE] with multiple diagnoses including chronic combined systolic (congestive) and diastolic (congestive) heart failure (pumping and filling heart failure). The Quarterly MDS, dated [DATE], documented Resident 3 as cognitively intact.Review of Resident 6's record showed they were originally admitted to the facility on [DATE] on a Managed Medicare plan. Resident 6 was sent to the emergency room on [DATE] and re-admitted to the facility on [DATE] under a managed Medicare plan and transferred to Traditional Medicare effective 05/01/2026. Further reviews showed no documentation to support the resident or POA was explained orally and in writing the impact to the beneficiary if they changed coverage.Progress note date 04/29/2026 at 4:28 PM, documented Social Services met with Resident 6 to discuss insurance coverage options. Resident 5 in agreement to enroll in traditional Medicare A and B benefits and disenroll from Medicare Advantage plan.Multiple attempts were made to interview resident on 05/19/2026, 05/20/2026, and 05/21/2026 with resident declination. <RESIDENT 7>Resident 7 was admitted to the facility on [DATE] with multiple diagnoses including unspecified Atrial fibrillation (a common heart arrhythmia). The admission MDS, dated [DATE], documented Resident 7 as cognitively intact.Review of Resident 7's record showed they were originally admitted to the facility on [DATE] on a Managed Medicare plan. Resident 7 was sent to the emergency room on [DATE] and re-admitted to the facility on [DATE] under a managed Medicare plan and transferred to Traditional Medicare effective 05/01/2026. Further reviews showed no documentation to support the resident or POA was explained orally and in writing the impact to the beneficiary if they changed coverage.Progress note date 04/29/2026 at 3:47 PM, documented Social Services met with Resident 6 to discuss insurance coverage options. Resident 5 in agreement to enroll in traditional Medicare A and B benefits and disenroll from Medicare Advantage plan.Resident 7 discharged from the facility on 05/18/2026 and has not returned any calls.<RESIDENT 8>Resident 8 was admitted to the facility on [DATE] with multiple diagnoses including spondylosis without myelopathy or radiculopathy lumbosacral region (an age-related degenerative arthritis of the lower spine). The Quarterly MDS, dated [DATE], documented Resident 9 as moderately cognitively impaired.Review of Resident 8's record showed they were originally admitted to the facility on [DATE] on a Managed Medicare plan and transferred to Traditional Medicare effective 05/01/2026. Further reviews showed no documentation to support the resident or POA was explained orally and in writing the impact to the beneficiary if they changed coverage.On 05/19/2025 at 3:23 PM, Resident 8 said he switched to Medicare at the beginning of the month. Resident 8 said he wanted this change as<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505485 | A. Building<br>B. Wing | 05/21/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Linden Grove Health Care Center | 400 - 29th Street Northeast<br>Puyallup, WA 98373 |

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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | he would get more therapy. Resident 8 said so far, he is very glad he switched to Medicare. Resident 8 said he had not been provided anything in writing explaining either disenrolling from his old plan or enrolling in the new plan.<RESIDENT 9>Resident 9 was admitted to the facility on [DATE] with multiple diagnoses including cerebral edema (the dangerous accumulation of fluid in the brain tissue). The admission MDS, dated [DATE], documented Resident 9 as moderately cognitively impaired.Review of Resident 9's record showed they were originally admitted to the facility on [DATE] on a Managed Medicare plan and transferred to Traditional Medicare effective 05/01/2026. Further reviews showed no documentation to support the resident or POA was explained orally and in writing the impact to the beneficiary if they changed coverage.Resident 9 had been sent to the ER and then admitted to the hospital on [DATE]. Unable to be interviewed.On 05/20/2026 at 10:13 AM, Staff A, Executive Director, said it was presented as how can we provide a better level of care by increasing the residents baseline function. Through the IDT process the residents were identified as possibly benefiting by changing insurance to Medicare so the residents might improve beyond their baseline. The Social Services Director then reached out to the identified residents and discussed their insurance options. The residents who wanted to change their insurance from a managed insurance to traditional Medicare were then processed. Oral discussion was provided on what the change in insurance would entail. Staff A said, no written material was given to the residents. Staff A said, there is not a policy addressing this issue.REFER TO: WAC 388-97-0260, -0300(3)(a) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505485 | A. Building<br>B. Wing | 05/21/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Linden Grove Health Care Center | 400 - 29th Street Northeast<br>Puyallup, WA 98373 |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect resident's right to be free from physical abuse for 2 of 4 sample residents (Residents 1 and 2) reviewed for resident-to-resident altercations. This failure placed residents at risk for abuse, psychosocial harm, and a diminished quality of life.Findings included.Review of the facility policy titled, Coordinating/Implementing Abuse, Neglect and Exploitation Policies and Procedures, dated April 2021, documents 1. Policies are in place that: a. prohibit and prevent resident abuse, neglect, exploitation and misappropriation of resident property. The policy further documents 2. Policies address the following as part of abuse, neglect, misappropriation prevention: c. Prevention.Resident 1 was admitted to the facility on [DATE] with multiple diagnoses including unspecified Dementia (a condition characterized by progressive or persistent loss of intellectual functioning) with other behavioral disturbances. The admission Minimum Data Set, (MDS-an assessment tool), dated 03/1/2026, documented Resident 1 as severely cognitively impaired.Resident 2 was originally admitted to the facility on [DATE] with multiple diagnoses including unspecified Dementia (a condition characterized by progressive or persistent loss of intellectual functioning) with other behavioral disturbances. The Quarterly MDS, dated [DATE], documented Resident 2 as severely cognitively impaired.Review of the Alleged Resident to Resident Altercation packet number 2444, dated 05/09/2026 at 7:15 PM documented Resident 2 struck Resident 1 in the activity room. Resident 1 had been sitting at a table in the activity room when Resident 2 told Resident 1 she was sitting in the wrong spot and threatened to hit her. Resident 1 told Resident 2 she would get in trouble if she hit anyone. Resident 2 then struck Resident 1 on the right arm. The immediate intervention was to separate the residents and place Resident 2 on 1 to 1 supervision with a staff member.On 05/19/2026 at 2:24 PM, an interview was conducted with Resident 1. Resident 1 did not remember the incident.On 05/19/2026 surveyor unable to interview Resident 2 as Resident 2 was unreachable due to having been admitted to the hospital. Record review of Resident 1's progress notes, dated 05/09/2026 at 10:48 PM, documented Registered Nurse was notified by facility staff that Resident 1 was physically hit on her right arm by another female resident (Resident 2) with her hand. Upon assessment Resident 1 denied pain or discomfort to area of concern. No skin discoloration or skin tear noted upon skin assessment. Nursing managers and facility Administrator notified of situation.Record review of Resident 2's progress notes, dated 05/10/2026 at 3:03 AM, documented At approximately 7:15 PM, Certified Nursing Assistant (CNA) reported to Registered nurse that Resident 2 struck a peer in the activity room. Residents 1 and 2 were separated, and 1 to 1 supervision was initiated at that time (for Resident 2). Resident 1 said she had been sitting at a table in the activity room when Resident 2 entered, Resident 2 told Resident 1 she was sitting in the wrong spot and threatened to hit her. Resident 1 also stated she told Resident 2 that she would get into trouble if she hit anyone. Resident 2 then struck Resident 1 on the right arm. During interview of Resident 2, Resident 2 said I'm going to kick her mother fucking ass! Resident 2 was educated that violence was not acceptable and that she needed to stay away from Resident 1. Resident 2 was placed on 1 to 1 supervision and redirected to stay away from Resident 1. A head-to-toe assessment was completed with no injuries noted. 911 was called with Puyallup Police response at 7:45 PM. The Police assessed the situation and transported Resident 2 to Good Samaritan Hospital. Family, Administrator, Director of Nursing Services, Resident Care Manager, the state hotline and the provider were notified.During an interview on 05/20/2026 at 10:13 AM, Staff A, Executive Director, stated Residents 1 and 2 were involved in a Resident-to-Resident altercation which involved Resident 2 hitting Resident 1. Staff were able to intervene and separate the residents. Resident 2 was placed on 1 to 1 monitoring. Resident 2 was subsequently assessed by the police and taken to the hospital. Staff A said he was the facility abuse coordinator and after any type of abuse<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505485 | A. Building<br>B. Wing | 05/21/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Linden Grove Health Care Center | 400 - 29th Street Northeast<br>Puyallup, WA 98373 |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | allegation there was a risk call. Staff A said this was a TEAMS meeting that included the Executive Director, Director of Nursing Services, Corporate Compliance, Corporate Social Services, Corporate Human Resources, Regional Consultant, and legal if necessary. Staff A said in this case Resident 2 has been accepted into an Adult Family Home (AFH) and the facility is waiting for an assessment to be provided by the state. Staff A said family is in agreement.Reference WAC: 388-97-0640 (1) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505485 | A. Building<br>B. Wing | 05/21/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Linden Grove Health Care Center | 400 - 29th Street Northeast<br>Puyallup, WA 98373 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide the necessary care and services for 1 of 4 residents (Resident 3) reviewed for quality of care when new skin impairments were not investigated to rule out abuse/neglect, investigation conclusions were not accurate to the identified skin impairment, treatment orders were not implemented at the time of the skin impairment identification and wound team recommendations were not followed. This failure placed residents at risk for unmet care needs, worsening wounds, and a decreased quality of life. Findings included.Resident 3 was admitted to the facility on [DATE] with multiple diagnoses including Alzheimer's disease (a progressive mental deterioration of the brain). The Quarterly Minimum Data Set, (MDS-an assessment tool), dated 04/24/2026, documented Resident 3 was severely cognitively impaired.Review of the United Wound Healing (UWH) note, dated 03/06/2026 at 9:48 AM, documented Patient would benefit from formal vascular assessment with arterial duplex (a noninvasive, painless diagnostic test that uses high-frequency sound waves to evaluate blood flow and structural integrity of the arteries in the body) based on prior Ankle Brachial Index (ABI) results (a quick, noninvasive test that compares the blood pressure in the ankle to the blood pressure in the arm).Review of the electronic medical record (eChart) on 05/19/2026, did not show an order having been received, implemented, or results for an arterial duplex. Progress note, dated 04/01/2026 at 7:53 PM, documented Resident has new right side knee wound, 4 X 3 centimeters (CM). Resident had redness and strips of blisters (small fluid filled sac or pocket that forms within the outer layers of the skin) on the right shoulder and hip. Resident does show some discomfort with the skin issue. Nurse Practitioner (NP) assessed resident and new order for zinc oxide twice a day are in place. Resident continues to be repositioned in bed every 2 hours and safely transferred to wheelchair with a Hoyer life. Resident wound care continues per MD orders. Review of the Incident Log dated April 2026 did not include an investigation for the above-mentioned skin impairment of redness and strips of blisters on the right shoulder and hip. Abuse/neglect was not ruled out Review of the Skin Alteration - Other Type packet number 2411, dated 04/08/2026 at 11:11 AM, documented, The resident was found to have a reddened area on the right hip, concerning for early pressure injury (localized damage to the skin and underlying soft tissue) formation . The Notes heading for packet number 2411 documented, During routine care and a scheduled dressing change, a small skin tear (a traumatic wound where the top layers of the skin separate from the underlying layers) was noted on the side of the groin area, measuring approximately 1 x 0.1 CM. This area had not been previously identified and given the number of existing wounds and his fragile skin condition, it appears to be a newly developed finding. The Notes area does not address the reddened area on the right hip. Abuse/neglect was not ruled out for the reddened area on the right hip Review of the UWH note, dated 04/10/2026 at 04:25 PM, documented Patient presents today with new area of maceration (the softening and breakdown of the skin caused by prolonged exposure to moisture) and ulceration (the medical process where the surface of the skin or a mucous membrane breaks down, sheds dead inflamed tissue, and creates an open sore known as an ulcer) on ventral (front or anterior side) penis most likely caused by incontinence (the involuntary loss of control over bodily functions). Patient had severe contractures (the permanent tightening or shortening of muscles, tendons, ligaments, or skin that prevents normal movement of a joint) and had to be repositioned by nursing. Recommend aggressive application of zinc oxide to buttocks, groin, and around penis to protect against Moisture Associated Skin Damage (MASD-an inflammatory condition that occurs when the skin is repeatedly exposed to bodily fluids) and facilitate wound healing.Review of the Incident Log dated April 2026 did not include an investigation for the ulceration on ventral penis Review of the Skin Alteration - Acquired Pressure injury packet number 2431, dated 04/24/2026 at 07:00 AM, documented, Upon doing wound care, UWH [NAME] found another wound on [Resident 3]. The notes heading for packet number 2431 documented the same investigation conclusion as Skin Alteration - Other Type packet<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505485 | A. Building<br>B. Wing | 05/21/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Linden Grove Health Care Center | 400 - 29th Street Northeast<br>Puyallup, WA 98373 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | number 2411. It documented during a routine care and a scheduled dressing change, a small skin tear was noted on the side of the groin area, measuring approximately 1 x 0.1 CM. The identified skin impairment for the new stage 3 pressure ulcer (PU-a severe skin injury featuring full-thickness skin loss that exposes the underlying fatty tissue) to left posterior thigh is not addressed. Abuse/neglect was not ruled out for the stage 3 PU to left posterior thigh.Review of the UWH note, dated 04/24/2026 at 03:36 PM, documented Wound to the Left lateral knee is on its way to full closure and is resolving. No signs of infection today. New stage 3 PU on left posterior thigh found on exam at today's visit. Sharp debridement (a medical procedure used to clear wounds of dead, damaged, or infected tissue) conducted to remove slough (yellowish, soft, and often stringy material that forms in wounds of dead or dying tissue, protein buildup, or bacterial contamination) and initiate proliferation (the stage where the body rebuilds the damaged area with new tissue). No signs of infection at today's visit.Review of the electronic Treatment Administration Record (eTAR) dated April 2026 documented, Zinc Oxide Ointment 10%. Apply to per additional directions topically two times a day for skin condition apply to affected area: right shoulder, right hip and as needed. The start date for the above order is 04/01/2026 with a discontinuation date of 05/06/2026. No provider treatment order for Moisture Associated Skin Damage, ulceration on ventral penis, or stage 3 pressure ulcer to left posterior thigh was documented Review of the UWH note, dated 05/01/2026 at 08:36 AM, documented Wound to the Left knee is resolved at today's visit with discoloration still evident but with 100% intact epithelial (body tissue that forms the protective covering on all internal and external body surfaces). Wound to the left medial lower extremity added today that shows no signs of infection. Wound to right buttocks is better visualized at today's visit and is reclassified as a stage 3 PU. Patient also presents with left buttock stage 3 PU at today's visit. No signs of infection in any wounds.Review of the incident log dated May 2026 did not include an investigation for Resident 3 Review of the eTAR dated May 2026 documented the following provider orders with a start date of 05/05/2026 and a discontinuation date of 05/06/2026:1. Wound care: bilateral gluteal fold (the prominent horizontal crease located just below the buttocks) clean with normal saline, apply thick layer of zinc every day shift2. Wound care: Left ankle clean with normal saline, apply medihoney (medical-grade, sterilized honey used for managing wounds, burns, and skin ulcers), cover with foam dressing every day shift3. Wound care: Left knee skin tear clean with normal saline, apply skin prep very day shift. Review of care plan documents, on 05/19/2026, under the focus open areas to bilateral buttock and penis and redness to right hip. showed the care plan was not updated to reflect skin impairment to right shoulder, MASD, left medial lower extremity, or left ankle.On 05/21/2026 at 1300, Staff B Resident Care Manager (RCM) / Licensed Practical Nurse (LPN) said, when a new skin condition is identified the floor nurse assigned to the resident should start an incident report and notify the Resident Care Manager and the Director of Nursing Services. Staff B said once she is notified of the new skin condition, she observes the wound and takes measurements. Staff B said the provider would be notified and a treatment order would be obtained. Staff B said the treatment should be uploaded to the eMAR and the care plan should be updated to what the skin condition is and an intervention should then be placed. Staff B said all recommendations from the UWH notes should also be processed. Staff B said UWH comes in early on Fridays, and she will print off the UWH notes after UWH uploads their notes later in the day. Staff B said she reviews the notes for her residents and will update the eTAR for any new recommendations. Staff B said the other side of the building will do the same thing. Staff B said the recommendation made by UWH on 03/06/2026 for arterial duplex should have been ordered and completed. Staff B said the progress note on 04/01/2026 describing strips of blisters to the right shoulder and right hip should have had an incident report. Staff B said the incident reports on 04/08/2026 and 04/24/206 should have had conclusion in the note section pertaining to the skin impairment identified in the incident report. Staff B said treatments should be added to the eTAR when the skin condition is identified and not days later. Staff B said she will be coming in on Friday to give instruction to the other RCMs as to the process when UWH is in the building. Reference WAC: 388-97-1060 (1) - (3) |