STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175122	A. BUILDING _____ B. WING _____	C 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	9701 MONROVIA STREET LENEXA, KS 66215

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00167465, KS00167468, and KS00167476. The 2567 was sent to the facilty on 12/07/21.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility identified a census of 136 residents. The sample included five residents; three residents reviewed for pressure ulcers (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). Based on record reviews and interviews, the facility failed to ensure weekly skin assessments were completed on Resident (R) 1 who was at risk for and had a history of developing pressure ulcers. This deficient practice increased the risk for delayed identification of complications or worsening of	F 686		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/07/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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existing pressure injuries for R1.

Findings included:

- R1 admitted to facility 03/29/18 and discharged to hospital 11/21/21.

R1's Electronic Medical Record (EMR) documented a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance.

The "Annual Minimum Data Set (MDS)" dated 02/16/21, documented R1 had a Brief Interview for Mental Status (BIMS) of three which indicated severed cognitive impairment. R1 required extensive physical assistance with one staff for bed mobility, dressing, eating and personal hygiene; extensive physical assistance with two staff for transfers and toileting; and total physical dependence with one staff for bathing. R1 was at risk for developing pressure ulcers but did not have any pressure ulcers at time of assessment. R1 had moisture-associated skin damage (MASD- inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva or mucous), had a pressure reducing device for her bed and chair, and received applications of ointments/medications.

The "Quarterly MDS" dated 11/21/21, documented R1 had a BIMS score of zero which indicated severe cognitive impairment. R1 required extensive physical assistance with one staff for bed mobility, dressing, eating, and personal hygiene; extensive physical assistance with two staff for transfers and toileting; and total

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physical dependence with one staff for bathing. R1 had three stage three (wound that extends into the subcutaneous tissue layer) pressure ulcers, two unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow/white material in the wound bed) and/or eschar (dry, dead tissue within a wound) pressure ulcers, and MASD. R1 had a pressure reducing device for chair and bed, received pressure ulcer care, and applications of ointments/medications.

The "Pressure Ulcer/Injury Care Area Assessment (CAA)" dated 02/25/21, documented R1 was at risk for skin breakdown due to decreased physical mobility and incontinence which could lead to pain, development of pressure ulcers, and other skin conditions. A full skin assessment was done weekly by a licensed nurse (LN), the Certified Nurse Aide (CNA) informed the nurse of concerns during the bathing/dressing process. Repositioning assistance was given, MASD was present and treatment in place. Risk factors included wound infection and further skin integrity decline. Pressure relief was provided as a cushion in the wheelchair and mattress on the bed. Adequate nutrition and hydration were encouraged.

The "Care Plan" dated 02/24/21, documented R1 was at risk for skin break down due to history of skin excoriation, decreased mobility and episodes of incontinence and documented the following interventions: unstageable wound on right thigh and heels bilaterally, wound care consult initiated, start date 11/21/21; coccyx (small triangular bone at the base of the spine) wound, check Treatment Administration Record (TAR) often for treatment changes, start date 09/28/21; assist R1 with

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repositioning as needed, start date 02/24/21; staff reported changes to nurse, doctor, and family, start date 02/24/21; nurse performed body audits and Braden scale assessments (assessment tool for predicting the risk of pressure ulcers) to monitor skin condition and risks, start date 02/24/21; and staff checked skin with bathing and care and reported any redness or open areas to nurse, start date 02/24/21.

R1's "Braden Skin Assessment" dated 04/14/21 documented she was at moderate risk for pressure ulcer development.

R1's "Medication Administration Record (MAR)" for 09/01/21 to 11/21/21 revealed weekly skin audits were completed 09/01/21, 09/22/21, 09/29/21, 10/20/21, and 11/10/21. Weekly skin audits were documented as "Not administered: Due to condition" on 09/08/21, 09/15/21, 10/06/21, 10/13/21, 10/27/21, 11/03/21, and 11/17/21.

A "Progress Note" on 11/20/21 at 12:35 AM documented R1 had redness and dryness on bilateral heels, skin prep (a solution when applied that forms a protective waterproof barrier on the skin) applied, staff continued to follow up.

A "Progress Note" on 11/21/21 at 09:42 AM documented R1 presented with altered mental status from baseline, lethargic (condition marked by drowsiness and an unusual lack of energy and mental alertness), and new inability to swallow food at breakfast. Physician order to send to Emergency Room (ER) for evaluation and treatment. R1 had a head to toe assessment performed which revealed wounds to coccyx, right inner thigh, and bilateral heels.

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On 12/01/21 at 02:21 PM, CNA M stated ways to prevent pressure ulcer development included applying creams after incontinence cares, repositioning, and check and changing every two hours. He stated the CNAs checked residents' skin during showers and reported any findings to the nurse.

On 12/01/21 at 02:31 PM, LN G stated ways to prevent pressure ulcer development included pressure relieving boots, floating heels in bed, and turning every two hours. She stated skin assessments were completed once a week by the nurse; CNAs notified the nurse of any concerns found during residents' showers. LN G stated a skin assessment might not have got done if there was an emergency or there was not enough time. She stated "due to condition" documented as a reason for not administering a skin assessment might have meant the nurse was not able to get the skin assessment done. She stated skin assessments should not have been missed but it happened. She stated she was unaware of any further skin concerns for R1 before she left the facility because she did not do any dressing changes on R1.

On 12/01/21 at 02:51 PM, Administrative Nurse D stated ways to prevent pressure ulcer development included turning, repositioning, heel protectors, and incontinence care. She stated every nursing staff member should be checking residents' skin. CNAs checked skin during cares and showers and reported concerns to the nurse. Weekly skin assessments were completed by the nurses. If the resident refused, then it should have been documented as refused. "Due to condition" meant it probably did not get done. She

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stated nurses should not have missed a skin assessment. R1 had the pressure ulcer to her coccyx and received skin prep to her heels but there were no other wounds reported to her before R1 discharged to hospital.

The facility's "Pressure Ulcer Prevention" policy, not dated, documented skin pressure risk assessment was completed on admission, quarterly with MDS, and with significant changes in condition. Any sign of skin irritation and pressure was reported to the charge nurse immediately. All skin observations were documented on the Bath Skin Report.

The facility's "Skin Monitoring" policy, not dated, documented the Braden Scale is included as part of the admission process and quarterly with the MDS. Bath Skin Reports were given to the nurses aides with their shower assignments and returned to the charge nurse as soon as completed. The areas of concern that were identified on the Bath Skin Report were assessed by the charge nurse and documented.

The facility failed to ensure weekly skin audits were completed on Resident (R) 1 who was at risk for and had a history of developing pressure ulcers. This deficient practice increased the risk for delayed identification of complications or worsening of existing pressure injuries for R1.