STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505296	A. Building B. Wing	05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis of Bellingham	3121 Squalicum Parkway Bellingham, WA 98225

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** 36787 Based on observation, interview, and record review, the facility failed to develop a plan of care, and implement interventions to prevent Pressure Ulcer/Pressure Injury (PU/PI) development for 1 of 1 resident (Resident 1) who was admitted without a PU/PI, but who had multiple co-morbidities with an increased risk for PU/PI development. The facility failed to provide staff education, ensure competency on the correct use of a bone stimulator (an external medical device that generated a radio frequency energy to the bone), prevent skin breakdown, and monitor ongoing skin integrity with the application of the bone stimulator. This failure resulted in physical harm to Resident 1 when they developed a stage III PI to their left foot from a medical device. Findings included . Review of the Minimum Data Set (MDS, an assessment tool) 3.0 Resident Assessment Instrument manual, v1.12.1, showed a PU defined as a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful. A stage III PU is defined as full thickness tissue loss, subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough (non-viable [dead] tissue) may be present but does not obscure the depth of tissue loss. Review of the National Pressure Injury Advisory Panel (NPIAP) literature, dated January 2020, showed PU that reach full thickness, are considered never events, (should never happen). Medical device related PIs result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant PI generally conforms to the pattern or shape of the device. The injury should be staged using the staging system. The literature showed the standard of best practices for prevention of medical device-related pressure injuries in long term care included: - Inspect the skin under and around the device at least daily (if not medically contraindicated). - Reposition devices (if feasible). - Educate the staff on correct use of devices and prevention of skin breakdown. - Be aware of edema (swelling) under device(s) and potential for skin breakdown. (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	Review of a facility policy titled, Prevention of Pressure Injuries, dated April 2020, showed the facility would reposition all residents at risk of PIs on an individualized schedule determined by the interdisciplinary care team, select appropriate support surfaces based on the resident's risk factors, in accordance with current clinical practice, and review medical devices with consideration to minimize tissue damage, including the application and ability to secure the device. Resident 1 admitted to the facility on [DATE] with diagnoses to include cardiac, kidney and respiratory disease. According to the Quarterly MDS assessment on 04/13/2023, the resident had moderately impaired cognition and required extensive assistance from staff to complete activities of daily living (ADL). The resident had no PU/PI present but was at risk of developing PU/PIs. Review of Resident 1's admission orders, dated 12/15/2022, showed to apply a bone stimulator device to the resident's left foot for three and a half hours every night. Review of the manufacture's bone stimulator literature, revised 01/08/2021, showed the device was indicated for the treatment of an established non-union fractures (failure of a fractured/broken bone to heal and mend over time) acquired secondary to trauma. In rare instances the device could cause reversible minor discomfort. The device could be cumbersome or uncomfortable, cause tingling or pain and a minor skin rash had been reported. The device use and care area of literature showed the device was to be inspected prior to each use for wear, deterioration, or damage. For safe usage, the literature directed the user to follow the manufacturer's instructions. Review of Resident 1's Treatment Administration Records (TAR) beginning 12/15/2022, showed the resident was to have a bone stimulator applied for three hours at night due to the resident's dislocated left ankle. The TAR directed nurses to place the device centered over the left ankle, bring the strap around the ankle, and fasten on the opposite end of the device, switch the power button on, it would run for three hours, then remove the device. The TAR did not include specifics on when to apply the device nor warnings or contraindications of the device. There were no directions for the nursing staff to assess the resident's skin or check for edema before or after application of the bone stimulator. Review of Resident 1's care plans dated 12/15/2022 through 05/15/2023, showed the absence of guidance for the bone stimulator device. Resident 1's care plan, dated 05/16/2023, was the first entry which documented that a bone stimulator was initiated, and showed that the bone stimulator was placed on hold for five days (until 05/21/2023), pending orthopedic reevaluation of continued need. Review of the progress note, dated 01/29/2023 at 4:25 PM, showed Resident 1 returned from their orthopedic appointment and the notes included x-rays showing stable alignment of the fractures. No revision surgery was recommended. Review of Resident 1's orthopedic surgeon visit note, dated 01/19/2023, showed the resident was there for a follow up visit and was last seen in the clinic on 11/10/2022. The note, dated 11/10/2022, stated there was evidence of a non-union fracture on Computed Tomography (computerized imaging). On 01/19/2023, the orthopedic surgeon documented the resident may be weight bearing as tolerated and the bone stimulator could be discontinued. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 1's Braden Scale (assessment tool to predict PU risk), dated 04/13/2023, showed a score of 16 (mild risk for predicting PU risk was a score between 15 to 18) indicated the resident was at mild risk for PU development. Review of Resident 1's progress note, dated 05/15/2023 at 7:09 AM, showed at 6:45 AM, Staff H, Certified Nursing Assistant (CNA), notified Staff D, Licensed Practical Nurse (LPN), there was an open area on the top of the resident's left ankle joint measuring 0.5 centimeters (cm) by 0.5 cm. Staff D documented the open area was on the ankle that the bone stimulator was on. Review of Resident 1's skin and wound evaluation, dated 05/16/2023 at 10:11 AM, showed a new left lateral (side) malleolus (ankle) wound that was a medical device related PI, acquired in-house at a stage III with full thickness skin loss measuring 1.2 cm in length by 0.9 cm in width, by 0.1 cm depth. The wound bed had 50% granulation (new skin) tissue and 50% slough (non-viable tissue). Review of a progress note on 05/16/2023 at 3:49 PM, showed the factors contributing to the event/incident were Resident 1 had a bone stimulator on their left ankle to support healing after previous fracture. The note stated that the strap of the stimulator went over the open area and the pressure and friction from the device likely caused the skin breakdown. Resident 1had edema (swelling) to the foot and ankle that would contribute to higher risk of skin breakdown. The analysis was the facility determined the wound was a device related PI from the bone stimulator they wore for three hours each night shift. The device centered over the lateral malleolus with the strap wrapping around the ankle. The device vibrated and caused the strap to push and rub on edematous (swollen) skin. Review of Resident 1's clinical record, dated 05/15/2023 at 7:40 AM, Staff I, contracted Physician's Assistant, documented the resident was seen today for evaluation of the wound on the crease of her foot. The wound team saw yesterday and felt like it was getting worse and requested a hold on the patient's bone stimulator. However at this time referred back from the patient's orthopedic and they have indicated that it can be discontinued. At this time the patient has a small wound in the crease of her ankle. We have been adjusting diuretics and the patient's legs do feel softer with less pitting edema (swelling) however the feet are still fairly swollen. The patient is good about wearing her compression socks however at this time we need to continue to monitor this wound. The patient continues to complain of foot pain on the left side and the foot that she broke. The patient has a small open area of the skin where her bone stimulator was placed. The area was approximately 1.2 cm and is small. There is some slough present and as such yesterday I put in orders for Medihoney (a type of wound gel). There is no surrounding signs of cellulitis or significant concern. Continue with the current medical regimen and monitor daily for any other concerns. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In a joint interview on 05/24/2023 at 2:55 PM, with Staff B, Consultant Registered Nurse (RN), and Staff A, Director of Nursing Services (DNS). Staff B stated the PI was device related and they felt the resident's edema contributed to the development of the wound. Staff B said they had identified that the facility had no process in place on when the device was to be applied, removed, and there was no area for skin inspection pre and post device application. Staff B said the facility failed to have the literature on the bone stimulator and there was no care plan in place regarding the bone stimulator until after the injury occurred. Staff B said the facility had been unaware there was an order to discontinue the device on 01/19/2023. Staff B said they had received a handwritten note from the provider after the visit. They were unaware there was a full dictation note from the visit until it was faxed on 05/19/2023. Staff B said staff called the orthopedic surgeon's office and they said the bone stimulator had been discontinued on 01/19/2023. Staff B said the facility identified this doctor visit process as another area for improvement. Staff A and Staff B stated there was no process or competency in place regarding the bone stimulator device, but they were working on that now. In an observation of the dressing change on 05/29/2023 at 4:03 PM, Resident 1 was lying in bed. The resident's left foot had edema with an open area and a marked indentation that measured approximately 0.9 cm by 0.4 cm by 0.1 cm. The wound bed was pink and consistent with epithelial tissue. The resident stated Ouch, that hurts during the application of the Medihoney. Staff C, LPN, stated the wound looked better than when they had seen it several days ago. Staff C said the edema was worse especially with the discontinuation of the resident's compression stockings. In a phone interview on 05/31/2023 at 1:59 PM, Staff D stated the bone stimulator did not vibrate at all, it was radiofrequency. Staff D confirmed the resident had edema to their feet. Staff D said that Staff H, NAC, found the open area the day before Staff D did when they removed the resident's compression stockings. Staff D stated Staff H reported the open wound to Staff E, LPN. Staff D stated they would place the bone stimulator on at 3:00 AM and then the day shift aide would take it off when the resident got up in the morning. Staff D said they never removed the device or inspected the skin after the treatment. Staff D stated they were interviewed about the wound several days ago and notified Staff A and Staff F, LPN/Staff Development Coordinator, the wound was originally identified on 05/14/2023. Staff D stated when they first observed the wound on 05/15/2023 it looked like a yellow, wet scab and measured 0.5 cm by 0.5 cm. Staff D stated they had been applying the bone stimulator in the same way for almost a year. Staff D said they received no training on the device but did read the pamphlet before they started applying it. In an interview on 05/31/2023 at 2:50 PM, Staff A stated there had been no recent PU prevention education. They said it was on the calendar to begin in June 2023. Review of the facility's training records, printed on 05/31/2023, showed that six of twenty-four NACs had received the prevention of PI/PUs training. There were no licensed nurses documented to have completed the training. In a phone interview on 05/31/2023 at 2:38 PM, Staff E, LPN, stated they had just talked to Staff A about the wound. Staff E said they were notified of redness to Resident 1's left foot on 05/14/2023. Staff E said they were busy and did not go assess the resident's leg that night. Staff E said they had received no training on the bone stimulator. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In a phone interview on 06/02/2023 at 8:12 AM, Staff J, RN, stated they last applied the bone stimulator to Resident 1 last on May 6th or 7th, 2023. Staff J said they would usually put the device on at 1:00 AM or 3:00 AM depending on how their night went. Staff J said if they placed it on at 1:00 AM they would take it off, but they relied on the aides to remove it if it was placed at 3:00 AM. Staff J said they would have to wake the resident up to put it on them and the last time they did, the resident told them, Don't put that on too tight. Staff J said the resident had more edema since admitting to this facility. Staff J said they had not seen the wound but had heard about it. Staff J said they had no training on the device but had learned about them briefly in nursing school. Staff J said the expectation was that when an open area or skin issue was found, they were to clean the area with normal saline, call the doctor to notify them, and obtain a treatment order, document to the wound in the progress notes, start an incident report, place the resident on alert, and notify the responsible party and DNS. This was a repeat deficiency from 01/26/2022 and 07/29/2022. Reference (WAC) 388-97-1060 (3)(b)