STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505236	A. Building B. Wing	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edmonds Care	21400 72nd Avenue West Edmonds, WA 98026

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43392 Based on interview and record review, the facility failed to ensure that residents received the appropriate number of showers/baths each week consistent with the resident's needs and choices for 2 of the 3 residents (Residents 1 and 2) reviewed for activities of daily living. This failure placed the residents at risk of poor hygiene and diminished quality of life. Findings included . RESIDENT 1 Resident 1 was admitted to the facility on [DATE]. Review of admission Minimum Data Set (MDS) assessment, dated 02/02/2022, showed Resident 1 had impaired cognition and was unable to make their needs known. Resident 1 was dependent on the assistance of two staff for showers and bathing and needed extensive assistance of two staff with bed mobility. Review of Resident 1's bathing task [listed in the electronic medical record] showed Resident 1 was scheduled to have showers every Monday and Thursday on evening shift. There was additional directives to have a nurse sign the skin sheet after each shower, and if the resident refused a shower, staff were to notify the LN [licensed nurse] and reschedule a shower for later that day or the following day. Record review of the records for Resident 1 from admission on 1/20/2022 until discharge on [DATE] showed that Resident 1 had received one shower on 02/9/2022. Further review of the progress notes, bathing task and miscellaneous documents did not show any documentation that indicated the resident had refused showers or baths, sponge bed bath or that an alternative shower dates & times were offered to the resident. RESIDENT 3 Resident 3 was a long-term resident at the facility. Review of quarterly MDS, dated [DATE], showed the resident was alert and oriented, dependent on two staff for showers/bath, and needed extensive assistance of two staff with bed mobility. (continued on next page)

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

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 3's bath and shower task showed Resident 3 was scheduled to have a shower on Wednesday and Saturday evening shift, and that Resident 3 prefers to clean self-daily. Further review of Resident 3's bath and shower task showed the resident did not receive a shower for 30 days (look back period from 03/08/2022. A progress notes dated 02/14/2022 at 11:36 AM, showed resident had declined shower on 02/12/2022 and wanted a shower on 02/14/2022. Nothing was document to show that the resident received this shower/bath. On 02/07/2022 at 9:31 AM, Resident 3 said she had not received a shower for weeks. Resident 3 said her normal showers were scheduled on Wednesday and Saturday, but the facility did not have enough shower aides. Resident 3 said, The shower lady [aide] normally get pulled out to help in the floor as an aide. Resident 3 said there were times she had refused showers because they offered to do a shower when it was close to dinnertime. When asked if the staff offered an alternative for shower on a different date/time or whether she had received a sponge bath, Resident 3 said, No. On 02/07/2022 at 11:32 AM, Staff E, Resident Care Manager, was asked what the facility policy was concerning showers. Staff E said each resident had a shower day scheduled depending on their preference and the schedule was kept in a shower book. When asked about their process for residents who missed their shower, Staff E said the aide will re-approach the resident about 3 times and report to the licensed nurse before documenting a refusal. The nurse will also approach the resident, and if the resident refuses, they will document in the progress notes about the refusal. Staff E also said a resident would be offered an alternative to take a sponge bed bath or a shower in a different date or time or wait for their next shower. When asked about shower documentation, Staff E said the shower aide would fill a shower sheet, which was found under the Miscellaneous tab in the resident's electronic records, under the task for showers/baths, and nurses will document in the progress notes. When asked if it was acceptable for a resident to go for a month without bath/showers, Staff E said, No, they will go and talk with the resident about the risks of not getting showers, will involve resident's family/representative, and/or even notify the physician and that will be documented in the resident's clinical records. Reference: (WAC) 388-97-1060(2)(c)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43392 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) Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and rolled wound edges are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. Eschar is dead tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound. Unstageable Pressure Ulcer (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 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 and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. Review of the undated facility policy titled, Pressure ulcer prevention/Treatment, undated and reviewed recommended that all residents were to be assessed on admission and weekly for four weeks, then quarterly, annually, and when there was significant change in condition using the Braden Risk Assessment (an assessment tool that predicts the risk for acquiring a skin pressure ulcer/injury), and Skin Integrity Assessment. RESIDENT 1 (continued on next page)

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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 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 Left heel PI, measuring 4.30 cm x 4.0 cm x 0.00 cm with 90 percent (%) epithelization (new skin-wound healing) and 10 % slough and was classified as Unstageable PI with an area of dry adherent slough. Wound 2 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Right heel PI, measuring 1.90 cm x 2.70 cm x 0.00 cm with 100% epithelialization, and was classified as deep tissue injury. Wound 3 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 Care Manager (RCM), Licensed Practical Nurse, (LPN) was asked what the facility's policy on skin assessment was. Staff C said that skin assessments were to be done on admission, weekly, quarterly, and when there was a significant change in condition. When asked where Resident 1 developed the 3 pressure injuries, Staff C said that Resident 1 developed the PI while in the facility. When asked if skin assessment was done from 01/27/2022 to 02/17/2022 and Staff C said, No, there was no skin assessment done for that period. Staff C Stated that skin assessment should have been done weekly during 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. (continued on next page)

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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] wound to be treated with NS [normal saline], pat dry and covered with foam dressing every shift and when needed from 01/06/2022 and was discontinued on 02/07/2022. Review of the care plan showed no documentation or intervention in the care plan for the resident's left buttock PI prior to 02/08/2022. Further review of Resident 2's clinical records from 01/06/2022 to 02/06/2022, showed no skin assessments were conducted during this period. Review of the progress note dated 02/07/2022 at 11:37AM, showed Resident 2's Right [left] buttocks wound has increased in size and measured 6.50 cm x 6.0 cm x 0.10 cm, but did not document what stage the PI 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 physician 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. On 02/14/2022 at 3:15 PM, Staff B, Interim Director of Nursing Services said that the left buttock PI was community acquired [started while the resident was outside the facility] and then worsened in the facility [it was a stage 2 that became unstageable PI]. Staff B stated that the wound was being treated by the wound consultant [writing orders and staff implementing]. Staff B was not able to find any skin assessments for Resident 2 from 01/06/2022 to 02/06/2022. Staff B responded via an email dated 02/15/2022 that Staff D, RCM, had not completed the skin grid assessment for Resident 2 between 01/06/2022 to 02/06/2022. Reference (WAC) 388-97-1060 (3)(b)