

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505512	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Garden Terrace Healthcare Center of Federal Way		STREET ADDRESS, CITY, STATE, ZIP CODE 491 South 338th Street Federal Way, WA 98003	

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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>46471</p> <p>Based on interview and record review, the facility failed to ensure 1 of 3 residents (Resident 1) reviewed for Pressure Ulcer/Pressure Injury (PU/PI) was provided the necessary treatment and services consistent with professional standards of practice to promote wound healing. This failure placed residents at risk for worsening skin conditions, skin breakdown, and a diminished quality of life.</p> <p>Findings included .</p> <p><Facility Policy></p> <p>The facility policy titled, Skin Integrity & PU/PI Prevention and Management, revised 07/09/2024, showed the facility would provide the necessary treatment and services, consistent with professional standards of practice, to a resident with PU/PI to promote healing, prevent infection, and prevent new ulcers from developing. The policy showed preventative measures identified to maintain and improve the resident's skin condition were implemented in the Care Plan (CP). The policy showed when skin breakdown occurred, it required attention and a change in the plan of care could be indicated to treat the resident.</p> <p><Resident 1></p> <p>According to the 01/21/2025 Facility Nursing Admission/Readmission Collection Tool, Resident 1 had medical conditions including memory impairment, unstable blood sugar levels, heart and kidney disease, malnutrition, and a surgically repaired hip fracture sustained from a fall. The assessment tool showed Resident 1 had altered skin integrity during the assessment and a Deep Tissue Injury (DTI - a damage to the soft tissue beneath the skin caused by pressure or shear forces) to their buttocks was identified.</p> <p>Review of the 01/22/2025 Baseline CP showed Resident 1 had a break in skin integrity. An intervention listed in the CP instructed the nursing staff to provide treatment as ordered.</p> <p>Review of the 01/24/2025 wound care provider report showed the skin covering Resident 1's DTI on their buttocks opened and measured 2.5 centimeters (cm) x 2.5 cm x 0 cm. The wound care provider recommended a treatment using a medical-grade honey-based dressing.</p> <p>(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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's January 2025 Treatment Administration Record (TAR) showed no treatment was scheduled and/or carried out by the nursing staff regarding the initiation of the medicated honey-based treatment as ordered by the wound care provider.</p> <p>A 01/27/2025 progress note showed Resident 1's representative wanted the resident transferred to the hospital for further evaluation of the buttocks wound. The facility census showed Resident 1 was transferred to the hospital on the same day.</p> <p>The 01/27/2025 facility investigation report showed, Due to receiving the [wound care team] orders for [honey-based treatment] late Friday night [01/24/2025], it was not processed until Monday [01/27/2025] morning . and led to the delay in the application of the treatment.</p> <p>In an interview on 02/07/2025 at 2:23 PM, Staff D (Certified Nursing Assistant) stated Resident 1 was able to use the bathroom when cued and assisted, and as the resident would allow.</p> <p>In an interview on 02/07/2025 at 2:46 PM, Staff C (Licensed Practical Nurse) stated they did not know Resident 1's buttocks wound was a PU and thought it was moisture-associated skin damage because of the resident's incontinence. Staff C stated they were not aware a medicated honey-based treatment was ordered for Resident 1 on 01/24/2025 because the order was not in the TAR, .[treatment order] was not shown in my computer.</p> <p>In an interview on 02/07/2025 at 3:23 PM, Staff B (Interim Director of Nursing) reviewed Resident 1's January 2025 TAR and confirmed the medicated honey-based treatment for the resident's buttocks wound was not carried out and/or provided by the nursing staff as ordered. Staff B stated it was important to implement and follow provider treatment orders for effective management of wounds and to facilitate PU/wound healing. Staff B stated they expected the nursing staff to implement and follow wound care treatments as ordered.</p> <p>REFERENCE: WAC 388-97-1060(3)(b).</p>		