STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

NorthWest HC Columbia Heights (WA) Operator NT-HCI LLC
Avamere at Wenatchee
1550 CHERRY STREET
WENATCHEE, WA 98801

RE: Avamere at Wenatchee License # 2415

Dear Administrator:

This letter addresses Compliance Determination(s) 27260 (Completion Date 08/01/2023) and 23061 (Completion Date 05/23/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/01/2023 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-2100-2-a, WAC 388-78A-2100-2-b, WAC 388-78A-2100-2-c, WAC 388-78A-2100-2, WAC 388-78A-2120-2-a, WAC 388-78A-2120-2, WAC 388-78A-2120-2-b, WAC 388-78A-2120-3, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-4, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2140-1-b, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2630-1-a, WAC 388-78A-2660-7

The Department staff who did the on-site verification:
Anna Cairns, ALF Long Term Care Surveyor
Elaine Lopez, Licensor

If you have any questions, please contact me at (509)572-7394.

Sincerely,

Michelle Closner

Michelle Closner, Field Manager
Region 1, Unit Z

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services

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Residential Care Services
Investigation Summary Report

Provider/Facility: Avamere at Wenatchee
Provider Type: Assisted Living Facility
License/Cert.#: 2415
Compliance Determination #: 23061
Intake ID: 76769
Investigator: Nicole Velazquez
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 04/26/2023 through 05/23/2023
Complainant Contact Date(s):

Allegation(s):

1) A named resident had a fall.
2) A named resident had pressure injuries to bilateral buttocks.

Investigation Methods:

Sample:	Total residents: 67 Resident sample size: 7 Closed records sample size: 0
Observations:	Environment, Named Resident, Residents, Cares, Staff to resident interactions, Staff availability and response to resident's needs.
Interviews:	Residents, Staff and others not associated with the facility.
Record Reviews:	Characteristic Roster, Resident Records (Face sheet, Assessment, Care Plan, Interim Service Plan, Progress Notes, Physician Orders), Facility Policy, Facility Incident Report and Investigations.

Investigation Summary:

1) Observations showed that residents were clean and groomed. Staff were observed to be available and responsive to resident's needs. Staff to resident interactions were observed to be appropriate and respectful. Resident interview showed that they felt safe and staff were responsive to their needs. Staff interview and record review showed that there were fall prevention measure in place prior to the fall, the named resident received car per service plan and all notifications were made.
2) The named resident was interview and was able to verbalize concerns regarding the prevention, care and treatment of the skin issues. Staff interview and record review showed that the facility failed to investigate the cause of the new skin issues, make appropriate notifications including the Department's Complaint Resolution Unit, make update to the named resident's medical records, monitor skin conditions for changes and seek out appropriate treatment for the pressure injuries which led to harm. The facility had deficient practice and citation written for WACs 388-78A-2100, 388-78A-2120, 388-78A-2140, 388-78A-2371, 388-78A-2630, 388-78A-2660.

This document was prepared by Residential Care Services for the Locator website.

Conclusion / Action:

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

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: Avamere at Wenatchee
Provider Type: Assisted Living Facility
License/Cert.#: 2415
Compliance Determination #: 23061
Intake ID: 78445
Investigator: Nicole Velazquez
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 04/26/2023 through 05/23/2023
Complainant Contact Date(s):

Allegation(s):
A named resident had a fall with injury.

Investigation Methods:

Sample:	Total residents: 67 Resident sample size: 7 Closed records sample size: 0
Observations:	Environment, Cares, Staff to resident interactions, Staff availability and response to resident's needs.
Interviews:	Residents, Staff and others not associated with the facility.
Record Reviews:	Characteristic Roster, Resident Records (Face sheet, Assessment, Care Plan, Interim Service Plan, Progress Notes, Physician Orders), Facility Policy, Facility Incident Report and Investigations.

Investigation Summary:
Observation, interview and record review showed that the named resident had a change in condition after their fall with injury. The named resident required more assistance with activities of daily living, had increased pain and they required more assistance for transfers. Record review showed that the named residents' changes in condition were not reflected on the nursing assessment or care plan. The facility had deficient practice and citation written for WACs 388-78A-2100, 388-78A-2120.

Conclusion / Action:

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

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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

RECEIVED
JUN 0 9 2023
BY: .....

Statement of Deficiencies	License #: 2415	Compliance Determination # 23061
Plan of Correction	Avamere at Wenatchee	Completion Date
Page 1 of 15	Licensee: NorthWest HC Columbia Heights (WA) Operator NT-HCI	05/23/2023

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 04/26/2023, 05/11/2023 and 04/26/2023 of:

Avamere at Wenatchee
1550 CHERRY STREET
WENATCHEE, WA 98801

This document references the following complaint number(s): 76769, 77115, 77382, 78445, 79966

The following sample was selected for review during the unannounced on-site visit: 7 of 67 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Nicole Velazquez, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit Z
1200 Alder Street
Union Gap, WA 98903

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.

Gwin Kaercher for Michelle Closner
Residential Care Services

06/02/2023
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.

This document was prepared by Residential Care Services for the Locator website.

Administrator (or Representative) 6-7-23 Date

WAC 388-78A-2100 On-going assessments. The assisted living facility must:

(2) Complete an assessment specifically focused on a resident's identified problems and related issues:

(a) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(b) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

(c) When the resident has an injury requiring the intervention of a practitioner.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to obtain an assessment when there was a change in condition for one of two Resident (Resident 2). This failure contributed to three skin injuries for resident 2 and placed residents at risk of skin injuries.

Findings included...

Facility policy revised 10/22/2021, titled, "Change in Condition Procedure," showed that for a significant change of condition including a fracture of a bone or pressure sores, residents were to have a nursing assessment completed.

Review of Resident 2's facility record showed that they were admitted on [redacted]/2022 with diagnoses of [redacted] and [redacted].

Nursing assessment dated 03/07/2023, showed that Resident 2 had a risk for skin breakdown without any noted active pressure injuries and without any wound care needs.

A progress note written by Staff D, Medication Technician, on 03/23/2023 showed Collateral Contact 1 (CC1), external physical therapist, had a therapy session with Resident 2. Resident 2 ambulated with a specialty walker. It notes that Resident 2 complained of pressure to their buttocks, and the skin on the Resident 2's buttocks was red and flakey. It also noted that Resident 2 had a ROHO cushion (specialty cushion for prevention and treatment of pressure injuries) in their wheelchair and that the cushion had too much air in it and may be the cause of their discomfort and skin changes. The specialty cushion should have a one-inch pocket of air between the chair and the resident's lowest boney part of the buttocks and was to be monitored daily.

This document was prepared by Residential Care Services for the Locator website.

A skin assessment completed by Staff A, Director of Nursing, dated 04/20/2023 showed that Resident 2 had a deep tissue injury to the left buttocks that measured 3.5 inches (in) by 2 in and a deep tissue injury to the right buttocks that did not have measurements documented. Another skin assessment dated 05/07/2023 by Staff F, Nurse, showed the exact same documented information. Resident record review failed to show any assessments were conducted for the ROHO cushion and the specialty walker.

Resident 2's NSA last updated 04/20/2023, was reviewed and showed:
• Resident 2 had a deep tissue injury (purple or maroon area of discolored skin due to damage of underlying soft tissue from pressure) to left and right buttocks.
• Supportive devices present on NSA were transfer poles and wheelchair.

Observation on 04/26/2023 at 2:05 PM, showed that Resident 2 had two ROHO cushions in their wheelchair and recliner, and a specialty walker in their room.

On 05/04/2023 at 11:09 AM, Staff B, Resident Care Manager, stated that Resident 2 had a history of pressure sores but that they did not have any special preventative measures in place. They did not know how to monitor the ROHO cushion and that they did not check the ROHO cushion for appropriate inflation levels. Staff B acknowledged that a new nursing assessment had not been done and the care plan had not been updated to address Resident 2's needs for treatment of pressure injuries and had not had preventative measures in place prior to the formation of the two deep tissue injuries.

On 05/11/2023 at 11:10 AM, Resident 2 stated that staff had not come in to follow up with them about their sores on their bottom. Resident 2 further stated that they were not able to reposition in their recliner. Resident 2 stated that they had notified staff that their buttocks was hurting and that they thought they were getting a sore on their buttocks and that no one followed up to get new treatments or to put any other preventative measures in place. Resident 2 stated that the treatment that was being put on the pressure injuries had been the same cream for months and did not help prevent them and had not helped with healing the deep tissue injuries that they had. Resident 2 stated that the only time the ROHO cushions had been checked was when the physical therapist checked it the one time. The ROHO cushions were not checked by facility staff or their private caregiver.

On 05/11/2023 at 11:15 AM, Resident 2 was observed to have three skin issues including deep tissue injuries to the right and left buttocks. The left buttocks had a Stage 3 pressure injury (full thickness wound caused by pressure) in the middle of the deep tissue on the left buttocks, that measured 1 centimeter (cm) by 0.5 cm.

On 05/12/2023 at 9:31 AM, Staff A acknowledged that the skin assessments that they had done on 04/20/2023 and the skin assessment done by Staff F on 05/07/2023 were identical and that the 05/07/2023 assessment was a copy of the 04/20/2023 assessment. Staff A stated that they had not been informed by staff of the pressure injuries worsening, and that the facility staff had not been routinely monitoring Resident 2's pressure injuries for changes in the appearance.

This document was prepared by Residential Care Services for the Locator website.

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, Avamere at Wenatchee is or will be in compliance with this law and / or regulation on (Date) 7-7-23 .

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

Administrator (or Representative) — Date: 6-7-23

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

(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 monitor skin and implement assessed interventions for a resident who developed skin injuries for one of two residents' (Resident 2). This failure contributed to three skin injuries for resident 2 and placed residents at risk of skin injuries.

Findings included...

Record review of section "Skin Monitoring" of facility policy titled, "CBC 24 Hour Process," revised 09/2017, showed that when a resident sustained a skin issue facility staff should:
Place the resident on the "Alert Log,"
Complete a skin integrity progress note and describe the skin condition.
The staff should document each shift until the nurse removes it from alert.

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A paper skin log was to be updated.
The facility staff should implement a treatment for the skin condition, if required.
Complete an incident report for the skin issue.

Resident 2's 03/14/2023 Negotiated Service Agreement (NSA) showed their diagnoses to include [redacted], and [redacted]. The NSA showed that Resident 1 had compromised skin integrity.

Physical Therapy Provider Summary Sheet, dated 03/23/2023, completed by Collateral Contact 1 (CC1), external physical therapist showed that Resident 2 had complaints of pressure on the right buttock. CC1 noted they observed the right buttock was red and flaky. The document showed that Staff D, Medication Technician, signed off the note as reviewed on 03/25/2023, and signed off by the Staff F, Nurse on 04/12/2023.

The Medication Administration Record (MAR) dated 04/2023 showed that Resident 2 required a medication technician to apply topical treatment to left buttocks for prevention of skin issues. The resident's treatment record did not show monitoring of any skin issues. There was no documentation of the skin issue on the right buttock.

Resident 2's revised negotiated service agreement (NSA) on 04/20/2023 showed deep tissue injuries (unopened, purple or maroon area of discolored skin due to damage of underlying soft tissue from pressure) on left and right buttocks.

Record review of Resident 2's medical record from 03/24/2023 to 04/20/2023 Resident 2's record did not include documentation of monitoring for status of skin integrity, nor did it include monitoring of the resident's deep tissue injuries of the right and left buttocks that were documented in the progress note on 03/23/2023 and on the NSA on 04/20/2023.

On 05/04/2023 at 11:09 AM, Staff B, Resident Care Coordinator, stated that Resident 2 had a history of pressure sores but that they did not have any special preventative measures for Resident 2's history of pressure injuries and did not have monitoring in place for their two deep tissue injuries. Staff B further stated that the facility staff did not monitor the ROHO cushion (specialty cushion for prevention and treatment of pressure injuries) for appropriate inflation and that may have caused Resident 2 to have recurring pressure injuries.

On 05/11/2023 at 11:15 AM, Resident 2 was observed to have three skin injuries including deep tissue injuries to the right and left buttocks. The left buttocks had a Stage 3 pressure injury (full thickness wound caused by pressure) in the middle of the deep tissue on the left buttocks, that measured 1 centimeter (cm) by 0.5 cm.

During an interview on 05/11/2023 at 11:30 AM, Staff A, Director of Nursing, stated that they were not aware that Resident 2 had a new Stage 3 open wound on the left buttocks.

This document was prepared by Residential Care Services for the Locator website.

On 05/12/2023 at 9:31 AM, Staff A stated that the facility staff had not been utilizing the facility Skin Log for monitoring Resident 2's deep tissue injuries.

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, Avamere at Wenatchee is or will be in compliance with this law and / or regulation on (Date) 7-7-23 .

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

Administrator (or Representative) — Date: 6-7-23

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Assisted Living Facility (ALF) failed to ensure that negotiated service agreements (NSA) was updated with interventions and treatment to address and prevent skin issues for one of two sampled resident (Resident 2). This failure contributed to three skin injuries placed residents at risk of skin issues.

Findings included...

Facility policy titled, "Process for Electronic Service Planning," last revised 10/2021 showed that the service plan should be completed as needed to ensure that the service plan reflects the resident's needs and to ensure coordination, oversight and monitoring of the resident's needs and preferences.

This document was prepared by Residential Care Services for the Locator website.

Facility face sheet showed that Resident 2 was admitted to the ALF on [redacted]/2022 with diagnoses of [redacted], and [redacted].

Nursing Assessment dated 03/07/2023 showed that Resident 2 was at risk for skin breakdown. There was no documentation of any any pressure skin injuries (full thickness open wound due to pressure), skin wounds and no documentation of a history of pressure injuries.

Resident 2's progress Note dated 03/08/2023, showed Collateral Contact 1 (CC1), an external physical therapist's treatment summary note, that resident was ambulating with a specialty walker.

Physical Therapy Provider Summary Sheet on 03/23/2023 showed a summary note for a visit to the facility, from CC1. It noted that Resident 2 used a specialty walker for walking. During the visit, CC1 noted that Resident 2 had skin changes (red and flaky) to right buttocks and that Resident 2 had complained of discomfort from pressure. It further noted that the ROHO cushion (specialty cushion for prevention and treatment of pressure injuries) in Resident 2's wheelchair had not been inflated appropriately and caused Resident 2's discomfort and skin changes. It was supposed to have a one-inch pocket of air between the chair and the resident's lowest boney part of the buttocks and that the ROHO cushion needed to be checked daily for proper inflation.

The updated NSA on 04/20/2023 showed that Resident 2 had a skincare plan that showed an deep tissue injuries (unopened, purple or maroon area of discolored skin due to damage of underlying soft tissue from pressure) to right and left buttocks without any updated interventions to treat or prevent worsening of the pressure injuries. The ROHO cushion, that required daily monitoring for appropriate inflation was not present on the NSA. The specialty walker was not listed as an assistive device used by Resident 2.

On 04/26/2023 at 2:05pm, observations showed that Resident 2 had two ROHO cushions in their wheelchair and a platform walker (a specialty device for walking) in their apartment.

On 05/04/2023 at 11:09 AM, Staff B, Resident Care Coordinator, stated that Resident 2 had a history of having pressure injuries and that they did not have any preventative measures in place. They acknowledged that the ROHO cushion was being used but that it was not on the NSA. The facility staff did not monitor the inflation of the ROHO cushion to make sure it was appropriately being used because it was not on the NSA with the appropriate instruction for monitoring.

On 05/11/2023 at 11:15 AM, Resident 2 was observed to have three skin injuries including deep tissue injuries to the right and left buttocks. The left buttocks had a Stage 3 pressure injury (full thickness wound caused by pressure) in the middle of the deep tissue on the left buttocks, that measured 1 centimeter (cm) by 0.5 cm.

This document was prepared by Residential Care Services for the Locator website.

During an interview on 05/11/2023 at 11:30 AM, Staff A, Director of Nursing, was informed of the new stage 3 pressure injury observed on 05/11/2023 at 11:15 AM. Staff A stated that they had not been notified of any new wounds to Resident 2's buttocks.

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, Avamere at Wenatchee is or will be in compliance with this law and / or regulation on (Date) 7-7-23 .

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

Administrator (or Representative) — Date: 6-7-23

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure the facility investigated and identified interventions to prevent deep skin injuries for one of two residents (Resident 2). This failure contributed to Resident's 2 three skin injuries, which one was an open wound.

Findings included...

Nursing assessment dated 03/07/2023, showed that resident had a risk for skin breakdown. There was no documentation of any active pressure injuries and no documentation of any wound care needs.

Physical Therapy Provider Summary Sheet dated 03/23/2023 from Collateral Contact 1

This document was prepared by Residential Care Services for the Locator website.

(CC1), an external physical therapist, showed that Resident 2 had complained of pressure to their buttocks and that the skin to Resident 2's buttocks was red and flakey. There were no documented investigations or interventions noted in the Nursing Service Agreement (NSA) to prevent future deep tissue wounds for Resident 2.

Resident 2's NSA updated on 04/20/2023, showed that Resident 2 had deep tissue injuries (purple or maroon area of discolored skin due to damage of underlying soft tissue from pressure) to left and right buttocks. The NSA did not show that the facility implemented measures to prevent future incidents for Resident 2.

During an interview on 05/11/2023 at 11:10 AM, Resident 2 stated that they had told facility staff about their discomfort on the buttocks and that they believed they were getting pressure sores. Resident 2 stated that the treatment and care did not change to help them with the deep tissue injuries and discomfort.

During an interview on 05/04/2023 at 11:09 AM, Staff B, Resident Care Coordinator, stated that there was not an investigation related to the new deep tissue pressure injuries on right and left buttocks. They also acknowledged that the cause of the pressure sores could not be determined, since an investigation was not completed. After Resident 2 was noted to have the new deep tissue pressure injuries, there were not any interventions put into place to prevent the current deep tissue injuries from worsening or to prevent similar skin issues going forward.

On 05/11/2023 at 11:10 AM, Resident 2 stated that they had told facility staff about their discomfort on the buttocks and that they believed they were getting pressure sores. Resident 2 stated that the facilities treatment and care did not change to help them with the deep tissue injuries and discomfort.

An observation on 05/11/2023 at 11:15 AM, showed that Resident 2 had three skin injuries on the left and right buttocks. On the left buttocks, Resident 2 had a stage 3 pressure injury (full thickness wound from skin loss due to pressure), measuring 1 centimeter (cm) by 0.5 cm.

On 05/11/2023 at 11:30 AM, Staff A, Director of Nursing, was informed of the observation done on 05/11/2023 at 11:15 AM showing Resident 2 having worsening of the pressure ulcer on the left buttocks. Staff A stated that they were not aware that the pressure injury was now open and was a Stage 3.

Plan/Attestation Statement

This document was prepared by Residential Care Services for the Locator website.

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, Avamere at Wenatchee is or will be in compliance with this law and / or regulation on (Date) 7-7-23 .

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

Administrator (or Representative) — Date: 6-7-23

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure that a staff member made a report to the department's Aging and Disability Services Administration Complaint Resolution Unit (CRU) hotline when one of two residents (Resident 2), had an incident of significant injury. This failed practice placed residents at risk for physical and emotional distress.

Findings included...

Review of the Department's Assisted Living Facilities Guidebook, dated February 2018, showed facilities are required to report neglect that may have resulted from a pattern, of more than one occurrence of inaction by an individual or entity with a duty of care for assisted living residents.

Review of the Resident 2's record showed they were admitted to the facility on [redacted]/2022 with diagnoses of [redacted] and [redacted].

Resident 2's negotiated service agreement last updated on 04/20/2023 showed that Resident 2 had deep tissue pressure injuries to the left and right buttocks.

Resident 2's skin assessment, completed by Staff A, Director of Nursing, dated

This document was prepared by Residential Care Services for the Locator website.

04/20/2023 showed that they had a deep tissue injury to each buttock. Measurements were noted for the left buttocks with no measurements noted for the right buttocks. It notes the weekly skin integrity checks were to be done and that staff were applying a paste twice a day to the buttocks.

During an interview on 05/04/2023 at 11:09AM, Staff B, Resident Care Coordinator, acknowledged that the facility neglected to put preventative measures in place for Resident 2 who had a history of pressure injuries that were recurring, including two deep tissue pressure injuries that had been noted in the resident's record. Furthermore, Staff B stated that the pressure injuries had not been reported to the state and investigation was not completed.

On 05/11/2023 at 11:00 AM Resident 2 stated that the facility staff neglected to provide them with the help that they needed to reposition in their chair for pressure relief. The facility staff had not been in to discuss their skin issue with them and had not been aware that they had a new pressure injury on their buttocks. Resident 2 further stated that there had not been any staff in to see them to review treatments and/or skin care prevention options.

On 05/11/2023 at 11:15 AM, Resident 2 was observed to have three skin issues including deep tissue injuries to the right and left buttocks. The left buttocks had a Stage 3 pressure injury (full thickness wound caused by pressure) in the middle of the deep tissue on the left buttocks, that measured 1 centimeter (cm) by 0.5 cm.

Record review on 05/11/2023 at 11:30 AM showed Resident 2's skin assessment, completed by Staff A, Director of Nursing, dated 04/20/2023 showed that deep tissue injuries were present on each buttock. Measurements were noted for the left buttocks with no measurements noted for the right buttocks. It notes the weekly skin integrity checks were to be done and that staff were applying a paste twice a day to buttocks. Another skin assessment for Resident 2, that was completed by Staff F, Nurse, dated 05/07/2023 showed the exact same information that was documented on 04/20/2023 by Staff A.

On 05/11/2023 at 11:30 AM, Staff A stated that they were not aware that Resident 2 had a new stage 3 open wound on their left buttocks. In review of Resident 2's skin assessments, Staff A stated that the skin assessments done on 05/07/2023 by Staff F appeared to have been copied from their skin assessment that was completed on 04/20/2023. They further stated that they could not determine whether an actual assessment was done on 05/07/2023 since the assessment had been copied.

Plan/Attestation Statement

This document was prepared by Residential Care Services for the Locator website.

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, Avamere at Wenatchee is or will be in compliance with this law and / or regulation on (Date) 7-7-23 .

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

Administrator (or Representative) — Date: 6-7-23

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(7) Not allow any staff person to abuse or neglect any resident.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure that residents were protected from neglect when they failed to provide interventions, monitor skin injuries, and failed to ensure the Negotiated Service Agreement (NSA) was updated with interventions to prevent and treat skin injuries for 1 of 2 residents (Resident 2). These failures resulted in Resident 2 not receiving interventions and treatment for skin injuries, experiencing discomfort, and developing three skin injuries.

Findings included...

Per WAC 388-78A-2020 "Neglect" means:

(1) A pattern of conduct or inaction resulting in the failure to provide the goods and services that maintain physical or mental health of a resident, or that fails to avoid or prevent physical or mental harm or pain to a resident; or

(2) An act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the resident's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100.

Review of Resident 2's face sheet showed that they were admitted to the facility on [redacted]/2022 with diagnoses of [redacted] and [redacted].

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Record review of Resident 2's nursing assessment dated 03/07/2023 showed that the facility assessed Resident 2 to have compromised skin integrity and was at risk for skin breakdown.

Physical Therapy Provider Summary Sheet dated 03/23/2023 from Collateral Contact 1 (CC1), an external physical therapist, showed Resident 2 had complained of pressure to their buttocks and the area was red and flakey. It further noted that the ROHO cushion (specialty cushion for prevention and treatment of pressure injuries) being used in Resident 2's wheelchair was not appropriately inflated and caused Resident 2 to have discomfort and skin changes. The note also stated that the ROHO cushion needed to be monitored for appropriate inflation daily. Appropriate inflation was noted to be a one-inch pocket of air between the chair and the resident's lowest boney part of the buttocks. The document showed that Staff D, Medication Technician, signed off the note as reviewed on 03/25/2023, and signed off by the Staff F, Nurse on 04/12/2023.

The progress note written by Staff D, Medication Technician, on 03/23/2023 showed CC1, external physical therapist, had a therapy session with Resident 2. Resident 2 ambulated with a specialty walker. The progress note confirmed CC1s summary that Resident 2 complained of pressure to their buttocks, and the skin was red and flakey. The progress notes also showed that Resident 2 had a ROHO cushion in their wheelchair and the cushion had too much air in it. There was no documentation of an assessment for the use of a ROHO cushion.

Resident 2's Negotiated Service Agreement (NSA) updated on 04/20/2023 showed that Resident 2 had compromised skin integrity without noting resident's history of pressure injuries. The NSA did not address treatment or prevention interventions for Resident 2's compromised skin integrity and risk of skin breakdown. The NSA showed no documentation that the ROHO cushions were being used or how to use the cushion to prevent skin breakdown by Resident 2 in their wheelchair and recliner. In addition, the NSA did not show that the ROHO cushions required daily monitoring to assure the cushions were set to the appropriate inflation.

An observation on 04/26/2023 at 2:05 PM, showed that Resident 2 had two ROHO cushions one in their wheelchair and one in their recliner.

On 05/04/2023 at 11:09 AM, Staff B, Resident Care Coordinator, stated that Resident 2 had deep tissues injuries to both left and right buttocks, along with a history of having pressure injuries. They stated that there were not any preventative measures in place for the current pressure injuries and had not had any preventative measures in place prior to the current pressure injuries despite Resident 2's history of pressure injuries. Staff B stated that the facility staff did not know how to track and monitor the ROHO cushions and that they did not check the proper inflation of the ROHO cushion.

During an interview on 05/11/2023 at 11:00 AM, Resident 2 stated that they had notified the facility

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staff of their discomfort to their buttocks but could not remember when that was. In addition, Resident 2 thought they were getting a pressure injury and told staff, but the staff did not do anything for them. Resident 2 further stated that they were not able to reposition themselves in the chair. Resident 2 also stated the staff did not check their deep tissue injuries to see if they had improved or worsened. The staff would only apply cream when taking them to the bathroom but not look at the wounds.

On 05/11/2023 at 11:07 AM, Staff E, Caregiver, stated that they did not know how to monitor or check the ROHO cushion or that it needed to be inflated correctly for Resident 2. Staff E further stated that they did not monitor skin issues unless an order was on the Medication Administration Record (MAR) or on the negotiated service agreement (NSA) and Resident 2 did not have anything listed on either of the documents. Staff E noted that Resident 1 did not have any pressure injuries to their buttocks that they knew of.

On 05/11/2023 at 11:09 AM, Staff G, Caregiver, stated that Resident 2 did not have any pressure injuries and that they were not trained to check Resident 2's ROHO cushions and did not know that they needed to be inflated correctly.

On 05/11/2023 at 11:15 AM, Resident 2 was observed to have three skin injuries to the right and left buttocks. The left buttocks had a Stage 3 pressure injury (full thickness wound caused by pressure) in the middle of the deep tissue on the left buttocks, that measured 1 centimeter (cm) by 0.5 cm.

On 05/11/2023 at 11:30 AM, Staff A, Director of Nursing, was informed of the stage 3 pressure injury to Resident 2's buttocks that measured 1 centimeter (cm) by 0.5 cm that was located inside the deep tissue injury on the left buttocks. Staff A stated that they were not aware that Resident 2 had the stage 3 open wound.

On 05/12/2023 at 9:31 AM, during a follow up interview, Staff A acknowledged that the skin assessments that were done by Staff A on 04/20/2023 and the skin assessment done by Staff F, Nurse, on 05/07/2023 were identical and that the 05/07/2023 assessment was a copy of the 04/20/2023 assessment. Staff A stated that they could not determine if Staff F, Nurse, had done the assessment on 05/07/2023 since it was a copied assessment with the documentation being identical. Staff A further stated that they had not been informed by staff of the pressure injuries worsening, and that the facility staff had not been routinely monitoring Resident 2's pressure injuries for changes in the appearance.

On 05/23/2023 at 3:05 PM, CC1 stated they had asked Staff A back in March to get Resident 1 up and walking more with the walker to increase Resident 1's mobility. Resident 1 sat in the wheelchair or recliner most of the time during the day and could not reposition themselves. This could also contribute to Resident 1's skin issues. Staff A told CC1 that they could not assist Resident 1 with ambulation because they did not have enough time or staff to do this.

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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, Avamere at Wenatchee is or will be in compliance with this law and / or regulation on (Date) 7-7-23 .

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

Administrator (or Representative) — Date: 6-7-23

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