Printed: 08/28/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505236  NAME OF PROVIDER OR SUPPLIER Edmonds Care		(X2) MULTIPLE CONSTRUCTION A. Building B. Wing  STREET ADDRESS, CITY, STATE, ZIP CODE 21400 72nd Avenue West Edmonds, WA 98026	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0676  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few			

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

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 505236

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505236	(X2) MULTIPLE CONSTRUCTION  A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2022	
NAME OF PROVIDER OR CURRUIT	-n	CTREET ADDRESS SITV STATE 7	D. CODE	
NAME OF PROVIDER OR SUPPLIE	±R	STREET ADDRESS, CITY, STATE, ZI	P CODE	
Edmonds Care	Edmonds Care		21400 72nd Avenue West Edmonds, WA 98026	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		ion)	
F 0676  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	SUMMARY STATEMENT OF DEFICIENCIES		was scheduled to have a shower on ean self-daily.  did not receive a shower for 30  colined shower on 02/12/2022 and resident received this shower/bath.  er for weeks. Resident 3 said her cility did not have enough shower nelp in the floor as an aide.  offered to do a shower when it was wer on a different date/time or  what the facility policy was alled depending on their preference because for residents who missed their and report to the licensed nurse and if the resident refuses, they will dent would be offered an alternative or their next shower. When asked over sheet, which was found under for showers/baths, and nurses will sident to go for a month without ut the risks of not getting showers,	

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NAME OF PROVIDER OR SUPPLIER Edmonds Care		STREET ADDRESS, CITY, STATE, ZIP CODE 21400 72nd Avenue West Edmonds, WA 98026		
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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	Provide appropriate pressure ulcer	care and prevent new ulcers from deve	eloping.	
Level of Harm - Actual harm	**NOTE- TERMS IN BRACKETS F	NAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 43392	
Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure residents received necessary treatment and services to prevent the development and worsening of pressure injury for 2 of 4 residents (Resident 1 & 2) reviewed for pressure injuries (PI). Failure to complete on-going skin assessments and develop & implement a PI care plan with individualized interventions resulted in harm (wound deterioration) to both residents who developed pressure ulcers.			
	Findings included .			
	According to the Minimum Data Set (MDS) 3.0 Resident Assessment Instruction manual, v1.17.1, a PI is defined as a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction.			
	Stage 2 (Partial thickness loss of skin presenting as a shallow open ulcer with a red, pink wound bed, without slough (a non-viable [dead] tissue; usually moist, can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed).			
	Stage 3 Pressure Ulcer (Full-thickness skin loss)			
	rolled wound edges are often prese of tissue loss. Eschar is dead tissue	which subcutaneous fat may be visible in the ulcer and granulation tissue and a present. Slough and/or eschar may be visible but does not obscure the depth d tissue that is hard or soft in texture; usually black, brown, or tan in color, and tic tissue and eschar are usually firmly adherent to the base of the wound and wound.		
	Unstageable Pressure Ulcer (Obsc	Obscured full-thickness skin and tissue loss)		
		ull-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed ecause the wound bed is obscured by slough or eschar.		
	Deep Tissue Pressure Injury (DTPI			
	Persistent non-blanchable deep red, maroon, or purple discoloration. This injury results from intense prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to the actual extent of tissue injury or may resolve without tissue loss.			
	recommended that all residents we quarterly, annually, and when there	y titled, Pressure ulcer prevention/Trea ere to be assessed on admission and w was significant change in condition us ne risk for acquiring a skin pressure ulc	eekly for four weeks, then sing the Braden Risk Assessment	
	RESIDENT 1			
	(continued on next page)			

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NAME OF PROVIDER OR SUPPLIER Edmonds Care		STREET ADDRESS, CITY, STATE, ZIP CODE 21400 72nd Avenue West Edmonds, WA 98026		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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	Resident 1 was initially admitted to the facility on [DATE] and was readmitted back to the facility on [DATE]. A review of the admission Minimum Data Set (MDS) assessment, dated 02/02/2022, revealed Resident 1 had impaired cognition, was unable to make his needs known, and required extensive assistance of two staff for bed mobility and transfers.  An initial skin assessment on 01/20/2022 showed the resident had multiple bruises. One on the left arm and another on the left hand. After the fall on admission, an assessment showed that the resident had two skin tears on the inner side of the right arm.  Review of the skin grid weekly evaluation [readmission skin assessment], dated 01/26/2022, showed Resident 1 had two surgical incisions, an open area, and three bruises. An open area was on the right elbow, measuring 1.5 centimeters (cm) length by 1.0 cm width. There was no documentation on the re-admission note to indicate resident had a PI.			
	Record review of progress notes and skin grid weekly skin evaluation from 01/27/2022 to 02/18/2022 (3 weeks) showed no documented evidence of any skin assessments.			
	Further review of records showed there was no individualized care plan and interventions for the pressure ulcer on the coccyx (tailbone area), or left and right heels prior to 02/18/2022.  Further review of the nursing progress notes regarding the skin assessment, dated 02/18/2022 at 1:15 PM, showed Resident 1 had developed three new skin impairments (PI):			
	Coccyx, measured 4.0 cm x 1.0 cm,			
	Right heel, measured 1.0 cm x 1.0 cm,			
	Left heel, measured 2.50 cm x 1.50	m x 1.50 cm.		
	Further review of the skin grid weekly skin evaluation dated 02/21/2022, showed a Stage 3 PI on the coccyx that measured 4.0 cm length x 1.0 cm width x 0.50 cm depth, and documented the coccyx PI was acquired in the facility.			
	Review of the electronic medical record (EMR) daily task, 'Skin Observation,' assigned to nursing assistants from 01/31/2022 to 02/28/2022 showed that staff consistently documented No in response to the question Did you see a new skin problem?			
	A review of an outside Wound Consultant report, dated 02/24/2022, showed Resident 1 had developed 3 PU wounds:			
	Wound 1			
		4.0 cm x 0.00 cm with 90 percent (%) e classified as Unstageable PI with an a		
	Wound 2			
	(continued on next page)			

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NAME OF DROVIDED OR CURRU		CERTAIN ARREST CITY CTATE 71	D CODE	
NAME OF PROVIDER OR SUPPLI	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE	
Edmonds Care		21400 72nd Avenue West Edmonds, WA 98026		
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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	Right heel PI, measuring 1.90 cm > deep tissue injury.	2.70 cm x 0.00 cm with 100% epithelia	alization, and was classified as	
Level of Harm - Actual harm	Wound 3			
Residents Affected - Few	Sacral [coccyx] (tail bone area) PI, measuring 3.30 cm x 1.40 cmx 0.90 cm with 75% granulation (new skin tissue), and 25% slough was classified as Stage 3 PI with undermining (is the destruction of tissue or ulceration extending under the skin edges so that the pressure ulcer is larger at its base than at the skin surface).			
	Record review showed the facility was treating Wound 3 on the sacral area by cleansing with normal saline, gels honey, and to cover with boarder dressing. Wound 2 was being treated with skin protectant and continue offloading measures. Wound 1 was being treated with skin prep and leave open to air.			
	A joint record review and interview on 03/01/2022 at 10:30 AM, Staff C, Residential Car Licensed Practical Nurse, (LPN) was asked what the facility's policy on skin assessment that skin assessments were to be done on admission, weekly, quarterly, and when there change in condition. When asked where Resident 1 developed the 3 pressure injuries, S Resident 1 developed the PI while in the facility. When asked if skin assessment was do to 02/17/2022 and Staff C said, No, there was no skin assessment done for that period.			
	RESIDENT 2			
	Resident 2 was initially admitted to the facility on [DATE], sent back to the hospital on 12/30/2021 and was readmitted back to the facility on [DATE] with diagnosis to include diabetes. A review of the admission MDS dated [DATE], showed Resident 2 had impaired cognition and was unable to make needs known. Further review of the MDS showed Resident 2 was totally dependent with transfers, required extensive assist of two persons with bed mobility, and had one Stage 2 PI.			
	On 02/07/2022 at 1:15 PM, Resident 2 was observed sitting up in his wheelchair with a pressure relieving cushion in place. The resident said sometimes he feels pain in his bottom when sitting in the chair for too long. Staff G, Registered Nurse, was asked how often Resident 2 was repositioned, Staff G said every 2 hours, and when needed.			
	Review of the initial skin assessment on admitted d 12/20/2021 showed Resident 2 had multiple scattered skin discolorations/bruises to both lower extremities and the skin assessment did not identify other skin issues.			
	Review of the wound nurse note [with a picture of the wound], at the hospital dated 12/31/2021, showed Resident 2 had a Stage 2 pressure ulcer [PI] on his right [left] buttock measuring 0.90 cm x 0.90 cm x 0.10 cm with partial thickness of 40% slough and 60% red tissue. Later observation on 03/01/2022 at 11:02 AM, showed that the wound was on the left buttock [and not on the right buttock].			
	A review of the skin grid skin evaluation completed by Staff F, RN, dated 01/04/2022, showed the resident had a Stage 2 PI on his left buttock measuring 2.10 cm x 1.20 cm with a Braden Risk Assessment score of 12 (an assessment tool that predicts the risk to acquire a skin pressure ulcer/injury) which indicated the resident was at a high risk of developing a PI.			
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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	Review of the January 2022 Medication Administration Records (MAR) and Treatment Administration Records (TAR) showed that a treatment was written for the right buttock [instead of the left buttock be treated with NS [normal saline], pat dry and covered with foam dressing every shift and when no from 01/06/2022 and was discontinued on 02/07/2022.			
Residents Anoted - Few	Review of the care plan showed no buttock PI prior to 02/08/2022.	o documentation or intervention in the o	care plan for the resident's left	
	Further review of Resident 2's clini were conducted during this period.	cal records from 01/06/2022 to 02/06/2	022, showed no skin assessments	
	Review of the progress note dated 02/07/2022 at 11:37AM, showed Resident 2's Right [left] buttocks w has increased in size and measured 6.50 cm x 6.0 cm x 0.10 cm, but did not document what stage the was.			
	Review of the skin grid weekly evaluation dated 02/10/2022 at 12:41 PM, showed the resident's left buttock PI had progressed to an Unstageable PI, measured 6.6 cm x 6.5 cm x 0.00 cm.			
	Review of the Wound Consultant's report dated 02/10/2022 at 4:05 PM, showed Resident 2's left buttock wound was classified as Unstageable, measured 6.6 cm x 6.50 cm x 0.00 cm, and the wound base was 100% (covered with) slough.  Review of the skin grid weekly evaluation completed by Staff C dated 02/07/2022 showed that the physiciar was notified of the right [left] buttock wound getting worst, and review of the MAR and TAR showed treatment was in place.			
	Observation and interview on 03/01/2022 at 11:02 AM, showed Staff C performed a dressing change on Resident 2's left buttock PI. The resident was laying on his back with the head of the bed raised. The left buttock wound was covered with 100% slough, a mild brown color was visible on the left buttock's dressing and no odor was noted. The resident denied pain when treatment was provided. When Staff C was asked to describe the wound. Staff C said it was Unstageable with 100% slough, with a brown color discharge on the dressing, and measured 6.6 cm x 6.5 cm x 0.00 cm.			
	community acquired [started while was a stage 2 that became unstag consultant [writing orders and staff Resident 2 from 01/06/2022 to 02/0	, Interim Director of Nursing Services s the resident was outside the facility] ar eable PI]. Staff B stated that the wound implementing]. Staff B was not able to 06/2022. Staff B responded via an ema grid assessment for Resident 2 between	nd then worsened in the facility [it I was being treated by the wound find any skin assessments for I dated 02/15/2022 that Staff D,	
	Reference (WAC) 388-97-1060 (3)	(b)		