STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505042	A. Building B. Wing	07/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballard Center	820 Northwest 95th Street Seattle, WA 98117

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 39651 Based on observation, interview and record review, the facility failed to prevent and timely identify, monitor, and treat a change in condition/skin breakdown for 1 of 3 residents (Resident 1) reviewed for change in condition and skin care. These failures caused harm to Resident 1 who was hospitalized and developed a severe form of skin breakdown and pain while at the facility. Findings included . Intertrigo (or Intertrigo dermatitis) is defined as an inflammatory condition of skin folds, induced or aggravated by heat, moisture, maceration, friction and lack of air circulation. Moisture Associate Skin Damage or MASD is defined as an inflammation and erosion of skin caused by prolonged exposure to various sources of moisture, including urine or stool, perspiration, wound exudate (discharge), mucus or saliva. Resident 1 was a long-term care resident of the facility. The resident's diagnoses list included heart failure, obesity, diabetes and intellectual developmental disability (developmental delayed). A review of Resident 1's skin care plan, dated 01/20/2021, showed the resident was at risk for skin breakdown related to obesity and diabetes. The care plan directed facility staff to monitor and observe the resident's skin every shift for signs and symptoms of skin breakdown. A review of nursing progress notes, dated 06/15/2021, showed the resident complained of feeling weak and that he felt a shock twice in the morning. Resident 1 was found to have a burn wound on his left lower back area. The resident was transported to the hospital for further evaluation. A review of the hospital records from 06/16/2021 to 06/29/2021 showed Resident 1 arrived at the hospital's emergency department on 06/16/2021 at 12:34 AM. The hospital records showed the resident was found to have a large purulent [consisting of, containing, or discharging pus] Skin and soft tissue infections [SSTI] on his left flank and groin intertrigo. The hospital records, inpatient wound consultation reports, and assessments showed the resident arrived at the hospital with several skin issues, which included the following two non-pressure related wounds present on admission (POA): (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	A. Left lower back full thickness wound (the skin damage extends below all layers of skin into the fat and/or beyond muscle, bones or tendon). The wound measured 2.5 centimeter (cm) in length and 1.5 cm wide with the depth unable to be assessed or measured due to the presence of 100% purulent slough (dead tissue). The surrounding skin was described as erythematous (skin redness), indurated (hardened/firm skin), denuded (loss of the outer layer of the skin caused by moisture and friction) and painful. B. Bilateral (both sides) groin and inner thighs MASD. The skin breakdown extends from the bilateral groin area, to the supra pubic (top/above the groin), and to the bilateral inner thighs area. The skin was described as erythematous with lesions (abnormal growth or appearance), fragile, denuded and painful. C. Coccyx (tailbone) unstageable pressure ulcer/injury (PU/PI). The wound measured 6cm in length and 1cm wide with the depth unable to be assessed or measured due to the presence of 100% slough. The surrounding skin was noted to have blanchable redness that measured 10 cm in length and 6 cm wide and was painful with wound palpation. The hospital records documented that the facility reported and noted a gradual change in Resident 1's mental status over the last 5 days and suspected the resident developed a burn on his L [left] flank, but are unsure where the skin changes there came from, which has been present for a few days per their report. The hospital records also showed that the hospital staff were concerned about the care and services the resident received from the facility, particularly the delay in recognition of the wounds and inadequate help with hygiene. A review of Resident 1's clinical records from 06/10/2021 to 06/16/2021 showed the facility had no documented assessment and/or record of a change in mental status or condition or MASD in the groin area or any documented pressure ulcer. The only documented wound assessment was dated 06/15/2021, prior to the resident's transport to the hospital. On 06/17/2021 at 2:30 PM, Staff B, Director of Nursing (DNS) stated, the facility had no record of Resident 1 having a change in mental status, or MASD or pressure ulcer. The DNS stated that the facility had identified the back wound on 06/15/2021, which was one of the main reasons Resident 1 was sent to the hospital for evaluation. The DNS stated that the nursing staff who sent the resident to the hospital did not conduct a head-to-toe skin assessment to check whether the resident had any other skin issues or breakdown prior to the hospital transport. The DNS further stated, Resident 1 was independent with toileting task and personal hygiene and that she was not aware of any other change in condition or skin issues on Resident 1. A review of the eINTERACT Transfer Form (hospital transfer form), dated 06/16/2021, completed by Staff C, Registered Nurse (RN) showed the resident had no other skin issues except the left lower back wound. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	On 06/21/2021 at 4:25 PM, Staff C, RN, stated that she completed the eINTERACT Transfer Form and wound assessment for Resident 1. Staff C stated she only assessed the left lower back wound of Resident 1 and she did not perform a head-to-toe skin assessment. Staff C stated she was not aware of any recent change in condition and any other skin breakdown on Resident 1. Staff C further stated, Resident 1 was independent with activities of daily living (ADL's) and staff were not providing any type of assistance including personal hygiene. On 06/21/2021 at 4:35 PM, Staff D, RN, stated that she was the nurse on duty when Resident 1 was transferred to the hospital on 06/15/2021. Staff D stated that she did not conduct a skin assessment at the time of Resident 1's transfer and was not aware of any other skin issues. On 06/21/2021 at 4:45 PM, Staff E, RN, stated that he recently conducted a head-to-toe skin assessment of Resident 1 on 06/14/21 at around 8:30 PM, but did not notice any skin problems. Staff E stated he was not sure why Resident 1 was then found to have significant wounds the following morning, less than 24 hours after he conducted a skin check. Staff E stated he was not aware of any changes in Resident 1's condition prior to this recent hospitalization . Staff E further stated, Resident 1 was independent with activities of daily living (ADL's) and staff were not providing any type of assistance including personal hygiene. On 06/24/2021 at 8:10 AM, Hospital Staff #1 (HS1) stated the doctors and hospital staff were concerned about Resident 1's condition when he arrived at the emergency room (ER) on 06/16/2021. HS1 stated that Resident 1's wounds should have been identified and cared for sooner. HS1 stated that the resident was disheveled with serious wounds on his back, coccyx, and groin area that were infected. During an observation and interview on 06/24/21 at 1:30 PM, Resident 1 stated he developed the wounds on his back, groin and tailbone area while at the nursing facility. The resident stated that he had not been feeling good approximately 3 to 5 days before he was hospitalized , and the wounds had developed because he had not been getting out of bed and moving around as he used to. The resident further stated that he could not recall any staff member or any nurse at the facility checking his skin except maybe before he left the faciity on a gurney. The resident said, They don't check my skin regularly and I don't get help [from staff] in cleaning myself. The resident also stated he had diarrhea and urine leak days before he was hospitalized . Resident 1 then showed his groin wounds for observation. The wound was treated with powder and the skin remained open with redness and minimal drainage. The resident also tried to show his back wounds, but the wounds had a wound dressing in place. According to the resident, his wounds were healing but were still very painful and All of it hurts. The resident stated the pain on his wounds was bad enough for him not to be able to sleep, and for him to lose his appetite and his ability to enjoy his day. On 06/24/2021 at 2:00 PM, Hospital Nurse #1 (HN1) stated that Resident 1 was admitted to the hospital with the wounds on his back, coccyx and groin area. HN1 also stated that Resident 1's wounds were infected and was treated with antibiotics. HN1 further stated that Resident 1 had complained of severe pain to his back and groin area, especially during care and/or even at rest. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 06/24/2021 at 2:15 PM, Hospital Nurse, HN2, stated that she was one of the ER nurses who admitted Resident 1. HN2 stated that Resident 1 was admitted to the hospital with a large purulent soft tissue injury on his back, groin MASD and pressure ulcer on his coccyx. HN2 also stated that the doctors who evaluated Resident 1 were concerned that these wounds did not appear to have been receiving care from the nursing facility. During a follow-up interview and record review on 06/30/2021 at 8:15 AM, Staff B, DNS, stated that the facility conducted an investigation related to Resident 1's wounds. Staff B stated that the facility first identified the wound on Resident 1's left lower back on 06/15/2021 and they had no record of any recent change in condition and/or any other skin breakdown. On 07/09/2021 at 11:30 AM, the resident stated that his wounds continued to cause pain and discomfort, but he was feeling a little bit better now because it wasn't as painful as before. Reference: (WAC) 388-97-1060 (1)(3)(b)

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(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. 39651 Based on interview and record review, the facility failed to timely identify, monitor and treat a pressure ulcer for 1 of 3 residents (Resident 1) reviewed for pressure ulcers/pressure injury (PU/PI). Additionally, the facility failed to implement Resident 1's directed plan of care to minimize the risk of the development of an avoidable pressure ulcer. These failures caused harm to Resident 1 who developed an untreated pressure ulcer while at the facility. Findings included . The National Pressure Ulcer Advisory Panel (NPUAP) Pressure Injury (Ulcer) definition and stages include: A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by nutrition, co-morbidities and condition of the soft tissue. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar (dead tissue). If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Resident 1 was a long-term care resident of the facility. The resident's diagnoses list included heart failure, obesity, diabetes and intellectual developmental disability (developmental delayed). A review of Resident 1's quarterly Minimum Data Set (MDS) assessment, dated 04/28/2021, showed the resident had impaired cognition and required staff supervision with bed mobility and transfers. A review of Resident 1's skin care plan, dated 01/20/2021, showed the resident was at risk for skin breakdown related to obesity and diabetes. The care plan directed facility staff to monitor and to observe the resident's skin every shift for signs and symptoms of skin breakdown. A review of Resident 1's nursing progress notes, dated 06/15/2021, showed Resident 1 was transported to the hospital for further evaluation and treatment of burn wound on his left lower back area. A review of the hospital records from 06/16/2021 to 06/29/2021 showed Resident 1 arrived at the hospital's emergency department on 06/16/2021 at 12:34 AM. The hospital records showed the resident had several wounds, including a large purulent (consisting of, containing, or discharging pus) skin and soft tissue infection (SSTI) on his left flank (side of the body between ribs & hip) area and an unstageable pressure ulcer at the coccyx (tailbone) area. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The hospital records showed the pressure ulcer wound on the coccyx measured 6 centimeter (cm) in length and 1 cm wide with the depth unable to be assessed or measured due to the presence of 100% slough. The surrounding skin was noted to have blanchable redness that measured 10 cm in length and 6 cm wide and was painful with wound palpation. Per the hospital records, the left lower back (flank) wound was described as a full thickness wound (the skin damage extends below all layers of skin into the fat and/or beyond muscle, bones or tendon). The wound measured 2.5 cm in length and 1.5 cm wide with the depth unable to be assessed or measured due to the presence of 100% purulent slough (dead tissue). The surrounding skin was described as erythematous (skin redness), indurated (hardened/firm skin), denuded (loss of the outer layer of the skin caused by moisture and friction) and painful. A review of the hospital's abdominal and pelvic CT scan (an x-ray image scan) report, dated 06/16/2021 at 5:04 AM, showed that the findings of the CT scan could be consistent with evolving chronic pressure injury/trauma. The hospital records also showed that the hospital staff were concerned about the care and services the resident received from the facility, particularly the delay in recognition of the wounds and inadequate help with hygiene. A review of Resident 1's clinical records from 06/01/2021 to 06/16/2021 showed the facility had no documented assessment and/or record of any pressure ulcer. The clinical records also showed no documented evidence the facility staff monitored and observed the resident's skin every shift for signs and symptoms of skin breakdown as directed by the resident's plan of care. On 06/17/2021 at 2:30 PM, Staff B, Director of Nursing (DNS) stated the facility had no record of Resident 1 having a pressure ulcer prior to his recent hospitalization . A review of the eINTERACT Transfer Form (hospital transfer form), dated 06/16/2021, completed by Staff C, Registered Nurse (RN) showed the resident had no pressure ulcer on 06/15/2021 prior to the hospital transfer. On 06/21/21 at 4:25 PM, Staff C, RN, stated that she completed the 06/15/2021 eINTERACT Transfer Form and wound assessment for Resident 1. Staff C stated that she only assessed the left lower back wound of Resident 1, and she did not perform a head-to-toe skin assessment. When asked why she documented None on the eINTERACT Transfer Form without fully assessing the resident's skin, Staff C was not able to provide an answer. Staff C stated she was not aware of any other skin breakdown on Resident 1. Staff C further stated, Resident 1 was independent with bed mobility and transfer, and was not on any turning or repositioning schedule to prevent and/or minimize the risk of pressure ulcer. On 06/21/2021 at 4:35 PM, Staff D, RN, stated that she was the nurse on duty when Resident 1 was transferred to the hospital on 06/15/2021. Staff D stated that she did not conduct a skin assessment of Resident 1 and was not aware of any pressure ulcer prior to and at the time of the hospital transfer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 06/21/2021 at 4:45 PM, Staff E, RN, stated that he recently conducted a head-to-toe skin assessment of Resident 1 on 06/14/2021 at around 8:30 PM, but did not notice any skin problems. Staff E stated he was not sure why Resident 1 was observed at the hospital with significant wounds the following morning, less than 24 hours after his documention that he conducted a skin check. Staff E further stated, Resident 1 was independent with bed mobility and transfer, and was not on any turning or repositioning schedule to prevent and/or minimize the risk of pressure ulcer. On 06/24/2021 at 8:10 AM, Hospital Staff #1 (HS1) stated that the doctors and hospital staff were concerned about Resident 1's condition when he arrived at the emergency room (ER) on 06/16/2021. HS1 stated that Resident 1's wounds should have been identified and cared for sooner. HS1 stated that the resident was disheveled with serious wounds on his back, coccyx, and groin area that were infected. During an observation and interview on 06/24/2021 at 1:30 PM, Resident 1 stated that he acquired the wounds on his back, groin and tailbone area at the nursing facility. The resident stated he had not been feeling good approximately 3 to 5 days before he was hospitalized , and the wounds he had developed on or about the same time because he had not been getting out of bed and moving around as he used to. The resident further stated, he could not recall any staff member or any nurse at the facility checking his skin except maybe before he left the faciity on a gurney. The resident added, they don't check my skin regularly and I don't get help in cleaning myself from staff. The resident also stated he had diarrhea and urine leak days before he was hospitalized . Resident 1 then tried to show his wounds, including the coccyx wound, however it had a wound dressing in place. The resident stated his wounds on his back and coccyx area caused so much pain that he could not lay flat and rest comfortably on his back. According to the resident, his wounds were healing, but were still very painful. All of it hurts. The resident stated that the pain on his wounds was bad enough for him not to be able to sleep, and for him to lose his appetite and his ability to enjoy his day. On 06/24/2021 at 2:00 PM, Hospital Nurse #1 (HN1) stated that Resident 1 was admitted to the hospital with the wounds on his back, coccyx and groin area. HN1 also stated, Resident 1's wounds were infected and was treated with antibiotics. HN1 further stated that Resident 1 had complained of severe pain to his back and groin area, especially during care and/or even at rest. On 06/24/2021 at 2:15 PM, Hospital Staff #2 (HN2) stated that she was one of the ER nurses who admitted Resident 1. HN2 confirmed that Resident 1 was admitted to the hospital with a large purulent soft tissue injury on his back, groin MASD and pressure ulcer on his coccyx. HN2 also stated that the doctors who evaluated Resident 1 were concerned that these wounds did not appear to have been receiving care from the nursing facility. During a follow-up interview and record review on 06/30/2021 at 8:15 AM, Staff B, DNS, stated that the facility conducted an investigation related to Resident 1. The DNS stated the facility first identified the wound on Resident 1's left lower back on 06/15/2021, and they had no record of a change in condition or any other skin breakdown. On 07/09/2021 at 11:30 AM, the resident stated that his wounds continued to cause pain and discomfort, but he was feeling a little bit better and it wasn't as bad as before. The resident stated he could not sleep and lay on his back because of his sore which makes it very uncomfortable. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 07/09/2021 at 12:05 PM, Staff B, DNS, stated that the resident now required more staff assistance with his activities including bed mobility, transfers, toileting and personal hygiene. Staff B stated the resident continued to require skin and wound care after his recent hospitalization . Reference: (WAC) 399-97-1060 (3)(b)