STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505086	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LANDMARK CARE AND REHABILITATION	**710 NORTH 39TH AVENUE YAKIMA, WA 98902**

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 0661 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to convey the discharge summary to the Primary Care Provider (PCP) to plan post discharge care for one of one Resident (#1) reviewed for planned discharge to home. The failure for the PCP to not have information necessary for post discharge care placed the resident at risk for worsening of a heel pressure ulcer and a one month delay to see a wound specialist. Findings included . Record review of the undated facility policy titled Hyatt Family Facilities - Discharge Summary and Plan, showed: - when the facility anticipated a resident's discharge to a private residence ., a discharge summary and a post-discharge plan will be developed . -a copy of the following will be provided to the resident, patient care provider and a copy will be filed in the resident's medical records: -An evaluation of the resident's discharge needs; -The post-discharge plan; and -The discharge summary. Resident #1. Medical record review showed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident had a plan to discharge to home after they regained their strength. The resident had no would on admission, skin was intact. Review of the 03/26/2020 plan of care showed the resident's discharge potential was probable and discharge planning will be addressed quarterly and as needed. The discharge plan had not been updated or revised during the resident's stay to include the need for post discharge wound care. Review of a 04/23/2020 nursing progress note showed the resident had a purple area to the lateral aspect of the Right heel measuring 3.5 centimeters (cm) long by 5 cm wide and appeared to contain a small amount of fluid. Bilateral heel protectors were obtained and placed on the resident. Record review showed a 06/01/2020 physician's progress note titled Discharge Summary showed a comprehensive note for discharge planning that included the [DIAGNOSES REDACTED]. During a phone interview on 08/06/2020 at 11:45 PM, Resident #1's PCP stated the information sent from the facility for Resident #1's 06/06/2020 discharge did not include any information of a Suspected Deep Tissue Injury (SDTI) on the resident's heel. According to the available information, the planned office appointment was about 3 weeks after discharge. The resident was seen in the PCP's office on 06/11/2020 (5 days after discharge) after Resident #1's private home provider contacted the PCP's office with concerns and questions about the wound. The PCP stated a wound specialist consult referral was made and (Resident #1) was not able to be seen until 07/07/2020 (one month after discharge) possibly delaying his recovery. Review of the 06/06/2020 discharge paperwork scanned into the resident's electronic medical record showed the following: -A Transfer / Discharge Report that included the resident's [DIAGNOSES REDACTED]. The form was signed by Staff C, Licensed Practical Nurse, and the resident's representative on 06/06/2020. -A Nursing Home Physicians Documentation of a Face to Face encounter for a home health referral signed by Staff E, Advanced Registered Nurse Practitioner (ARNP), on 06/05/2020 that indicated the resident had a history of [REDACTED]. The referral did not include a [DIAGNOSES REDACTED]. -A Discharge Progress Note by Staff E dated 06/05/2020 that did not include examination of the resident's skin, [DIAGNOSES REDACTED]. During a phone interview on 08/21/2020 at 1:30 PM, Staff E stated she was asked by Staff B, acting Director of Nursing, to sign the resident's discharge paperwork on 06/05/2020, as the resident was going home the following day. Staff E stated the physician did an exam and discharge summary earlier in the week (06/01/2020) and she would not just sign discharge papers until she saw the resident. Staff E stated since a full exam had been done, she did a visual assessment that included asking the resident and the nurse if there were any skin issues and neither stated there were any. She did not recall seeing any pressure relief heel protectors on the resident. She wrote a discharge progress note and signed the required papers. During a phone interview on 08/26/2020, Staff A, Nursing Home Administrator, stated she thought the 06/05/2020 discharge progress note by Staff E was the discharge summary and was not aware there was another discharge summary in the progress notes from the physician on 06/01/2020. I do not know how that happened. Reference: WAC 388-97-0080(7)(a)(b)(c) .
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** Based on interview and record review the facility failed to prevent the development of a pressure ulcer after admission to the facility for one of two residents (#1) reviewed for pressure ulcers. This failure caused harm to the resident resulting in a deep tissue injury to the Right heel that caused pain and eventual loss of the limb after discharge. Findings included . The National Pressure Ulcer Advisory Panel (NPUAP) April 2016, Pressure Ulcer Stages: Suspected Deep Tissue Injury (SDTI) - depth unknown Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar (piece of dead tissue that is cast off from the surface of the skin.) Evolution may be rapid exposing additional layers of tissue even with optimal treatment. Resident #1. Resident record review showed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the 03/27/2020 admission nursing assessment showed the resident's skin was intact and heels are firm. Review of the 03/27/2020 Braden Pressure Ulcer Risk assessment showed the resident's score was 21. (A score of 15 to 18 is lowest risk on scale.) A score of 21 indicated the resident had no pressure ulcer risk. Review of the 04/03/2020 comprehensive assessment showed Resident #1 was cognitively intact, required extensive physical assistance from two staff for bed mobility and had no pressure ulcers. This assessment determined the resident was at risk for pressure ulcers do to requiring extensive assistance to change position in bed and was frequently incontinent of bowel and bladder. Interventions in place were a pressure reducing mattress on the bed (the standard mattress) and pressure relieving cushion in the wheel chair. Review of the 03/27/2020 Skin at Risk plan of care showed the resident was at risk due to immobility and weakness. The prevention interventions on the plan included to identify potential causative factors and eliminate/resolve when possible. However, the plan did not include assisting the resident to change position on a schedule or to elevate the resident's heels off of the mattress to relieve pressure. Review of the 04/23/2020 progress note showed the resident had a purple area to the lateral aspect of the right heel measuring 3.5 centimeters (cm) long by 5 centimeters wide and appeared to contain a small amount of fluid. Bilateral heel protectors were obtained and placed on the resident. Review of a 04/23/2020 nursing progress note showed Apart from therapy, (the resident) does not move off (their) back much, even with reposition, when (they) allow it. (Physician) updated on skin. Review of the facility 04/23/2020 incident report showed the resident was in the shower and a nursing assistant found a blister and blackened area to the right heel. Predisposing factors included weakness and resident refuses to get out of bed frequently. The incident report did not include an investigation and root cause analysis of what caused the pressure injury to the right heel. Review of the Skin at Risk plan of care showed on 04/24/2020 a SDTI to the right lateral heel was added without any new interventions. Review of the April through June 2020 treatment records showed a 04/24/2020 order to apply [MEDICATION NAME] and let dry to right lateral heel once a day. The treatment was documented as

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505086	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LANDMARK CARE AND REHABILITATION	**710 NORTH 39TH AVENUE YAKIMA, WA 98902**

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	(continued... from page 1) done until discharge on [DATE]. Review of a 05/29/2020 skin assessment showed (Resident #1) continues to have large red area to right heel, area dry, no drainage . (the last documented nursing assessment eight days prior to discharge.) Review of the 06/06/2020 Discharge Minimum Data Set assessment showed the resident left the facility with one unstageable pressure ulcer presenting as deep tissue injury. During a phone interview on 08/05/2020 at 1:50 PM, Staff D, Registered Nurse and Treatment Nurse, stated Resident #1's heel wound started from rubbing their heels on the bed. It started as a blister that popped and the tissue was real dark underneath. The treatment was to paint the heel with [MEDICATION NAME], applied heel protectors and an air overlay mattress. The interventions in place prior to the wound was the pressure reducing mattress and weekly skin checks. During a phone interview on 08/06/2020 at 11:45 PM, Resident #1's Primary Care Provider (PCP), stated their office was not aware of the resident's heel ulcer at discharge on 06/06/2020 and had an appointment scheduled on 06/23/2020. The resident's in home care giver contacted their office on 06/10/2020 requesting more betatine and refill on pain medication. The foot ulcer was observed during a video call and it was decided (Resident #1) required a face to face appointment the next day in the office. At the appointment a wound clinic consultation was scheduled for 07/07/2020 (one month after discharge.) Review of the resident's PCP records showed the following: -A video tele-medical visit was conducted on 06/10/2020 due to the private home provider requesting more wound treatment supplies and pain medication. Resident #1 expressed that the heel wound was painful and ran out of pain medication. A decision was made (by the PCP) to have a face to face acute appointment the following day. - The resident was seen by their PCP on 06/11/2020 in the office. The right heel wound was extremely dry. The wound was a black color in the middle measuring 2.5 cm by 5 cm. A referral was made for wound care at the hospital wound clinic. During a phone interview on 08/21/2020 at 2:25 PM, Resident #1's representative stated they took the resident to the emergency room due to a foul odor coming from the right heel wound. The resident had an amputation of the right lower leg and was currently in the hospital. Review of information received from Resident #1's PCP on 08/27/2020 showed the resident had a right lower extremity amputation from a spreading infection of the pressure ulcer into the bone [MEDICAL CONDITION] (an infection in the blood). Initially there was a [MEDICAL CONDITION], but was determined to need additional infected tissue so ultimately (Resident #1) had an above the knee amputation. Reference: WAC 388-97-1060(3)(b)