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 _____	12/28/2016

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 0285 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Coordinate assessments with the pre-admission screening and resident review program for mentally-ill and mentally-retarded patients.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Level 1 Pre-Admission Screening and Resident Review (PASRR) was accurate for a resident that was being considered for admission to the facility. This failed practice affected 1 of 5 residents (1) reviewed for PASRR, placing Resident 1 at risk for not receiving the care and services needed in the most appropriate setting. Findings include: Resident 1 was admitted to the facility 10/4/16. Hospital discharge documentation revealed multiple medical diagnoses, including history of [MEDICAL CONDITION](TBI) due to a motor vehicle accident at age 17 and a stroke status [REDACTED]. Review of the medical record revealed an undated Level 1 PASRR form marked as 'nursing facility admission pending' completed by a hospital staff. The PASRR form indicated Resident 1 had no intellectual disabilities (ID)/related condition indicators that would require a referral for a PASRR Level II evaluation. Also in the medical record was a revised Level 1 PASRR form, dated 11/14/16, which had been completed by facility social service staff. This newer form indicated the resident met 3 out of 4 ID/related condition Indicators: -documented evidence of a related condition with severe, chronic disability of intellectual function of onset before age 22; -received services from an agency that serves individuals with intellectual disabilities; and -exhibited 3 or more serious functional limitations. On 11/16/16, a fax was sent to the state Developmental Disabilities Administration indicating the original PASRR from the hospital was incorrect & the corrected PASRR indicated the resident showed indicators of ID/related condition requiring referral for a PASRR Level II evaluation. In an interview on 11/30/16 at 8:45 am, Staff A, Social Services, was asked about the PASRR forms. Staff A said that during discharge planning with the resident's caregiver/supported living services agency, she was informed the resident was ID and required more services. Staff A said that she had been aware of the resident's TBI diagnosis, but had not known that Resident 1 was considered ID due to the TBI occurring at age 17.
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 observation, interview, and record review, the facility failed to ensure a resident received care consistent with professional standards of practice to prevent pressure ulcers (PU) for 1 of 1 sample residents (2). Failure to timely identify/recognize a leg brace as increasing the risk for PU development, and timely implement specific interventions to closely monitor & reduce the risk of pressure from the brace resulted in the Resident 2 developing 2 unstageable pressure ulcers with eschar (necrotic tissue). Findings include: Resident 2 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident was to be non-weight bearing on the R leg & wear a R knee brace. The Admission nursing skin assessment dated [DATE] indicated there was no existing pressure ulcer. The only body mark listed was the surgical incision down the front shin on the R lower extremity (LE). The Care Area assessment (CAA) for PU dated 10/25/16 indicated Resident 2 was admitted with a R tibia fracture for surgical wound care & monitoring. There were no other skin issues identified, but it indicated the resident remained at risk for skin breakdown due to decreased mobility & incontinence. A plan of care was developed to maintain skin integrity & prevent breakdown containing information for staff provide incontinence care, assist with turn & reposition as needed, and skin monitoring during daily care & assessment weekly. The CAA did not identify the leg brace as potential risk factor for increased rubbing and/or pressure to the skin potentially leading to skin breakdown. The electronic Treatment Administration Record (eTAR) record for October 2016 contained an order for [REDACTED]. The eTAR did contain orders to do a weekly skin observation & Braden scale (pressure sore risk tool). The eTAR did not include a nursing order directing/instructing licensed staff to assess Resident 2's skin under the brace during surgical incision care, with special attention to possible pressure points where metal or rigid hard part of the brace may touch/press on the skin. Progress notes from October 18 - 25 indicated dressing changes to the R LE surgical incision site and LE brace in place: On 10/26/16, a weekly skin check was completed and noted a purple area to inner right ankle, as well as 'slight redness to R heel area' & no open area. There was no documented evidence of continued ongoing monitoring of the 'redness to R heel area'. The was also no documented evidence of a review or revisions made to the resident's Plan of Care for the skin integrity section. Progress notes from October 28 - 25 indicated dressing changes to the R LE surgical incision site, a splint boot and LE brace, with no new skin issues. Then on 11/5/16 documentation showed that during a dressing change to the surgical incision, a black area was noted to the R Achilles, just above the heel area. There was no open area. The note indicated the resident wore the Leg brace at all times. On 11/7/16, a Skin wound team progress note indicated Resident 2 had a black area on her back R LE at the Achilles area that measured 4 x 4.5 centimeters(cm). It was noted as dark purple in color surrounded with red. The note indicated that the brace worn by the resident has a 1 inch metal type piece in back which appeared to have caused the breakdown. The facility staff checked with orthopedics who stated the brace must be worn at all times & to pad the bottom area of the brace to prevent further breakdown. Therapy was to assist with padding. However, the progress note did not indicate whether the rest of the resident's R LE was thoroughly assessed for any other potential pressure areas related to the brace. On 11/13/16, a progress note indicated a second eschar area was discovered on the posterior (back) R calf. On 11/16/16, the areas were assessed by the facility Skin Wound team: 1st site = R Achilles became larger, 5 x 5.4 cm with 100% eschar.

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) 2nd site = A new pressure ulcer to the right calf was 3.2 x 2.4 and unstageable. Areas likely related to the brace, therapy notified who will assess & pad brace .Achilles portion of brace already padded. The November 2016 eTAR contained new orders including: On 11/5/16, a treatment was initiated related to the black area on the R Achilles (heel area), apply skin prep twice a day. On 11/8/16, daily skin checks and skin observations were updated on the skin sheet. On 11/18/16, staff were to cleanse & apply liquid skin protectant to the R calf every 3 days for eschar. On 11/30/16 at 10:30 am Resident 2 was lying in bed with her lower legs resting on pillows. When asked if she had any skin problems caused by her leg brace, Resident 2 briefly lifted the bed sheet to show the top section of the brace on her leg and pointed at a special boot on floor, I also have a boot. During an interview on 12/8/16 at 2:15 pm, Staff B stated she was familiar with the resident, I did her incision dressing/wrap several times. She(Resident 2) was to wear the full R leg brace at all times. I tried to figure out what may have caused the PU & looked at the brace. The brace had a hard metal strip all the way up the back of the leg from ankle to above knee/thigh. The rest of the brace was soft with Velcro straps on top. The only time it came off was for showers, I think, and then opened it each time we did dressing care & wrap of the incision site. I think daily skin checks started after we found the eschar area. So when found the first PU, it was low end of Achilles above the heel, circular looking eschar. Used marathon skin protectant on it after initial skin prep. So OT padded and foamed up the lower part of the metal strip by the Achilles PU. But then approximately a week later, a second area eschar was found right on back of calf, longer thin shaped (like the metal strip). I think OT then applied more padding to that area. When asked about use of the boot observed in Resident 2's room, I think that was to prevent footdrop, therapy tried it. During an interview on 12/8/16 at 4 pm with Staff C & D, Staff C said the wound team progress notes was where the facility documented information regarding pressure ulcers, and that the other skin sheets kept in nursing unit treatment binders were used by the floor nurses to document other (non-pressure) skin issues such as bruises, skin tears, etc. Staff C indicated the resident's 1st PU site was just above the R heel & already had full eschar when it was first observed, then OT padded the brace around that area. Then some days later, the 2nd PU area of eschar was found on the back center of the R calf & appeared to be along the area of the brace's metal piece, Then we had OT pad the brace in that area. Review of Occupational therapy (OT) notes showed: On 11/7/16 showed that the resident was not wearing brace on the R LE; not mobilized until orders clarified. On 11/9/16, positioning of the R LE was to achieve neutral positioning and assure pressure relief. On 11/18/16, padding was added to the lateral supports of brace to increase skin protection. Review of Physical therapy (PT) notes showed: On 11/7/16, gentle repositioning on RLE as the brace was off, awaiting padding modification and the brace had not arrived. On 11/9/16, a heel lift boot was placed on the R foot as suggested by nursing and fitted to assist in proper positioning. The facility's Braces/Splints Nursing Procedures dated 12/2009 included the following: 8. Hand or foot should be supported and straps secure, but not too tight. 9. Follow wearing schedule as outlined by therapist or physician. 10. Carefully inspect skin and appearance during applications. The facility failed to timely identify & recognize Resident 2's leg brace as potentially increasing the risk for presure ulcer development, and timely implement specific interventions to reduce the risk of pressure from all potential pressure points and friction points with the brace resulted in the Resident 2 developing 2 unstageable pressure ulcers.
F 0520 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** Based on interview and record review, the facility failed to identify in the facility Quality Assessment and Assurance Program (QA&A) that there was an ongoing issue surrounding pressure ulcers or skin injuries that included assessing, care planning, monitoring and implemention of appropriate preventive corrective actions. The facility failed to recognize care and services that resulted in the severity of resident harm. Findings include: Throughout the survey the following deficiencies were identified: The QA&A committee failed to identify ongoing deficiencies in regards to ensuring residents who enter the facility do not developed a pressure ulcer. Refer to F 314, CFR 483.25(c) This is a repeat deficiency from Abbreviated surveys conducted on 04/07/16 and 08/15/16. In an interview on 12/28/16 at 9:52 AM, the Administrator stated she had not been in the facility during the time of the first citation in April. She was there during the second time the facility was cited pressure ulcer care. The Administrator stated the QA&A meets monthly. The Administrator confirmed that after the last citation it was discussed in QA & A. The Administrator was not able to provide any addition information regarding why the facility's QA&A committee had not been effective in correcting skin concerns.