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 _____	06/21/2017

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, the facility failed to ensure appropriate preventive measures were consistently implemented to prevent the development of pressure ulcers for 2 of 2 sample residents (4, 2). Failure to ensure preventive interventions were specific, communicated to staff, implemented, and monitored for consistent implementation & effectiveness resulted in the development of heel pressure ulcers for Resident 4 and 2. Findings include: Resident 4 Resident 4 was admitted to the facility on [DATE] after hospitalization for a right(R) [MEDICAL CONDITION] and other [DIAGNOSES REDACTED]. The resident was assessed to have moderate cognitive impairment and required extensive 2-person assist with bed mobility, transfers, and toileting. The resident no longer resided at the facility. During a telephone intervew with a family member (FM) of Resident 4 on 6/15/17, the FM stated the resident developed a heel blister that was the size of a tennis ball and that facility staff never floated the heels (did not elevate the resident's heels off the mattress to avoid pressure). The FM also said the resident was not accepted back to her previous assisted living residence specifically due to the presence of the pressure ulcers that developed at the nursing home. Review of the medical record revealed a 4/6/17 Patient Admission Screen that documented Resident 4 did not have an existing pressure ulcer on admit. A 4/6/17 nursing admission note indicated the resident was confused and forgetful, able to follow commands & cooperated well with care, and had no skin alteration noted except a right(R) hip surgical incision. It was also noted the resident had high levels of pain during incontinent care and was grimacing & crying when repositioned with relief via application of ice to the incision and pain medication. The admission Braden scale for predicting pressure sore risk indicated the resident was at moderate risk. The written plan of care (P(NAME)) was initiated on 4/7/17 related to the resident being at risk for skin alterations due to incontinence, dementia, & impaired mobility with the goal to decrease/minimize skin breakdown risks. The P(NAME) included interventions for staff to encourage to reposition as needed, use assistive devices as needed, and float the resident's heels as able. Nursing progress notes from 4/7/17 - 4/12/17 did not have documentation indicating Resident 4 was being repositioned or that her heels were being floated to reduce pressure. On 4/11/17, a physical therapy (PT) note indicated Resident 4 needed maximal assist for bed mobility mainly to manage both lower extremities (LE) on/off the bed. Then on 4/12/17, a PT note indicated therapy was focused on improving the resident's mobility on R LE due to swelling from recent surgery. The therapist noted a blister on Right(R) LE and notified a nurse. The therapist indicated the resident was placed in bed and, Floated both heels using 2 pillows for each leg. On 4/12/17, a nursing note revealed PT had reported a blister on Resident 4's R heel. Nursing assessed the blister and noted it was not open. There were no measurements or description of the heel area such as color, mushy/firm or condition of the skin surrounding the blister. A 4/13/17 nursing note indicated Resident 4 had a fluid-filled blister on the R heel, a stage 2 pressure sore measuring 4 centimeter(cm) by 8.5 cm. without surrounding redness or pain. Nursing requested a physician order [REDACTED]. A dayshift nursing note on 4/13/17 indicated Resident 4 had prevalon boots to both feet & feet elevated with a pillow, & 4/13/17 evening shift noted bilateral feet floated with pillow below the feet. On 4/14/17 evening shift, heel boots were applied. There were no further nursing notes documenting floating heels or wearing boots until a facility wound team assessment with an outside wound care consultant on 4/18/17. The wound care team noted the intact blood-filled blister on the R heel and that Resident 4 was wearing prevalon boots, was compliant with position changes & elevating heels, and had an alternating pressure relief air mattress on her bed. A nursing note on 4/19/17 indicated, Heels (boot?) applied while in bed, always wears one on R foot even when not in bed. Then on 4/20/17, MD & family were notified about a new pressure sore on Resident 4's L heel. An assessment on 4/21/18 described the L heel pressure sore as a dark red suspected deep tissue injury(DTI)*, 1.0 x 1.0 cm (likely related to pressure per the wound consultant note). A wound team assessment on 4/25/17 noted the resident still had an intact Unstageable blood-filled R heel blister and the Unstageable L heel DTI measurement had increased in to 1.6 x 1.6 cm and was black in color. The P(NAME) was revised on 4/13/17 for suspected DTI to R & L heels revised intervention to encourage & assist as needed to turn and reposition, and to use pillows &/or positioning devices as needed. The P(NAME) did not include specific instructions for staff regarding frequency of repositioning, when to float heels, use of prevalon boots (boots that help minimize pressure, friction and shear on the feet, heels and ankles of non-ambulatory individuals) or include information on whether the resident was switched to an air mattress to further reduce pressure. Review of the April & May 2017 electronic treatment administration records (eTAR) revealed 4/13/17 orders for nursing to do a daily skin check/observation and to apply [MEDICATION NAME] to bilateral heels twice a day. The ETARs did not contain information informing/reminding nurses to monitor for consistent repositioning and elevation/floating of heels off the mattress, use of prevalon boots or use of an air mattress. During an interview with a nursing resident care manager (RCM B) on 6/21/17 at 3:40 pm regarding communication and monitoring of daily individual care interventions to staff, RCM B said that communication of care interventions, such as wearing prevalon boots, would be in tasks in the nursing assistant (NA) Kardex. RCM B said the electronic Kardex was not available for viewing after a resident's discharge, but the RCM did find a Kardex task entry in the system for Resident 4 with an initiation date on 4/6/17 to suspend heels prevalon boots (FYI) Patient has pressure sore on bilateral heel- no shoes until pressure sore healed. She said that nurses would then be alerted via the electronic system if an NA hadn't documented completion of the assigned tasks. She said that nurses would most likely communicate new/revised interventions and specific monitoring needs via shift report (nurse to nurse). *Suspected Deep Tissue Injury (sDTI): Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. https://www.mnhospitals.org/Portals/0/Documents/ ./pressure-ulcer-staging-card.pdf RESIDENT 2

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) Resident 2 was admitted on [DATE] from another nursing facility with [DIAGNOSES REDACTED]. The resident was assessed as requiring extensive 2-person assist with bed mobility, transfers, and toileting with functional impairment of range of motion on 1 side LE. review of the resident's medical record revealed [REDACTED]. The admission Braden scale for predicting pressure sore risk indicated the resident was at risk. The initial 3/30/17 P(NAME) for being at risk for skin alteration included interventions to encourage to reposition as needed, float heels as able, and to use pillows &/or positioning devices as needed. A Care Assessment related to pressure ulcers dated 4/5/17 indicated the resident was at risk for skin breakdown and required extensive assist with bed mobility due to weakness and pain with movement. Staff were to provide care and encourage and assist with turn & repositioning as needed. Review of nursing progress notes from 3/29/17 -4/6/17 did not document staff encouragement or assistance with repositioning or floating of the resident's heels to reduce pressure. On 4/7/17 evening shift nursing noted resident has pain with bed mobility Both heels soft Left(L) heel with discoloration,elevated on pillows to keep off mattress. Then on 4/9/17, a nursing note noted Resident 2 had a left heel pressure sore elevated on 2 pillows. A 4/10/17 fax reported to the physician that Resident 2's left heel has a dark discoloration, soft, measuring 3 x 1.4 cm. and the ball of great toe has an intact blood blister; and both heels elevated on prevalon boots. A 4/11/17 described the L heel reddened around and center with dark green soft area and complains of pain when touched. Blood blister to L ball of great toe intact. The P(NAME) was revised on 4/10/17 to encourage and assist as needed to reposition, special (air) mattress on bed, administer treatment per orders and reposition resident up in bed so foot is not touching the foot of bed. A nursing skin assessment note dated 4/18/17(late entry) noted the resident ad an Unstageable pressure sore to L heel measuring 3.5 x 2.5 cm with dark purple/black surround & yellow at center; and a blood blister to ball of L great toe. It noted the resident prefered to stay in bed, wore prevalon boots at all times, had an air mattress, and a wound consultant was to evaluate/treat the foot areas. In an interview with a unit nurse 6/15/17 at 10:20 am, the nurse said she has recently seen Resident 2's pressure ulcer, It is small and with new skin approximately 1 inch diameter. He mostly stays in bed, air mattress, he has extreme arthritis pain whenever moved, and gets (a narcotic medication) every 4 hours which helps his pain. During an interview with on 6/21/17 3:05pm with RCM A, the RCM said the resident has a facility-acquired pressure ulcer on his heel that hasn't healed yet. She said the resident came from another nursing home, but we didn't get much information about the resident's care needs at first. (Resident 2) pretty much did not want to get up out of bed from the beginning, we would try to have him get up out of bed, but he didn't really want to, he is essentially bedbound by choice. RCM A said staff know what specific interventions are in place for an individual resident, that's on the tasks from the care plan so NAs know what to do, we don't put it specifically on treatment record. We remind the NAs to make sure all the residents are positioned frequently and to make sure resident have their boots on if ordered. We don't specifically indicate a repositioning frequency, like every 2 hours. Staff can use pillows for elevating heels/repositioning, and we have the blue bridge cushions for those resident with heel problems. This failed practice was not made available to the department until an additional complaint was made and investgated. Reference: WAC 388-97-1060 (3)(b)