STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

AMENDED
05/09/2024

Aegis Senior Communities LLC
Aegis of Queen Anne at Rodgers Park
2900 3rd Ave W
Seattle, WA 98119

RE: Aegis of Queen Anne at Rodgers Park License # 2381

Dear Administrator:

This letter addresses Compliance Determination(s) 40271 (Completion Date 05/08/2024) and 35339 (Completion Date 02/27/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/08/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2120-1, WAC 388-78A-2120-2-a, WAC 388-78A-2120-2-b, WAC 388-78A-2120-2, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-3, WAC 388-78A-2120-4, WAC 388-78A-2120, WAC 388-78A-2600-1-a, WAC 388-78A-2600-1-b, WAC 388-78A-2640-1-a

The Department staff who did the on-site verification:
Lisa Hauk, Complaint Investigator
Jamie Singer, Field Manager

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Aegis of Queen Anne at Rodgers Park
License/Cert.#: 2381
Compliance Determination #: 35339
Investigator: Lisa Hauk
Provider Type: Assisted Living Facility
Intake ID: 114977
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 01/18/2024 through 02/27/2024
Complainant Contact Date(s): 01/17/2024

Allegation(s):

1. The Named Resident (NR) developed a pressure wound due to negligent care at the Assisted Living Facility (ALF) which led to a hospitalization and death.
2. The ALF did not notify the NR's physician or legal representative of an extensive, infected pressure wound.
3. The ALF did not provide or seek medical treatment other than ointment for the extensive pressure wound.
4. The NR may not have been receiving enough nourished or fluids.

Investigation Methods:

Sample:
Total residents: 95
Resident sample size: 2
Closed records sample size: 1

Observations:
Residents
Activities
Dining
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Identified staff
Nursing staff
Residents
Family members
Physician

Record Reviews:
Characteristics Roster
Medical records
Hospital records
Incident investigation
Facility policies

Investigation Summary:

1. Interview and record review showed the NR had a pressure wound for 10 days.

Licensed nurses at the ALF did not follow their policies and did not assess or monitor or document on the wound. Staff at the ALF did not seek treatment or treat the open wound with anything other than ointment prior to hospitalization. See citation WAC 388-78A-2120(1)(2)(a)(b)(4).
2. Interview and record review showed the physician and legal representative were notified of the NR's pressure wound on 12//18/2023. The pressure area healed two days later. The ALF did not follow their policies and did not notify the legal representative or the physician that the NR's wound had recurred and worsened in January 2024. See citation 388-78A-2640(1)(a).
3. Interview and record review showed the ALF was applying ointment to the NR's pressure area that healed in December of 2023. The ALF did not follow their policy when the pressure wound recurred and worsened in January 2024. The ALF did not notify the NR's physician or seek treatment or treat the open wound with anything other than ointment. See citation 388-78A-2600(1)(a)(b).
4. Interview and record review showed the ALF identified the NR's decline in condition, followed their policies, notified the physician and received an order for dietary supplement, documented the NR's intake of the supplement and assisted the NR with meals. No violation of regulation identified.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies	License #: 2381	Compliance Determination # 35339
Plan of Correction	Aegis of Queen Anne at Rodgers Park	Completion Date
Page 1 of 11	Licensee: Aegis Senior Communities LLC	02/27/2024

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 01/18/2024 and 01/18/2024 of:

Aegis of Queen Anne at Rodgers Park
2900 3rd Ave W
Seattle, WA 98119

This document references the following complaint number(s): 114977

The following sample was selected for review during the unannounced on-site visit: 2 of 95 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Lisa Hauk, Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Jamie Singer
Residential Care Services

03/07/2024
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Anna White
Administrator (or Representative)

3/20/2024
Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to identify, monitor, evaluate and take action in response to changes in skin condition when 1 of 2 sampled residents (Resident 1) developed a wound. These failures resulted in Resident 1 developing a large, infected unstageable wound without monitoring, nursing care or medical treatments.

Findings included...

Review of Healthline.com, on 01/31/2024 stated pressure ulcers (also known as bedsores and decubitus ulcers) ranged from closed to open wounds and were classified into a series of four stages based on how deep the wound was. Stage 1 ulcers affect the upper layer of skin, and the wound has not yet opened. Treatment for Stage 1 ulcers are to remove pressure and keep the area clean and dry. Stage 2 ulcers are when the top layer of skin has opened creating a shallow wound. Treatment for Stage 2 ulcers are to remove pressure and keep the area clean and dry, seek medical attention, and use specialized wound dressings to keep the area from becoming more severe or infected. Stage 3 ulcers have progressed to breaking completely through the top two layers of the skin and into the fatty tissue below. At this stage it is important to monitor for infection. Treatment for stage 3 ulcers are to seek medical attention, possible antibiotic therapy, and procedure to remove dead tissue to promote healing. Stage 4 pressure ulcers are the most serious. These ulcers extend below the subcutaneous fat into the deep tissues, including muscle, tendons, and

ligaments and can extend as far down as the cartilage or bone. Signs of a Stage 4 ulcer is drainage, a dark hard substance known as eschar (dead tissue), signs of infection such as foul smell, pus, and visible muscle and sometimes bone. Treatment for Stage 4 ulcers is to seek hospital attention immediately. Review of Advancedwoundcare.org showed an unstageable wound is covered with necrotic (dead) tissue (slough or eschar). Unstageable wounds are either a Stage 2 or Stage 4.

NOTE: Revised Code of Washington (RCW) 18.88A.030 Nursing Assistant Scope of practice—(1)(a) A nursing assistant may assist in the care of individuals as delegated by and under the direction and supervision of a licensed (registered) nurse or licensed practical nurse.

Record review showed the ALF admitted Resident 1 on [redacted]/2023 with a diagnosis of [redacted]. Review of an Individualized Service Plan (equivalent to a Negotiated Service Agreement) stated Resident 1 had increased risk of and potential for skin breakdown(s) and care staff were to conduct routine checks to identify new skin issues and report to nurse.

Review of Resident 1's records showed the ALF identified skin breakdown on 12/17/2023. Records showed Resident 1's Primary Care Provider (PCP), on 12/18/2023, and family, on 12/17/2023, were notified of a 2.5 centimeter (cm) x 1.5 cm skin discoloration with two small "breakdowns" on her coccyx (the tailbone area of the body, upper bottom). Records showed the ALF initiated two separate skin related Temporary Service Plans (TSP), one activated on 12/17/2023. The TSP included to check the dressing on the right upper coccyx. Records showed the ALF had never obtained a dressing order from Resident 1's PCP. The TSP stated care staff were to conduct routine checks to identify new skin issues and report to nurse. The second TSP was activated on 12/18/2023. Interventions included if any new skin issues are observed to report to nursing staff. Record review showed Resident 1's PCP wrote and signed an order, dated 12/21/2023, for use of barrier cream, such as Vaseline, with directives to please report for any signs of infection.

Review of a Progress Note (PN), dated 12/19/2023, showed Staff C (Wellness Nurse- Registered Nurse) documented, "Pressure wound seems completely healed. No redness or bruising." A PN, dated 12/20/2023, showed Staff D (Wellness Nurse – Licensed Practical Nurse) documented Resident 1 had no open areas on her right buttock (coccyx) and was "removed from alert charting for skin."

Review of a PN, dated 12/31/2023, showed Staff F (Caregiver) documented that Resident 1's pressure ulcer on her coccyx was bleeding more. This was noted 12 days after the facility documented Resident 1's pressure ulcer was completely healed. There is no documentation in Resident 1's records that an ALF nurse was notified. There was no documentation that Resident 1's wound or coccyx was assessed by a nurse on 12/31/2023. There was no documentation Resident 1's PCP was notified.

In interview, on 1/18/2024 at 11:21 am, Staff D (Wellness Nurse – Licensed Practical Nurse)

stated on 01/01/2024 she observed a large open area on Resident 1, "from her anus right to the top of her coccyx" in length. Staff D stated, when she spread the area apart she would estimate the wound to be around a quarter of an inch wide. Staff D stated she notified the ALF nursing staff and Resident 1's PCP.

Record review showed no documentation Staff D actually observed Resident 1's coccyx. There was no documentation Staff D assessed of the wound, there was no documentation describing the wound noting its size, stage, or condition. There was no documentation Staff D notified Resident 1's PCP on 01/01/2024.

Review of a PN, dated 01/02/2024, showed Staff A (Health Services Director) documented, "Nursing following up with skin check." However Resident 1's records did not show nursing conducted a "follow-up". There was no documentation an assessment of the wound was conducted, there was no description of the wound noting its size, stage, or condition on 01/02/2024. There was no documentation Resident 1's PCP was notified.

Review of a PN, dated 01/03/2024, four days after the caregivers noted bleeding from Resident 1's coccyx, the ALF documented for the first time since 12/20/2023 the status of Resident 1's coccyx/wound. The PN documented by Staff C (Wellness Nurse – Registered Nurse) showed Resident 1 had a "6 cm x 3 cm raw area to her gluteal cleft that spreads to her left buttock with a stage 1 pressure ulcer over her coccyx." Record review showed there was no documentation Resident 1's PCP was notified. There was no documentation a request for wound care or treatment was requested.

Records showed from 01/03/2024 through 01/10/2024 there was no documentation ALF nurses observed, monitored, assessed, or treated Resident 1's wound her coccyx after 01/03/2024. There was no documentation of any communication with Resident 1's PCP after the signed order, dated 12/21/2023, for use of barrier cream, such as Vaseline, with directives to please report for any signs of infection.

Review of Resident 1's Medication Administration Records for December 2023 and January 2024 showed the order for barrier cream, such as Vaseline, was never transcribed or charted as administered. However, there was a flow sheet with directions that stated, "Skin Check Assess a pressure wound on the top of the right buttock. Cover with dressing" twice a week. However, records showed the ALF never obtained orders for wound dressings for Resident 1. Review of this flow sheet showed Resident 1's skin check and pressure wound assessment was provided by Staff K (Medication Technician) on 12/18/2023 and 01/08/2023, Staff J (Medication Technician) on 12/21/2023, 12/28/2023 and 01/04/2024, Staff F (Medication Technician) on 12/25/2023, and Staff L (Medication Technician) on 01/01/2024.

In an interview, on 02/01/2024 at 9:45 AM, Staff A confirmed medication technicians were performing and documenting the skin checks, "That is an error and we've since trained with the nurses. It should have been a nursing task". In an interview on 02/15/2024 at 9:14AM, when asked if it was in the scope of practice for Nursing Assistants to perform skin assessments Staff A stated, "No." Record review of an email dated 02/12/2024 at 12:53

PM, Staff A wrote, "There is no nurse delegation for pressure wounds as it requires nursing judgement."

Record review showed Resident 1 was sent to the hospital on [redacted]2024. However, emergency medical care was obtained due to the results of a blood draw, not do to skin breakdown.

Review of hospital records showed Resident 1 was seen in the Emergency Department (ED) on [redacted]/2024. The hospital documented when Resident 1 arrived at the ED she had a 7 cm x 5 cm unstageable pressure ulcer over her coccyx. The pressure ulcer was foul smelling with moderate surrounding erythema (abnormal redness of the skin) and eschar (dead tissue) with yellow slough (hard and dry pus), and moderate amounts of yellow/tan draining. The ED physician documented the pressure ulcer was "infected" with surrounding cellulitis (reddening of the skin due to infection). Imaging conducted in the ED showed the pressure ulcer contained a 1.5 x 1.6 cm fluid filled abscess (a tender mass filled with pus due to infection). Resident 1 was admitted to the hospital for further medical treatment and evaluation.

Observation of photograph taken in the ED, on [redacted]/2024, showed a large deep and tunneling wound on the sacrum.

Hospital records showed Resident 1 passed away on [redacted]/2024.

In interview, on 01/17/2024 at 3:16 PM, Collateral Contact 1 (CC1 - Resident 1's Representative and Power of Attorney) stated when Resident 1 was examined in the ED she had a very large pressure ulcer, the size of a tennis ball, with a deeper infection all the way to the bone. CC1 stated the hospital physician told her the wound was the result of inadequate care and not being repositioned properly. CC1 stated she contacted Resident 1's PCP who stated the ALF staff had only communicated that Resident 1 had discoloration on her bottom, nothing about a large open wound. CC1 stated the only reason the wound was noticed and got medical attention was because Resident 1's PCP ordered blood work which revealed elevated results resulting in the ALF calling 911.

Interview and record review, 02/01/2024 at 9:45 AM, showed Staff A's Health and Services Director position description form, revised 08/31/2020, stated the "The Health and Service Director is responsible for: Conducting change of condition assessments, Provide early diagnosis of resident health changes, use Aegis policies to establish best practices to identify changing in resident health care needs and initiate appropriate response, which includes contacting primary care provider and families and consulting with other health care practitioners as needed and approved." When asked if Staff A ever looked at Resident 1's skin after 12/17/2023, Staff A stated she did not and stated she knew nothing about the wound. Staff A was shown the picture of Resident 1's coccyx wound that was taken in the ED on [redacted]/2024. When asked if she was aware Resident 1's wound was as extensive as shown in the picture Staff A stated, "Oh my God! No. Not at all." When asked what she would have done if she knew the wound was that bad, Staff A stated, "With something like that, we would send somebody out to the hospital." When asked if the ALF staff monitored

and treated Resident 1's skin appropriately, Staff A stated, "No. Not if it looked like that." Staff A stated, "[Resident 1's wound] is concerning. I'd never heard anything of her wound being to that extent. Obviously, there was a breakdown in communication." Staff A confirmed the family and the PCP had not been notified after 12/18/2023. Staff A confirmed the wound was not assessed regularly by nursing staff, "which it should have been". Staff A confirmed barrier cream was not charted.

In interview, on 01/18/2024 at 11:54 AM, Staff E (Associate Care Director) stated she had noted a wound on Resident 1's sacrum that started, "about two weeks before she went to the hospital". Staff E stated she had notified the ALF nursing staff that the wound was getting worse and bleeding. Staff E stated, "I felt bad about the wound."

In interview on 01/18/2024 at 12:08 PM, Staff H (Medication Technician) stated that she reported to nursing when she saw Resident 1's wound and was told by nursing to apply the cream that was in Resident 1's room to the open area. Staff H stated, "We [the caregivers] just wanted them [the nursing staff] to do something but they kept saying the doctor needed to see her first."

Review of hospital records showed a note, dated 01/11/2024, documented by the Palliative (Palliative care is specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness.) Care Nurse Practitioner. The note stated Resident 1's family had been notified of some skin irritation on Resident 1's coccyx that had healed in December 2023 however the family heard nothing more about the wound until it was found in the hospital, and they saw how extensive it was. "Early December family was told that [Resident 1] had some skin irritation on her sacrum [coccyx]and that the staff at Aegis would be applying a cream. They heard nothing more about this wound until [Resident 1] was admitted to the hospital and they saw how extensive the wound is. Because of this, they do not want her to return to her prior facility.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Aegis of Queen Anne at Rodgers Park is or will be in compliance with this law and / or regulation on (Date) 4/12/2024 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Anna White — Administrator (or Representative)

3/20/2024 — Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(b) Provide the necessary care and services for residents, including those with special needs;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement their policies regarding skin management and reporting changes of condition for 1 of 2 sampled residents (Resident 1). These failures contributed to Resident 1 developing a large, infected unstageable wound without receiving the necessary care and services.

Findings included....

Review of the ALF's policy, "Skin Management Protocol", revised 08/10/2016 showed the following

- The HSD (Health and Services Director) or Resident Services Director is required to notify the Regional Health Services Consultant of any skin condition over a stage.
- Skin Observation/Wound Observation Record will be initiated for skin breakdown, clearly identifying who is providing the skin or wound care and who the skin or wound care was ordered by. Proper skin documentation is to be continued two times a week at minimum. Initiate a temporary Plan.

Review of the ALF's policy, "Resident Change of Condition Reporting Protocol", revised 04/20/2023, "Any change of a resident's condition that is observed by a Care Manager, must be reported in writing to the Health Services Director, using the "WISDOM2ACT" function in Eldermark.

- If the change of condition is short term change of condition (less than 14 days), the Temporary Service Plan should be used; no changes should be made to the Service Plan for change of condition that will last less than 14 days.
- All sudden changes of conditions should have immediate nurse intervention for assessment and evaluation to determine if 911 or physician evaluation through other means should be initiated.
- Health Services Director is responsible for: Assessing the condition; Following-up; Calling 911 if necessary; Overseeing that the condition change is addressed in the Service Plan/Temporary Service Plan and that ongoing appropriate care is provided.
- The Health Services Director will see that the appropriate assessment of the reported condition and any necessary follow-up takes place. The HSD will either complete the assessment personally or designate another nurse or department head to do so, as deemed appropriate.
- Changes of condition and associated care changed should be discussed daily at roster meetings. Any resulting changes to the Service Plan/Temporary Service Plan will be noted

by the HSD or Care Director, as well as if applicable, it should include alert charting and all should be shared with appropriate staff members, not later than the next day after the change of condition is first observed.

Record review showed the ALF admitted Resident 1 on [redacted]/2023 with a diagnosis of [redacted]. Review of an Individualized Service Plan (equivalent to a Negotiated Service Agreement) stated Resident 1 had increased risk of and potential for skin breakdown(s) and care staff were to conduct routine checks to identify new skin issues and report to nurse.

Review of Resident 1's records showed the ALF identified skin breakdown on 12/17/2023. Review of a Progress Note (PN), dated 12/19/2023, showed Staff C (Wellness Nurse- Registered Nurse) documented, "Pressure wound seems completely healed. No redness or bruising." A PN, dated 12/20/2023, showed Staff D (Wellness Nurse – Licensed Practical Nurse) documented Resident 1 had no open areas on her right buttock (coccyx) and was "removed from alert charting for skin." Review of a PN, dated 12/31/2023, showed Staff F (Caregiver) documented that Resident 1's pressure ulcer on her coccyx was bleeding more. Review of a PN, dated 01/01/2024, showed Staff G (Associate Health Service Director- Licensed Practical Nurse) documented Resident 1 was "on skin monitoring for area and it will be assessed when resident is up for the day." Review of a PN, dated 01/03/2024, four days after the caregivers noted bleeding from Resident 1's coccyx, the ALF documented for the first time since 12/20/2023 the status of Resident 1's coccyx/wound. The PN documented by Staff C (Wellness Nurse – Registered Nurse) showed Resident 1 had a "6 cm x 3 cm raw area to her gluteal cleft that spreads to her left buttock with a stage 1 pressure ulcer over her coccyx."

Records showed from 01/03/2024 through 01/10/2024 there was no documentation ALF nurses observed, monitored, assessed, or treated Resident 1's wound on her coccyx after 01/03/2024.

Review of hospital records showed Resident 1 was seen in the Emergency Department (ED) on [redacted]/2024. The hospital documented when Resident 1 arrived at the ED she had a 7 cm x 5 cm unstageable pressure ulcer over her coccyx. The pressure ulcer was foul smelling with moderate surrounding erythema (abnormal redness of the skin) and eschar (dead tissue) with yellow slough (hard and dry pus), and moderate amounts of yellow/tan draining. The ED physician documented the pressure ulcer was "infected" with surrounding cellulitis (reddening of the skin due to infection). Imaging conducted in the ED showed the pressure ulcer contained a 1.5 cm x 1.6 cm fluid filled abscess (a tender mass filled with pus due to infection). Resident 1 was admitted to the hospital for further medical treatment and evaluation.

Observation of photograph taken in the ED, on [redacted]/2024, showed a large deep and tunneling wound on the sacrum.

For further details on Resident 1's wound see Washington Administrative Code 388-78A-2120 in this Statement of Deficiencies.

Record review showed Resident 1 had no Skin Observation form completed. When caregivers noted Resident 1's skin had re-opened there was no documentation the HSD was notified in writing. There was no documentation Resident 1's skin change of condition had immediate nursing interventions or received immediate medical attention. There was no documentation the HSD assessed Resident 1 after the caregivers noted a change in skin condition. There was no documentation of follow-up or evidence the HSD oversaw Resident 1 received on-going appropriate care. There was no documentation Resident 1 was placed on alert charting after 12/20/2021.

In interview, on 02/01/2024 at 9:45 AM, Staff A (Health Service Director) stated she did not know Resident 1 developed an unstageable wound and stated she never assessed or looked at Resident 1's skin. In Interview on 02/15/2024 at 9:14 AM, Staff A stated she did not notify the Regional Health and Services Consultant as she was unaware of the skin breakdown. Staff A stated the ALF did not use a Skin Observation Form. Staff A stated no medical interventions were requested for Resident 1 after her skin re-opened on 12/31/2023.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Aegis of Queen Anne at Rodgers Park is or will be in compliance with this law and / or regulation on (Date) 4/12/24 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Olivia White — Administrator (or Representative)

3/20/2024 — Date

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to report the recurrence of a pressure ulcer to the Primary Care Physician and Resident Representative for 1 of 2 residents (Resident 1). These failures contributed to Resident 1 developing a large, infected unstageable wound, without any authorized medical interventions or treatment after 12/21/2023.

Findings included.....

Review of Resident 1's records showed the ALF identified skin breakdown on 12/17/2023. Records showed Resident 1's MD and family were notified of a 2.5 centimeter (cm) x 1.5 cm skin discoloration with two small "breakdowns."

Review of hospital records showed Resident 1 was sent to the Emergency Department (ED) on [redacted]/2024. The ED noted when Resident 1 arrived at the ED, she had a 7 centimeter (cm) x 5 cm unstageable pressure ulcer over her coccyx. The pressure ulcer was foul smelling with moderate surrounding erythema (abnormal redness of the skin) and eschar (dead tissue) with yellow slough (hard and dry pus), with moderate amounts of yellow/tan draining. The ED physician documented the pressure ulcer was "infected" with surrounding cellulitis (reddening of the skin due to infection). Imaging conducted in the ED showed the pressure ulcer contained a 1.5 x 1.6 cm fluid filled abscess (a tender mass filled with pus due to infection) Resident 1 was admitted to the hospital for further medical treatment and evaluation.

Observation of photograph taken in the ED, on [redacted]2024, showed a large deep and tunneling wound on the sacrum.

For further details on Resident 1's wound see Washington Administrative Code 388-78A-2120 in this Statement of Deficiencies.

In an interview, on 01/17/2024 at 3:16 PM, Collateral Contact 1 (CC1- Resident 1's Resident's Representative) stated she had been contacted via email from the ALF on 12/17/2023 informing her that Resident 1 had "skin discoloration" on her right buttock referring to it as a pressure wound that was 2.5 centimeters x 1.5 cm in size with two small skin breakdowns. CC1 stated during a Zoom meeting on 12/19/2023, Staff I (Care Director) stated the ALF was monitoring the situation and would keep her informed if there were any changes. CC1 stated she did not hear anything further from the ALF regarding Resident 1's wound. CC1 stated Resident 1 was found to have an extensive pressure ulcer when she arrived at the emergency department on [redacted]/2024, the wound was the size of a tennis ball with a deeper infection all the way to the bone. CC1 stated she spoke with Resident 1's Primary Care Provider (PCP) who stated she had recently communicated with the ALF about the wound in which the ALF described it as only being skin discoloration without any openings in the skin. CC1 stated she was never informed of any changes or worsening of Resident 1's skin and had not had any communication with the ALF since 12/19/2023.

Record review showed the ALF faxed Resident 1's PCP on 12/18/2023. The fax stated, "Your patient, [Resident 1], has a new discoloration on her right buttock. Pressure wound 2.5cm x 1.5 cm of skin discoloration with 2 small skin breakdowns. Can we have an order for barrier cream, please." The PCP responded and signed on 12/21/2023 with orders, "I approve of use of barrier cream, such as Vaseline. Please alert me for any signs of infection."

Record review showed no further communication with Resident 1's PCP regarding the status of Resident 1's wound.

In interview, on 02/15/2024 at 9:52 AM, Collateral Contact 2 (CC2 – Supervisor for Resident 1's PCP) confirmed the ALF had not notified the PCP of the unstageable pressure ulcer that developed after 12/18/2023. CC2 stated that the only time the ALF communicated anything about Resident 1's wound was on 12/18/2023. CC2 stated the ALF told Resident 1's PCP, on 12/18/2023, specifically the status of Resident 1's did not include open skin. CC2 stated, "We should have been notified about any skin breakage. Had we known the extent of [Resident 1's] wound, we would have ordered Home Health to directly assess and address the wound and maybe we would have ordered antibiotics."

In interview, on 02/14/2024 at 2:30 PM, CC1 stated, "They [ALF] never followed up with me after the first call in December." When asked what she would have done if she had known the extent of Resident 1's pressure wound, CC1 stated, "I would have called 911. I don't understand how it got as bad as it did without anybody noticing."

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Aegis of Queen Anne at Rodgers Park is or will be in compliance with this law and / or regulation on (Date) 4/12/2024 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Ilona White
Administrator (or Representative)

3/20/2024
Date