STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505202	A. Building B. Wing	06/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Skilled Nursing and Rehabilitation	4430 Talbot Road South Renton, WA 98055

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29644 Based on interview and record review, the facility failed to promptly respond to, and resolve grievances for 10 (Resident 2, 3, 4, 5, 6, 7, 8, 10, 11 & 12) of 10 residents reviewed for grievances. Failure of the facility to investigate and resolve grievances placed the residents at risk for a diminished quality of life. Findings included . Review of the facility Grievance/Complaint Log undated policy showed that, The disposition of all resident grievances and/or complaints will be recorded on our facility's Resident Grievance/Complaint Log. During an interview on 06/07/2021 at 10:50 AM, Staff D, Social Services Assistant stated that the Administrator had the Grievance Log. During an interview on 06/07/2021 at 12:05 PM, Staff B, Director of Nursing stated that Staff A, Administrator did not log the Grievances for April, May or June of 2021, but did have the grievances filed. Review of the 2021 Grievance Binder showed Grievances were logged from January 2021 through March 2021. There were no logs for April, May, or June of 2021. Review of the facility Filing Grievances/Complaints undated policy showed that, upon receipt of a grievance, the allegations will be investigated and a written report of findings given to the Administrator within five working days of the complaint. The Administrator reviews the findings of the investigation to determine what corrective actions, if any need to be taken. The resident, or person filing the grievance, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems, A written summary of the investigation will be provided to the resident. During an interview on 06/07/2021 at 12:27 PM, Staff A stated that Grievances were reviewed in the morning Stand-Up meeting, distributed to the appropriate department to provide a solution. Social Services ensured it was done, and when done, I review and sign. When asked how many days the facility had to resolve a grievance, Staff A replied, No more than five days. Resident 2 (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 05/25/2021 at 1:14 PM, Resident 2's representative stated that Resident 2 was only being allowed two showers a week. Review of a Concern & Comment Form dated 05/26/2021 showed Resident 2 asked for daily showers, but was told by a staff member that they could only have two showers per week. According to the form, the concern was reported to the IDT (Interdisciplinary Team. The staff member was unable to resolve the concern at the time it was shared and documented, Care Plan will be updated to reflect daily showers, along with staff education. Review of the 04/19/2021 Care Plan showed bathing was not addressed. Review of tasks completed from 05/17/2021-05/31/2021 showed the resident was showered once on 05/26/2021, was offered and refused on 05/04/2021 and 05/28/2021. The back of the form, the Facility Investigation and Response was blank, with no action to resolve/respond to the concern documented. During an interview on 05/25/2021 at 1:14 PM, Resident 2's representative stated that Resident 2's, laundry is being ruined and that Resident 2's black shirts have been bleached. Review of a Concern & Comment Form dated 05/26/2021 showed Resident 1's representative reported that Resident 1 had missing clothes and that the resident's new black T-shirts had been bleached. According to the form, the concern was reported to the IDT Team. The staff member was unable to resolve the concern at the time it was shared. The 05/26/2021 investigative findings documented were that a staff member found the two of the Resident's T-shirts were Bleached and also an underwear. Resident also mentioned they were missing a pair of shorts so, the staff member looked in the laundry but was unable to find them. Under the section, Action taken to resolve/respond to concern, dated 05/26/2021 was documented, Please replace 2 3XL Black T-Shirts cotton, 1 [NAME] Boxer Briefs and one Nike Short. Attached were three printout samples with prices for replacement. The concern form was not signed off as completed by the Administrator. No receipts were attached. Resident 3 Review of a Grievance Form dated 04/20/2021 showed that Resident 3 notified Staff E, Social Services, that they did not get the dinner as requested (chicken Caesar salad). Staff E went to the kitchen to request a meal. The chef notified Staff E that the kitchen did not have any salad or lettuce. Staff E notified the resident who chose an alternative meal. Under actions or recommendations to be taken, Staff E documented, Please address with dining manager to ensure items stocked match scheduled meal for the day. The Grievance Form was not signed as given to the dining manager. The investigation and resolution of the Grievance was blank, with no action documented as taken. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the progress notes showed no documentation regarding the Grievance or follow up with the resident regarding the concern. Record review showed a quarterly Dietary Profile was dated 04/27/2021, but it did not address the resident's concerns. During an interview on 06/07/2021 at 1:25 PM, Resident 3 stated that they were notified the kitchen was out of lettuce. Resident 3 added, They're always out of stuff, so why do they have it on the menu then? Resident 4 Review of a Grievance Form dated 05/03/2021 showed that Resident 4 purchased briefs, with a receipt that showed the items were delivered to the facility on [DATE]. The building was searched and the items were not found. The actions/recommendations were that three boxes of protection plus overnight underwear should be replaced. There was no signature indicating the Grievance was received or assigned to anyone to follow up. The Grievance Summary Report, including investigation, resolution or follow up with the resident was not completed. During an interview on 06/07/2021 at 1:38 PM, when asked if the facility had replaced the briefs, Resident 4 stated, I don't know. Resident 5 Review of Nursing Note dated 04/21/2021 at 1:02 PM showed, Resident 5, was angry upset that the kitchen did not have hot wings. The resident asked for hot wings and ramen noodles for lunch. The resident asked the CNA (Certified Nursing Assistant) to take away the tray and get the Noodles. Once the CNA returned the resident shoved the noodles back to the CNA saying get all of it out of here I don't want any of it. Resident 5 went to their room door, upset and stated, this is not right I should get what what I ask for. The staff member apologized and informed the resident that they would speak or get a message to the kitchen manager to come and see the resident The staff member also asked for the social worker, who came and saw resident. Review of a Grievance Form dated 04/21/2021 showed that Staff E was notified that Resident 5 was upset as they ordered chicken wings which were on the, every day menu and was told there were no chicken wings stocked at that time. Under recommendations, Staff E documented on 04/22/2021, Please address with dining manager to ensure items stocked match scheduled meal for the day. Review of Nursing Note dated 04/21/2021 at 1:13 PM showed, After the Social worker left [resident] came to the door gave apology to me and asked to see the CNA to apologize (sic) to her. We asked if there is anything else we could get her from the kitchen. There was no signature indicating the Grievance was received or assigned to anyone to follow up. The Grievance Summary Report, including investigation, resolution or follow up with the resident was not completed. During an interview on 06/07/2021 at 1:20 PM, Resident 5 stated that no one followed up regarding the concern. Resident 6 (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a Grievance Form dated 04/20/2021 showed Staff E was notified of the missing left hearing aide. The Resident allowed Staff E to their search room and belongings. Hearing aide was not found in the resident's room. Laundry and maintenance staff were notified of missing items. Hearing aid was not found at this time. Staff E placed a call to the resident's family to notify of them of the missing hearing aid and discuss the plan. Staff E's documented recommendations on 04/22/2021, were, Due to order to care for hearing aids, if resident and family interested in replacement, facility should replaced (sic). Audiologist appointment will need to be scheduled . Review of the Grievance Summary Report showed no documentation the facility followed up, resolved, or notified family. Review of Social Services Notes dated 04/23/2021 showed that the resident's daughter would like the facility to move forward with replacing left Hearing Aide. On 04/30/2021 Staff E scheduled an appointment for 05/07/2021. During an interview on 06/07/2021 at 1:20 PM, Resident 6's family stated that after having taken the resident to the hearing aid appointment, I haven't heard from them. They were trying to determine who was going to pay for them. During the interview, Resident 6's family stated that the facility found the hearing aid, it showed up a month later on the bedside table. I got a call asking if I brought one, I had not. Review of a 05/20/2021 Nursing Note showed, staff was in the room and noted a hearing aid lying on the resident's night stand. D Staff were unsure if it was the missing hearing aid. At the time resident was wearing one hearing aid that resident's daughter had left for the resident to use, I placed the hearing aid in the left ear. Resident is now wearing aid in both ears, I spoke with Resident's daughter who will be here tomorrow to visit and look at them then. Resident 7 According to the Minimum Data Set (MDS - an assessment tool), Resident 7 was not available for observation or interview. Review of a Grievance Form dated 05/21/2021 filled out by Staff D, showed that Resident 7's spouse reported that at every visit the resident was wearing the same dirty clothes, although the resident had plenty of clothes to change into. Under the section, What actions or recommendations do you feel need to be taken? was written, Care staff need to make sure Resident is wearing clean clothing every morning. The Grievance Form was not signed as received, the Grievance Summary Report, including facility follow-up and resolution of the Grievance was blank. Review of the 02/12/2021 Care Plan, revised 05/25/2021 showed the resident was totally dependent on staff for dressing and staff were directed to assist with electronic visitation with family. The plan of care did not include directives to staff to ensure the resident was wearing clean clothing every morning. Review of the progress notes showed no documentation regarding the Grievance, investigation, conclusion, resolution or notification to the grievance. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident 12 Review of a Grievance Form dated 04/08/2021 filled out by Staff E, showed Resident 12 reported multiple missing clothing items. The recommendations documented by Staff E was Resident would like laundry to come to their room and label all items. Resident to speak to daughter about doing laundry rather than facility. During an interview on 06/07/2021 at 1:30 PM, Resident 12 stated that they were missing a bunch of laundry and had received no items back. The resident stated that their name was not on them. Clothes were observed in the resident's closet and some clothing was not labeled. The grievance was not signed as received by a department for investigation. The Grievance Summary Report, including facility follow up, resolution, and notification was not complete. Residents 8, 10 &11 Similar findings were noted for Resident 8 who filed grievances on 05/03/2021 and 05/11/2021 regarding wound care, Resident 10 who filed a grievance of missing items on 04/28/2021 and Resident 11 who filed a grievance of missing items on 04/15/2021. During an interview on 06/07/2021 at 12:27 PM, when asked who notified the resident afterwards of the resolution, Staff A stated That needs to be set up . Review of the Grievance Forms showed the back of the form contained the Facility Investigation and Response. Staff A stated that social services is supposed to work on that section, and get an intervention. According to Staff A, most of them were handled by Staff E, Social Services, who Handed (it) to me and left (departed). According to Staff A, Staff E quit working at the facility sometime in April. REFERENCE WAC 388-97-0460 (1)(2).

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44295 Based on observation, interview, and record review, the facility failed to ensure three (Residents 1, 9 & 8) of three residents reviewed, received the necessary care and services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. The facility failed to ensure Resident 1 received acute medical interventions timely, after experiencing a change in condition including decreased mentation, increased abdominal distention, that prevented prompt treatment that resulted in hospitalization and may have contributed to the resident's death. In addition, the facility failed to monitor and treat non-pressure wounds for 3 of 3 residents (Residents 1, 9 & 8) reviewed for non-pressure wounds. Failure of the facility placed residents at risk for delay in care and treatment, increased risk of poor outcome and diminished quality of life. Findings included . Resident 1 Review of the facility's undated Change in a Resident's Condition or Status Policy, showed that the facility should promptly notify the resident, attending physician, and representative of changes in the resident's medical/mental condition and/or status. The policy showed that the nurse will notify the resident's attending physician or physician on call when there has been a(an): significant change in the resident's physical/emotional/mental condition; refusal of treatments or medications two or more consecutive times; and/or need to transfer the resident to a hospital. Review of Resident 1's POLST (Physicians's Order for Life-Sustaining Treatment), showed on [DATE] the Resident signed the POLST and chose CPR (Cardiopulmonary Resuscitation) with Full treatment including the use of antibiotics if life can be prolonged, long term medically assisted nutrition by tube, and hospital transfer. According to the [DATE] 5 Day Minimum Data Set (MDS- an assessment tool) Resident 1 was readmitted to the facility from a local hospital on [DATE] after having surgery to fix a right femoral fracture on [DATE]. According to the MDS, Resident 1 had diagnoses to include, diabetes mellitus, cirrhosis of the liver, nonalcoholic steatohepatitis (NASH- liver inflammation) and hepatic encephalopathy (HE--loss of brain function when damaged liver cannot remove toxins from the blood). Review of the Nursing Care Plan for Diabetes Mellitus, initiated on [DATE] showed interventions to monitor, document, report as needed any signs or symptoms of hyperglycemia (increased blood sugar), such as fatigue, dry skin, abdominal pain, increased thirst and appetite. Interventions included to monitor, document, report as needed any signs or symptoms of hypoglycemia (decreased blood sugar), such as sweating, confusion, slurred speech, lack of coordination and increased heart rate. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of [DATE] Physician's Orders (PO) showed on [DATE] orders to check blood sugar three times a day. Review of Physician's Orders (PO) and MAR from re-admitted on [DATE], through [DATE] showed no blood glucose monitoring or side effect documentation. Review of Inpatient Nephrology Consult Note from the hospital dated [DATE], showed an abdominal ultrasound was done on [DATE]. Results showed a large amount of ascities (abnormal fluid build up in the abdomen due to liver disease) and a paracenthesis (removal of fluid) was performed on [DATE] at 4:53 PM. Review of the facility Nursing Admission/Readmission Evaluation dated [DATE] at 4:27 PM showed Resident 1 had a paracentesis (fluid removal) drainage site with dressing to the right abdomen. Review of physician orders (PO) dated [DATE]-[DATE] showed no orders to monitor drainage site, change drainage site dressing or monitor weight and abdomen girth for changes in ascities. Review of the Nursing Progress notes showed no indication Nursing Staff clarified with the Physician for orders to monitor and treat the wound. Review of the Nursing Care Plan (dated [DATE]) for Resident #1, showed no interventions for the resident's liver disease. On [DATE] at 3:21 PM, Resident 1 was observed laying in bed, with bruising and a scab to right knee, a dressing and bruising to right hip. Attempts to interview Resident 1 at that time were unsuccessful due to the resident's confusion. Review of a Medical Doctor (MD) re-admission note dated [DATE] showed that Resident 1 appeared to be alert and oriented to self and place with abdominal distention that was not present on previous admission. According to the MD note, the resident was seen for a diagnosis of cirrhosis of the liver (impaired liver function) and Hepatic Encephalopathy (HE -loss of brain function when damaged liver cannot remove toxins from the blood), with recommendations to ensure resident had ,d+[DATE] stools per day, any change in mentation would warrant a stat (immediate) ammonia level as high risk for resident to go into hepatic encephalopathy. The MD noted the resident should continue on Lactulose (medication used to treat complications of elevated blood ammonia levels), rifaximin (medication to reduce HE) and spironolactone (medication used to treat fluid retention). Review of the [DATE] Medication Administration Record (MAR) showed Resident 1 did not consistently receive medications to manage Liver Disease. Documentation showed Lactulose (medication used to treat complications of liver disease) was refused on ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], [DATE]. Documentation showed Rifaximin (medication to reduce HE) was refused on ,d+[DATE], ,d+[DATE], , d+[DATE], ,d+[DATE] and [DATE]. Sprionolactone (medication used to treat fluid retention) was refused on , d+[DATE], [DATE]. The Nursing Skilled Progress note dated [DATE] at 12:45 AM, showed Resident 1 to be alert to person, with normal bowel sounds, warm skin with good skin turgor (assess dehydration) and no behaviors observed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the MD Encounter -MD Admission History and Physical Note dated [DATE], the resident was seen and the MD noted Resident 1's abdomen was quite distended. The MD planned to obtain a baseline CMP (Comprehensive metabolic profile- measures, glucose level, electrolyte and fluid balance, kidney and liver function) and H3 (detects the presence autoantibodies- proteins that attack the immune system) and a CBC (Complete blood count - evaluate the cells that circulate in the blood and overall health). Review of POs orders for [DATE] showed the facility had not carried out Physician recommendations for labs as stated in the MD Encounter note on [DATE]. Review of Lab Results showed no labs were drawn or results received for labs planned [DATE]. On [DATE] at 01:43 AM a Nursing Skilled Progress note showed Resident 1 was confused, observed with abdominal distention, poor po (by mouth) intake, and warm skin with sluggish skin turgor. Per the summary, the Licensed Nurse (LN) showed, Resident has not been awake enough to take medications. Will let the MD know by the communication book. Review of the MD Communication and Order Sheet, signed on [DATE] by the LN showed the problem/concern was, the resident never awake enough to take food or medications. The communication was noted by the Physicians Assistant (PA) on [DATE] with no new orders given. On [DATE] at 01:08 AM a Nursing Skilled Progress note showed Resident 1's need for skilled care to be resident is very ill with liver disease . has not been eating or taking medications. Rests in bed and when awake talks to people who are not there. Resident 1 was documented to be confused, with abdomen very swollen from liver disease, poor po intake with GI (Gastrointestinal) complications being abdominal distention and hypoactive (sign that intestinal activity has slowed) bowel sounds. Skin warm with sluggish turgor, which might be related to dehydration. Resident 1 was not receiving therapy services because the resident was not able to perform therapy requirements. The Nursing Skilled Progress note summarized Resident 1 continued to be confused, often talked to someone who was not there and was sleeping most of the time. The facility notified the physician that the resident was not eating or taking fluids and was not taking medications. Review of the MD Communication and Order Sheet dated [DATE], unsigned by an LN showed the problem/concern was patient is refusing medications and fluids, poor appetite. On [DATE] it was noted by the PA with orders to; please have speech therapy and dietician evaluate. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a [DATE] at 01:57 AM a Nursing Skill Progress Note showed Resident 1 was not alert, won't eat or take fluids. Refuses medications. Bed ridden and very ill due to liver disease. LN documented Resident 1 was confused, their abdomen was distended and swollen, mucous membranes were dry sticky and was not consuming oral fluids, and had hypoactive (decreased) bowel function and skin that was warm, and dry with sluggish skin turgor, supporting dehydration. Skin was documented to be yellow in color (jaundice- excess of the pigment billirubin, caused by liver disease). Staff documented the resident was experiencing hallucinations (perceptual experiences in the absence of real external sensory stimuli) and delusions (misconceptions or beliefs that are firmly held, contrary to reality). The resident was unable to participate in therapy services and the LN summarized that Resident 1 continued to refuse to take fluids, and if staff attempted to get the resident to take a drink the resident spit it out, and was unable to take medications. Staff notified the MD Resident 1 was refusing food, fluids and medications and the resident's abdomen was getting bigger. Apparently the resident's urinary output was unusually low because staff documented the resident normally voids (urinates) once a shift. A Nursing progress note dated [DATE] at 5:22 PM showed Resident 1 was refusing medication, poor appetite and provider notified, indicating a significant decline in condition. But staff documented, No acute changes at this time indicating staff failed to identify a significant decline in medical condition. Despite the resident's decline and the physician's orders on [DATE] at 6:00 PM for Alert Monitoring for any acute changes related to poor appetite and refusing medication to be documented every shift, staff still failed to identify the resident's continuing and dramatic decline in condition. On [DATE] at 01:25 AM a Nursing Skilled Progress Note showed Resident 1 to be confused with hallucinations, not eating, drinking or taking medications with a large protruding abdomen and poor po intake. Resident 1's skin was documented as warm, dry, yellow in color with sluggish skin turgor, indicating dehydration. The resident was not able to participate in therapy due to inability to follow directions. The LN summarized the note as Resident 1 was not alert, was unable to state their name, refused all attempts to get the resident to eat or drink, only took ,d+[DATE] cup of apple juice today and that is all. The resident refused medications, by clamping their teeth and wouldn't open their mouth. The resident would at times call out for their mother or dad and sometimes spouse. The resident would sometimes sing nursery rhymes, and seemed to be having hallucinations and spoke to someone they thought was in the room when no one was there. A nursing progress note dated [DATE] at 01:51 AM showed the LN documented a plan to let the MD know that the resident was not eating or drinking or taking medications. the day shift nurse left a note for the MD as well. Review of MD orders showed on [DATE] at 2:27 PM an order for a CMP, NH3 and CBC (laboratory tests-labs) was placed to assess for hepatic encephalopathy, cirrhosis and altered mental status. The labs were collected at [DATE] at 5:25 PM. According to the lab report the Resident had a critical elevated Sodium level, the lab documentation showed, Critical Sodium was called to the facility and read back by the Stat Coordinator at [DATE] at 9:27 PM. Results showed Resident 1 had a GFR (Glomerular filtration rate- a blood test that checks kidney function) of 16, indication of a low kidney functioning. Per the lab GFR reference range, less than 15 indicated renal failure. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	There was no indication staff continued monitoring the resident during the day and evening shifts on [DATE], according to the resident's electronic medical record. On [DATE] at 12:40 AM a Nursing Skilled Progress Note showed Resident 1 continued to be confused, was not eating, drinking or taking medications. A Nursing Progress Note at 01:45 AM showed, Resident 1 was given apple juice by request but spit out all medication. The facility was notified by the lab tech at 2400 (Midnight) about critical lab value serum Sodium 165. Staff notified the on-call physician, who ordered to push fluids but the resident refused; suggesting staff did not communicate the resident's dire condition. The on-call physician said to send Resident 1 to the hospital via a non-emergent ride to treat the sodium level at the ER (emergency room) as the facility did not have the required treatment available, (D5W, Intravenous sugar solution in water) because the medication systems were not functioning, making the treatment inaccessible to the facility staff at the time it was needed. Resident 1's spouse stated in an interview on [DATE] at 1:34 PM that the resident passed away. During an interview on [DATE] at 3:56 PM, Staff B, Director of Nursing stated that a change of condition was any change from the resident's baseline and the LN should have adequately conveyed the resident's decline in condition when notifying the provider, to ensure timely effective treatment was provided. The LN said staff should have notified the responsible party and documented actions taken. Non-Pressure Wounds Review of the facility's undated policy for Skin Breakdown, showed that the nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores. In addition, the nurse shall describe and document the following: full assessment including location, stage, length, width, depth, presence of exudates (drainage) or necrotic tissue (dead skin), pain assessment, residents mobility status, current treatments, including support services and all active diagnoses. For treatments and management of the wound, the physician will authorize pertinent orders related to the wound treatment, including wound cleansing and debridement (removal and cleaning) approaches, dressings and applications of topical agents if indicated for type of skin alteration. Resident 1 Review of the 5 Day MDS (Minimum Data Set- an assessment tool) dated [DATE], showed resident had no diabetic foot ulcer present. Review of the hospital Discharge Placement Report, dated [DATE], under Medical Problems, showed Resident 1 had a diabetic ulcer on part of right foot and a diabetic ulcer of left foot with fat layer exposed associated with an underlying condition due to diabetes mellitus, both noted on [DATE]. An Admission/Readmission Evaluation dated [DATE] at 4:27 PM showed Resident 1 had skin issues present on admission, to include; the right abdomen had a paracentesis (a procedure to remove abnormal build up of fluid in the abdomen) drainage site with dressing, rear of right thigh with twenty staples on the right hip, extensive bruising to the right thigh, bruising to both arms, scattered scabs to both of the lower legs and left foot/toe and plantar (sole of foot) blackened calluses and two blackened calluses to right foot plantar. (continued on next page)

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	505202	A. Building B. Wing	06/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Skilled Nursing and Rehabilitation	4430 Talbot Road South Renton, WA 98055

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of PO from [DATE] through [DATE] showed no orders to monitor or treat the right paracenthesis drainage site, the staples, bruising and incision to the right hip, bruising to the arms, and calluses to both feet. Review of nursing notes showed no documentation of contacting Medical Doctor (MD) to obtain these orders. Review of the [DATE] Treatment Administration Record showed no non pressure wound care or monitoring was performed. Review of the Skin Integrity Nursing Care Plan (CP) dated [DATE] for Resident 1 showed the skin impairments were not addressed on the plan of care. In addition there were no interventions to prevent further skin breakdown. Review of the Diabetes Mellitus CP initiated on [DATE] showed instructions for the nurse to monitor for foot care needs, and document findings. Review of Skilled Nursing Notes and Nursing Progress Notes from readmission on [DATE] until discharge on [DATE] showed no documented wound care to the drainage site or the right hip staples. Resident 9 According to the Entry MDS dated [DATE], Resident 9 admitted to the facility on [DATE]. According to the hospital Discharge Placement Report, dated [DATE] Resident 9's medical problems consisted of Cellulitis (infection of skin tissues) of lower extremities, venous insufficiency of both lower extremities and venous stasis (slow blood flow in the veins) ulcer to both the right and left lower leg with fat layer exposed. Further review showed no discharge orders for treatment of the ulcers. Review of the Resident's Nursing Care Plan dated [DATE] showed that resident 9 had the potential for skin impairment but did not include the actual wounds the resident had on their lower extremities. Review of the Kardex dated [DATE] showed no skin impairment or directions to nursing staff on how to care for the residents wounds. Review of the Nursing Admission/Readmission Evaluation dated [DATE] showed staff were unable to determine the resident's skin condition on admission. The following day the resident was assessed to have two open areas, one on each leg, the left lower lateral and back of right calf. Review of the [DATE] Weekly Skin Observation, showed that the resident had a right lateral calf wound 6 cm (centimeters) x 3 cm open area red, no sign or symptoms of infection, and back of left calf open area 11 cm x 8 cm. Red open area and no sign or symptoms of infection. Some bleeding when dressing was changed. Review of the POs showed no order for the dressing change that was documented as completed by the nurse. Suggesting staff performed a dressing change without a physician's order. Review of an MD Progress Note dated [DATE] at 09:13 AM, showed the MD documented a plan to continue wound care to the left and right lower extremity stasis ulcers. The physician wanted staff to notify the medical provider if signs of infection developed. Review of the clinical record showed no documentation between [DATE]- [DATE] that supported staff contacted the physician to obtain treatment orders for wounds. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Resident 9 was seen by a wound team on [DATE] according to the wound assessment and treatment plan. At this time treatment recommendations were made. Review of the MD Orders showed the wound team recommendations were not ordered until [DATE]. The treatment order was scheduled for that day at 10:00 PM. Review of the [DATE] MAR showed the order was not performed. The next treatment was scheduled for [DATE], and was documented as 9- see progress note. Review of the administration progress note showed the Resident refused dressing changes at that time because the dressings were already changed. Resident 8 On [DATE] at 11:35 AM Resident 8 was observed at the bedside with dressings to the bilateral lower extremities. In an interview at that time, Resident 8 stated that he had stasis ulcers to both legs. Review of POs showed on [DATE] treatment orders were obtained for the left leg wound, every 48 hours and for the right leg wound every night shift every other day. Review of the [DATE] TAR showed the right leg wound dressing was documented as done [DATE], but not [DATE] as resident was sleeping. Review of the [DATE] TAR showed on [DATE] the right leg wound dressing was documented as done as scheduled, but the left wound dressing was not. Review of the nursing administration progress note dated [DATE] at 1:47 AM showed, Not able to do tonight. No reason was provided. Review of a [DATE] Grievance Form dated [DATE] showed Resident 8 reported wound dressing were not done. Further review of the [DATE] TAR showed no dressings to the left or right legs were documented as completed on [DATE] as scheduled. Review of the nursing administration progress note dated [DATE] at 10:30 PM showed, Not able to do this tonight. But no reason was provided. Review of POs showed [DATE] orders for Daily wound care BLLE wounds to include dressing change. There were no directions specified for the order. Review of the resident's record showed the order was not present on the [DATE] TAR suggesting the dressings were not changed. Review of a Grievance Form dated [DATE] showed Resident 8 stated, Nursing has not changed my bandages in the past three days. According to the grievance documentation, Upon inspection notable bloody discharge seeping through bandages and odor. During an interview on [DATE] at 3:17 PM, Staff B stated that the wound team made rounds at the facility on Wednesday, completed dressing changes and documented in their own electronic medical record. For a resident to be seen by the wound team, there needed to be a referral and a physician's order. When the wound team was not there the Licensed Nurses were expected to complete and document dressing changes, which did not occur. REFERENCE WAC [DATE](1)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 44295 Based on observation, interview and record review, the facility failed to monitor and provide necessary treatment and services consistent with professional standards of practice for 1 of 1 residents (Resident 1) reviewed for Pressure Ulcers. This failure placed the resident at risk for increased pain, discomfort and diminished quality of life. Findings included . Review of the facility undated policy for Pressure Ulcers/Skin Breakdown, showed that the nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores. In addition, the nurse shall describe and document the following: full assessment of pressure sore including location, stage, length, width, depth, presence of exudates or necrotic tissue, pain assessment, residents mobility status, current treatments, including support services and all active diagnoses. For treatments and management of the wound, the physician will authorize pertinent orders related to the wound treatment, including wound cleansing and debridement approaches, dressings and applications of topical agents if indicated for type of skin alteration. The Resident Assessment Instrument (RAI) Manual defined the stage of a pressure ulcer (PU) as followed: A stage I pressure injury (ulcer) was described as non-blanchable redness of intact skin, A stage II pressure injury (ulcer) was described as partial thickness loss with exposed dermis (second layer of skin). Resident 1 According to the 05/07/2021 5 Day Minimum Data Set (MDS-an assessment tool) Resident 1 was readmitted to the facility from a local hospital on 05/03/2021 after having surgery to fix a right femoral fracture on 04/23/2021. Review of the Resident Kardex (A brief overview of patient and plan of care) dated 06/08/2021, showed no directions to Nursing Staff for skin interventions to prevent skin breakdown or promote healing. On 05/04/2021 at 3:21 PM, Resident 1 was observed laying on back, in bed. Resident 1 stated, I want to sit up. During an interview on 06/07/2021 at 11:20 AM, Staff G, Nursing Assistant, stated that care to Resident 1 was only provided in the bed. Staff G stated that Resident 1 was never put in a chair after re-admit from the hospital. Staff G stated that the resident required two person extensive assist with turning and re-positioning. An interview on 06/01/2021 at 1:34 PM, Resident 1's spouse, stated that the resident was not turned while at the facility and had developed bed sores. According to the hospital Discharge Placement Report, dated 05/03/2021, the resident had a pressure injury of the right buttock, Stage 2 which was first noted on 04/23/2021. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Skin Care Plan initiated on 03/19/2021, showed the resident had potential for impairment to skin integrity with the goal of resident will maintain or develop clean and intact skin by the review date. The care plan did not address the actual pressure area to the right buttocks and no preventative measures in place to prevent further pressure ulcers. Review of the facility Nursing Admission/Readmission Evaluation dated 05/03/2021 at 4:27 PM showed Resident 1 had a skin issue to the right buttocks described as an open wound measuring 3.5 cm (centimeters) x 3.5 cm. An Medical Doctor (MD) Encounter note dated 05/06/2021 showed resident was seen by the MD who did not note or write orders for the pressure ulcer at this time. Review of the MD orders from 05/03/2021-05/11/2021, showed no treatment or monitoring was ordered for the pressure ulcer to the right buttocks. Review of the Nursing Progress notes showed no documentation the MD was contacted for treatment or monitoring orders. Review of the Nursing Progress notes showed no documentation after 05/03/2021 that pressure ulcer care was provided to Resident 1. During an interview on 06/07/2021 at 11:25 AM, Staff H Licensed Practical Nurse (LPN), stated that Resident 1 had wounds to their legs but they did not know of any pressure ulcers. During an interview on 06/15/2021 at 3:29 PM, Staff B Director of Nursing (DON), stated that the licensed nurse should notify the provider, complete a incident report and obtain treatment orders when a pressure ulcer is discovered by the nursing staff. REFERENCE WAC 388-97-483.25 (b) (1)(i)(ii)