STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505017	A. Building B. Wing	04/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Care Center	2821 South Walden Street Seattle, WA 98144

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on observation, interview, and record review, the facility failed to ensure 2 (Resident 1 & 2) of 3 residents reviewed for pressure ulcers (PUs) received the necessary treatment and services, consistent with professional standards of practice, to promote healing, and prevent new ulcers from developing. Failure to complete weekly skin assessment as ordered, document wound progress and update the Care Plans (CP) placed residents at risk for deterioration in skin condition, and diminished quality of life. Failure of the facility to assess skin integrity to identify PUs timely, and implement interventions to include updating the CP, caused harm to Resident 1 who developed a facility acquired right heel PU, which deteriorated and resulted in hospitalization where identification of multiple untreated, facility acquired PUs on left side of the resident's body were discovered. Failure of the facility to identify PUs timely, and implement a preventative measure timely caused the harm to Resident 2 who experienced worsening of a sacral (lower back bone area) PU from intact skin to open wound and developed two facility acquired bilateral heel PUs. Findings included . According to the National Pressure Injury Advisory Panel (NPIAP) PU/PI staging definitions include: a Stage 4 PU is a wound with full thickness skin and tissue loss with exposed fascia (connective tissue), muscle, tendon, ligaments, cartilage, or bone; a Stage 3 PU with full thickness loss of skin, in which fat is visible on the ulcer and rolled wound edges is present; an Unstageable PU is defined as a full thickness skin and tissue loss where the base of the wound is obscured by slough (dead skin cells) and/or eschar (dead tissue) where until sufficient slough and/or eschar can be removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined; Deep Tissue injury (DTI) is intact or non-intact skin with localized area of persistent non blanchable deep red, maroon or purple discoloration. Pain and temperature change often precede skin color changes. Resident 1 According to the 09/24/2022 Admission/5 day MDS, Resident 1 admitted to the facility on [DATE], cognitively intact and had diagnoses including Asthma, Malnutrition, and immune thrombocytopenic purpura (bleeding disorder when blood does not clot properly). According to this assessment, Resident 1 was at risk for developing pressure ulcers and had no unhealed PU, Resident 1 required two-person extensive assistance for bed mobility and toileting. According to the 09/20/2022 nursing admission skin assessment, Resident 1 admitted with no PUs. (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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's December 2022 assessments showed facility failed to complete the weekly skin assessments on 12/13/2022 and 12/20/2022. A review of Resident 1's 12/21/2022 nursing progress note showed the resident had open area on left hip and DTI PU on right heel. This note showed Resident 1 preferred to lay in bed on their left side due to often pain in their right lower body. A 12/27/2022 physician note showed Resident 1 had a stage two PU on left hip and the resident complained of pain nine out of 10 on pain scale and went down to seven out of 10 after pain medication provided. Physician note showed no documentation about Resident 1's right heel PU. Review of a 01/03/2023 wound care provider's progress note showed Resident 1's PU deteriorated to a stage three PU on left hip which measured 1centimeter (cm) X 2 cm X 0 cm with moderate drainage and Unstageable PU on right heel which measured 6 cm X 6 cm X 0 cm with moderate drainage. Wound care provider documentation showed Resident 1's both lower extremities were warm and well perfused (sufficient blood flow to the extremities). A review of Resident 1's record showed the facility was aware Resident 1 was at risk for developing PUs but failed to evaluate the need for and implement additional pressure relief such as an air mattress until 01/05/2023 to prevent PUs. The 01/06/2023 revised skin CP showed Resident 1 was at risk for skin issues related to decreased mobility, incontinent of bowel and bladder, use of anticoagulant medications and refusal of repositioning. Nursing interventions included instructions to staff to provide diet as ordered, incontinence care, to use pressure reducing devises and for nurses to do weekly skin assessment, document, and report to the provider any changes. Review of a 01/10/2023 wound care provider's progress note showed the left hip wound was resolved and the right heel wound was surgically debrided and continued to assess the wound on weekly wound round. The 02/27/2023 revised skin CP showed Resident 1 had a right heel wound. Nursing interventions included instructions for staff to avoid pressure, perform treatment as ordered, provide positioning devices as pillows or wedges and conduct weekly skin assessments The weekly skin assessments dated 02/28/2023, 03/07/2023, and 03/15/2023 addressed the right heel PU. There were no weekly skin assessments completed on 03/22/2023 and 03/29/2023 as the physician ordered. Review of a 03/28/2023 wound care provider's progress note showed Resident 1's stage four PU on right heel had deteriorated with increased necrotic tissues and heavy bloody drainage with strong odor, and measured 6 cm X 5 cm X 1.5 cm with undermining (when wound edges separated from the surrounding healthy tissue under the wound) 2cm from 12 to 1 o' clock. A 03/28/2023 Nursing progress note showed Resident 1 was scheduled to go for CT scan for right heel on 03/27/2023 and the resident refused to go in the wheelchair related to pain in their back. Resident 1 was sent to the hospital for right heel CT scan on 03/29/2023 around 4:30 PM in a stretcher. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	According to hospital record, on 03/29/2023 at 5:31 PM Resident 1 was admitted in the emergency department for right heel wound evaluation. The hospital record showed Resident 1 admitted with six PUs not previously identified by the facility. According to the hospital records, Resident 1 had multiple wounds on their left side of the body including left sacrum with DTI PU which measured 4 cm X 7.5 cm, left lower back with DTI PU which measured 2 cm X 1 cm, Stage three PU on Left buttock which measured 4.5 cm X 6cm, DTI PU on left trochanter which measured 0.5 cm X 2cm, Stage two PU on left upper spine which measured 5 cm X 2cm, DTI PU on left lower/lateral spine which measured 0.5 cm X 1.5cm. Observation and interview on 03/31/2023 at 3:07 PM, while Resident 1 was at the hospital, showed Resident 1 was lying in bed, alert and able to make their needs known. Resident 1's right heel was wrapped with dressing, left buttock with purple color DTI, left sacrum with dark purple color DTI, left upper and lower spine wounds were covered with dressing. When the resident was asked about their wounds, Resident 1 stated they had two wounds that they knew of: One on their right heel and one on left hip. Resident 1 stated they had those two wounds for a while, unable to remember exact date. Resident 1 stated they needed help to turn on their side in bed, but they liked to stay on their left side due to pain on their right side of the body. Resident stated they had chronic pain which was managed with pain medications. In an interview on 03/31/2023 at 10:54 AM, staff I (Licensed Practical Nurse- LPN) stated Resident 1 had an open wound on right heel, which was not improving and the wound doctor sent the resident out to the hospital for evaluation. When staff I was asked about the facility process for sending any resident out to the hospital, Staff I stated the nursing staff completed the resident's head to toe skin assessment, pain assessment and copy of physician orders and sent with the resident to the hospital. When staff I was asked for Resident 1's skin assessment or pain assessment documentation, Staff I was unable to locate the documentation and said that they did not check the resident's skin. Staff I said that they should have completed the skin check before Resident 1 left the facility. In an interview on 03/31/2023 at 11:08 AM, Staff C (Resident Care Manager- RCM) stated Resident 1 admitted to the facility in September 2022 with no PU. The resident had COVID 19 (a contagious disease caused by a virus, the severe acute respiratory syndrome) in December 2022 and they developed PU on their right heel. Staff C stated Resident 1 did not show severe symptoms but was moved to COVID unit. Resident 1 preferred to stay on their left side in bed, and was at high risk for developing PU. The facility provided an air mattress in their bed to relieve pressure after they developed the PU on their heel. Staff C stated nursing staff was doing weekly skin assessment and documented in the resident's record. A wound team with a wound care provider had been doing weekly wound assessment. When staff C was asked about the difference between the weekly skin assessment and wound assessment, staff C stated weekly skin assessment was completed by nursing staff and documented in the resident's record, and weekly wound assessment was completed by wound care provider with wound team only for the residents with open wounds. Staff C stated Resident 1 had only one PU on their right heel. Staff C was unable to locate the skin assessment or pain assessment for Resident 1 completed on 03/29/2023 in their record. In an interview on 04/04/2023 at 1:45 PM, Staff K (Wound Care provider) stated Resident 1 was assessed by wound team on 03/28/2023 for a right heel wound. Staff K stated the right heel wound was the only wound on their list to assess, the facility staff did not notify them of any other wound for Resident 1 that needed to be assessed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 04/04/2023 at 4:04 PM, Staff J (Certified Nursing Assistant- CNA) stated they took care of Resident 1 on 03/28/2023 and the resident stayed in bed all shift on their left side. Staff J stated they emptied the resident's urinal once and they did not have to provide incontinence care because the resident did not have bowel movement on that day. Staff J stated they did not look at their skin. In an interview on 04/04/2023 at 2:34 PM, Staff C stated Resident 1 was at risk for developing PUs. Staff C stated Resident 1 had behavior of refusing care, repositioning, and staying on their left side in bed. Staff C confirmed they did not update the CP about the resident preference to be on their left side to instruct the staff to offer other options and implement other devices or interventions. Staff C stated they should have placed the interventions like air mattress or heel floaters in bed earlier to prevent the PUs but they did not. In an interview on 04/04/2022 at 4:30 PM, Staff B (Director of Nursing) stated they were aware of Resident 1's wound history and stated that staff missed weekly skin assessments and head to toe skin check prior to sending the resident out to the hospital and staff should have done. Staff B stated weekly skin assessment, early identification of skin impairments and implementing PU prevention timely were important to maintain skin integrity and to prevent new PU from developing. Resident 2 According to the 12/06/2022 Admission/5 day Minimum Data Set (MDS- an assessment tool), Resident 2 admitted to the facility on [DATE] with complex medical diagnoses including respiratory failure (a serious condition that makes it difficult to breathe on its own), Asthma (a condition in which airways get swollen and makes hard to breathe), and Cognitive communication deficit (difficulty with thinking and how someone uses language). The skin assessment showed Resident 2 had two stage one PUs (non-blanchable redness) (skin color stays red when pressed with fingertip and when pressure removed) on buttocks (lower back area) and was at risk for developing pressure ulcers. This assessment showed Resident 2 required two-person extensive assistance with bed mobility and toileting. According to the 11/29/2022 nursing admission note, Resident 2 admitted with blanchable redness (skin turns white when pressed with fingertip and then turns red when pressure removed) to sacrum that measured 9.5 cm X 11.5 cm, and blanchable redness to right upper buttock that measured 4.0 cm X 4.0 cm and no open wound. The 11/29/2022 Skin CP showed Resident 2 had alteration in skin integrity. On 02/13/2023 the CP was revised to include moist associated skin damage (MASD) open area to the scrotum. On 02/21/2023 the CP was updated to reflect the stage one sacral PU had deteriorated to a stage three PU. Nursing interventions included instructions to staff to do treatment as ordered, notify physician and family for any skin change, and for nurses to do weekly skin assessments. Review of a 03/07/2023 wound provider notes showed Resident 2 was assessed with a stage three sacral wound that measured 0.5 cm X0.5 cm X 0.1cm with minimal drainage. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 2's medical record showed a 03/09/2023 nursing progress note documentation for suspected deep tissue injury (DTI) versus open area to coccyx/left buttock area and redness to midback area. A 03/11/2023 progress note showed Resident 2 was sent to hospital for evaluation related to respiratory issues. According to the 03/11/2023 Discharge return anticipated MDS, Resident 2 had one stage three PU, and two unstageable/DTIs PUs, none of which were present at admission. A review of the 03/24/2023 readmission assessment showed Resident 2 readmitted with three PUs; two stage three PUs on right buttock which measured 4 cm X 4 cm and 5 cm X 5 cm, and a stage one PU on middle spine which measured 6 cm X 3 cm X 0 cm. The assessment failed to identify the depth of the wounds on right buttock. A review of Resident 2's CP showed CPs were not updated or revised upon readmission on 03/24/2023. Further review of the resident record showed no weekly assessments for the other two PUs documented on readmission assessments on 03/24/2023. Review of a 03/28/2023 wound care provider's progress note showed Resident 2 had one unstageable PU on sacrum which measured 3.5 cm X 7 cm X 0.3 cm with moderate drainage. Observation on 03/31/2023 at 1:23 PM showed Resident 2 was sleeping on their right side on a regular mattress in their bed A 04/02/2023 nursing progress note showed Resident 2's guardian came to visit the resident and noticed Resident 2 complained of pain in their feet. The guardian informed staff about the concern. At that time, staff looked at Resident 2's feet and noted new PU on their right heel. Further review of Resident 2's record showed no pain assessment was completed after staff was notified regarding the resident's complained of pain. A review of Resident 2's pain assessment record showed last pain assessment was completed on 03/24/2023 on readmission. Review of Resident 2's March 2023 and April 2023 MARs showed nursing staff failed to complete the weekly skin assessments as ordered by the physician on 03/27/2023 and 04/03/2023. On 04/04/2023 at 12:42 PM, Resident 2 was observed lying in bed with their both heels resting on the mattress and at 1:45 PM, Resident 2 was sleeping on their back in bed with pillows under their right side and heels. The wound team with the wound care provider assessed the resident's wounds and provided the treatment in their room. In an interview on 04/05/2023 at 12:45 PM, Resident 2's representative (RR) stated they visited the resident on 04/02/2023, Resident 2 was lying in bed and complained of severe pain in their feet. RR stated they notified the nursing staff that Resident 2 was in pain. RR stated the nursing staff looked at the resident's feet and noted the PU which caused the pain. RR stated they had to ask the staff multiple times to place air mattress in Resident 2's bed to relieve the pressure. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 04/04/2023 at 1:50 PM, Staff G (Licensed Practical Nurse) stated they were Resident 2's regular nurse and worked there since November 2022. Staff G stated Resident 2 liked to stay in bed and needed extensive assistance with feeding and bed mobility. Staff G stated Resident 2 had sacral open wound and two days ago, another new wound developed on their right heel. Staff G stated nurses provided weekly skin assessment and documented in the resident's records as ordered. When Staff G was asked about Resident 2's last skin assessment record, Staff G could not find weekly skin assessment since readmission 03/24/2023 in the record. Staff G stated they missed Resident 2's weekly skin assessment. In an interview on 04/04/2023 at 2:00 PM, Staff K stated Resident 2 was seen for sacral wound for few weeks and today Resident 2 's two new PUs; a stage 3 on the right heel and a DTI on the left heel, were assessed. In an interview on 04/04/2023 at 2:16 PM, Staff D (Resident Care Manager) stated Resident 2 was admitted to the facility in November 2022 with no open wounds. Resident 2 developed sacral open wound in the facility in December 2022 and this week they developed two new PUs on their heels. Staff D stated the wound care provider assessed the wounds every week and recommended the treatments. Floor nurses provided weekly skin assessment and documented in the resident's records. Staff D was unable to locate any weekly skin assessment for Resident 2 in their record after 03/24/2023. Staff D stated they missed the weekly skin assessments as ordered by the physician for Resident 2. In an interview on 04/04/2023 at 3:52 PM, Staff B stated weekly skin assessment, monitoring, early identification of skin impairments and implementing PU prevention timely were important to maintain skin integrity and to prevent new PU from developing. Staff B stated they were aware of Resident 2's wound history and confirmed staff missed weekly skin assessments as ordered. Staff B stated staff should have done weekly skin assessment as ordered. REFERENCE: WAC 388-97-1060(3)(b)