STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505319	A. BUILDING _____ B. WING _____	04/07/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANOR CARE HEALTH SERVICES	3701 188TH STREET SOUTHWEST LYNNWOOD, WA 98037

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 0314 **Level of harm** - Actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to ensure residents who entered the facility without a pressure sore did not develop a pressure sore while in the facility for 1 of 1 sampled resident(1). Failure to ensure staff consistently, thoroughly, and/or accurately evaluated the resident's pressure sore risk factors related to changes in clinical condition, defined & implemented specific individualized interventions that were consistent with the resident needs, and consistently monitord, evaluated & revised the interventions for effectiveness resulted in the development of an infected necrotic pressure sore causing harm to Resident #1. Findings include: Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data set assessment ((MDS) dated [DATE] indicated the resident had very limited communication abilities, and memory impairment with severely impaired decision-making ability. The resident had a urine catheter, was incontinent of bowel, and required extensive 2 person assist for bed-mobility, transfers, and toileting. The MDS indicated the resident had no pressure ulcers. The Admission nursing skin assessment indicated Resident 1 did not have any skin issues or pressure ulcers on admission. The resident was identified as being at risk for pressure ulcers due to extensive assist with activities of daily living (ADLS), immobility, altered mental status, incontinence, and 1-sided weakness. A Braden scale for predicting pressure sore risk was done on 2/10/16. Resident 1 was assessed as being, At risk for pressure sores related to his slightly limited mobility, ability to make frequent changes in body position independently, no apparent problem with friction/shear, and the ability to independently move in bed & chair. Another Braden scale done on 2/23/16 indicated Resident 1 was at Hi risk related to being bedfast, completely immobile, and requiring moderate to maximal assist in moving. A third Braden scale completed on 3/1/16 indicated Resident 1 was at Moderate risk related to being chairfast, making frequent changes in position independently, and requiring minimum assist with moving. A review of the February & March 2016 Electronic Treatment Administration records (ETAR) revealed a physician's orders [REDACTED]. Do a Skin Check one time a day, every 7 days for skin observation and update the skin sheet: The skin checks were initialed by nurses as being completed on: 2/10, 2/17, 2/24, 3/2, & 3/9/16. But, there was no evidence of updated skin sheets in the chart. There were 2 nursing notes dated 3/1/16 & 3/13/16 that indicated the resident had redness to his coccyx. The ETAR indicated there was a new physician's orders [REDACTED]. On 4/7/16 at approximately 11:15 a.m., the Director of Nursing (DON) was asked if there were any skin sheets filled out by nursing staff related to the weekly skin checks. The DON indicated skin worksheets were completed by the shower aides. The shower aides mark skin issues (if any) on body diagram & give them to the Licensed Nurses (LNs). A review of all provided shower aide skin worksheets for Resident 1 revealed the following: On 2/23/16, documentation showed an Old red area and there was circle on buttock crease area; On 2/29/16, documentation showed a Red area and there was a circle on buttock crease area; On 3/2/16, documentation showed a Red blanchable & circled on buttock crease area. The initial 2/15/16 Care Plan, identified the resident as being, At Risk for alteration in skin integrity r/t incontinence & impaired mobility. There were 3 listed Interventions: -barrier cream to peri/buttock area prn (as needed); -observe skin condition with ADL care daily, report abnormalities; -provide preventive skin care routinely & prn. Resident 1's At Risk for Alteration Skin integrity Care Plan was revised/updated on 3/1/16 to include the following interventions: -Encourage fluids, -Encourage resident to reposition as needed, -Use assistive devices prn, and float heels as able. The Kardex, a information tool, used by the nursing assistants (NA) as a quick reference guide for the particular nursing care needs of each patient, that included the following tasks to be done for Resident 1: Encourage and/or assist the resident to reposition frequently. Task descriptions included: ADLs usually needed 1-2 person extensive assist, Bed mobility, Pressure reducing cushion for chair and/or wheelchair; Pressure reducing mattress; Repositioned (every shift); Special need frequent checks/reposition frequently; Turn and/or Reposition (Every Shift). During an interview on 4/7/16 at 11:10 a.m., the Administrator, stated the NAs worked 8-hour shifts. She said the NAs expected to document the completion of specified Karedex tasks every shift, rather than documenting the completion of the task each time it was done throughout a shift. Review of the provided NAC documentation for the 'Repositioned' section of the Karedex task revealed inconsistent documentation as to whether the resident was repositioned every shift while at the facility. Review of nursing progress notes from 2/9/16 - 2/29/16 documented the resident required variable assistance for ADLs (extensive assist 1-3 persons to total assistance). There were no nursing notes in this time period which indicated ongoing nurse monitoring of resident's positioning, bed mobility or notes describing the condition of Resident 1's skin. Review of nursing progress notes from 3/1/16 - 3/14/16 revealed the following: On 3/1/16, it was noted the resident required a 2-3 person assist with tranfers using a hoyer (lift device), bed mobility, and toileting. The residents coccyx (tailbone) area had some blanchable redness, there were new orders for a skin cream (to be applied to the area for prevention), and frequent turning & repositioning applied this shift. On 3/11/16, an interdisciplinary care conference was held in which the DON addressed multiple questions from family regarding medications, the UTI, the catheter, repositioning, and hydration.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.

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F 0314 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) On 3/12/16 and 3/13/16, there were day shift progress notes indicating the frequent turning of Resident 1, but there was no other documentation that the resident was being turned or that his coccyx area was being assessed. On 3/13/16, an evening progress note indicated Resident 1 was being frequently turned .'Resident has a redness at coccyx area, slight swollen and warm to touch. Medication applied for redness. MD notified, new order for blood tests & wound culture.' There was no documentation of an assessment of a wound that would justify a culture being done. On 3/14/16, there was a late entry nursing note at 10:30 a.m. that indicated an RN had been attempting to feed the resident since 9 a.m. The note indicated Resident 1's family member came in and asked whether the RN had looked at the (resident's) wound. The note indicated the RN informed the family that the RN had not seen the wound, as the Resident had been repositioned & was currently being fed, but the RN would look at wound at some point. There was no further indication that nursing staff had observed the resident's skin condition or wound, as the resident was then sent out to a hospital emergency room for an acute change of condition. Review of physical therapy (PT) documentation revealed the following: PT assessments on 2/10/16, 2/23/16, 3/8/16, & 3/14/16 resident 1 was Total Dependent on staff for bed mobility. A PT note on 2/24/16 indicated the resident was lying supine (flat on back) in his bed. An attempted transfer with a 2 person assist was unsuccessful due to the resident being extremely stiff & resistant, and he required a 3-person assist. For wheelchair(wc) management: the assessment of his current seating system for appropriate modifications and design of new wheelchair was to enable functional independence from a standard manual wc to tilt-in-space to allow for pressure relief and safety. On 2/26/16, it was noted the resident was resistant to movement .repositioning in tilt-in-space wc several times due to sliding forward. On 3/4/16, it was noted by the therapy department per their documentation that wounds were present: transfer & standing activities in parallel bars to promote pressure relief .very stiff and resistant .family reported about pressure sore in sacral area. Nursing already aware and monitored wound. On 3/8/16, PT noted the resident's progress has been slower than initially anticipated due to illness & significant cognitive impairment .bed mobility Max assist of 2 person. (Resident 1) was left in room, sidelying on Left side in bed to relieve pressure off sacral area. As per family, pressure sore on sacral area. This therapist noted redness on same area. During an interview on 4/7/16 at 8:50 a.m., LN A was asked if Resident 1 could move in bed or chair by himself: No, not at all, he needed to be fed and was total care. It took 2-3 people to move him. Because he was so stiff & rigid. He 'kind of' stayed in place when repositioned. Later at 10:50 a.m., LN A was asked whether Resident 1 had a pressure ulcer: Not really, it was probably developing .but I remember his skin as being red, that's why I started him on frequent turning (in the beginning of March 2016). In regards to a wound culture being ordered/done, I don't remember a wound culture being done .maybe because the wife wanted it? She often insisted on things whether or not needed. The LN was unable to provide any information about the condition of the resident's skin. During an interview with the DON on 4/7/16 at approximately 11:15 a.m., the DON was asked regarding why & in what area did staff obtain a wound culture and whether it was an open wound on 3/13/16. The DON shrugged and said, The wife wanted it done, she often wanted things done, even though there was nothing there . The DON was unable to provide any information in regards to the wound or what her expectations of how staff should have assessed or documented the wound. On 3/14/16 day shift, Resident 1 was sent to a hospital emergency department (ED) related to fever and low blood pressure. A review of the initial ED triage nurse at 12:37 p.m. noted Resident 1 found to have a large wound to mid coccyx. The wound is linear and runs vertically. It is 5 centimeters (cm) long and 1 cm wide fissure-like wound. There is deep tissue involvement as wound is roughly 0.5 cm deep with pink/reddened tissue with some slough (necrotic) tissue. Around the wound it is reddened and swollen throughout the entire low back, buttocks area. The ED physician noted the resident had a sacral decubitus ulcer with central fissuring. A hospital wound care consult note dated 3/15/16 noted Resident 1 had an unstageable sacral pressure ulcer with signs of infection width 2.2 cm, length 4.0 cm with 50% slough. Throughout the resident's stay in the facility, there was infrequent documentation in the progress notes to indicate ongoing consistent nurse monitoring for frequent repositioning & turning of Resident 1. There was little to no documentation for the ongoing effectiveness of the skin at risk interventions especially in regards to Resident 1 needing total assistance for bed mobility, ADL needs, his physical rigidity and the changes in his skin condition. There was no documentation of increased monitoring of the resident's condition of skin after coccyx redness was identified. Nor was there a thorough description(s) with measurement of the coccyx redness and whether the skin had a pressure-related open skin area(s) on the coccyx even though a wound culture was ordered.