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	175549	A. BUILDING _____ B. WING _____	R 04/19/2021

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{F 000}	INITIAL COMMENTS The following citations represent the findings of a non-compliance revisit and complaint investigation KS00161278. The 2567 was sent to the facility on 4/29/21.	{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 39 residents. The sample included three residents reviewed for pressure ulcers. Based on observations, interviews, and record reviews the facility failed to ensure one Resident (R) 2 received wound care consistent with professional standards of practice when physician ordered wound care treatments were not completed. Findings included: - The "Medical Diagnoses" tab of R2's electronic medical record (EMR) documented diagnoses of	{F 686}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/29/2021

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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muscle weakness, difficulty walking, pressure ulcer (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) unstageable (obscured full thickness skin and tissue loss) of sacral region (large triangular bone between the two hip bones), and diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).

The "Admission Minimum Data Set" dated 03/25/21 documented a Brief Interview for Mental Status score of 14, which indicated intact cognition. R2 required limited assistance with bed mobility, extensive assistance with personal hygiene, dressing, and transfers, and total staff assistance with walking, locomotion and toileting. He had an indwelling catheter (tube inserted into the bladder to drain urine into a collection bag) and was frequently incontinent of bowel. R2 had one stage four pressure ulcer (a pressure ulcer with full thickness skin and tissue loss) which was present on admission. He had a pressure reducing device on his wheelchair and bed and received pressure ulcer care.

The "Pressure Ulcer/Injury Care Area Assessment" dated 04/01/21 documented R2 was admitted with a stage four pressure wound and had a wound vac (a vacuum assisted closure used as a method of decreasing air pressure around a wound to assist in healing) ordered. He had a pressure reducing mattress and wheelchair cushion. He required limited staff assistance with bed mobility.

The "Physician's Order" tab documented an order

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for: negative pressure wound therapy to sacrum (wound vac) change as directed every Monday, Wednesday, and Friday to sacral area dated 4/4/21 with a start date of 04/05/21.

Review of the "Treatment Administration Record" (TAR) from 04/05/21 through 04/19/21 revealed a lack of documentation for the wound vac treatments being done on Wednesday 04/07/21 and Monday 04/12/21.

The "Robinson Wound Care" notes reviewed from 03/26/21 through 04/16/21 revealed the following measurements for the sacral wound:
03/26/21= 5.6 centimeters (cms.) in length, 4.4 cms. in width, and 4 cms. in depth
04/02/21= 7.5 cms. in length, 4.6 cms. in width, and 4 cms. in depth
04/09/21= 5.5 cms. in length, 5.6 cms in width, and 2 cms. in depth
04/16/21= 6.6 cms. in length, 2.4 cms. in width, and 1.5 cms in depth

Review of the "Daily Skilled Nurse's Notes" dated 04/07/21 revealed R2 had a wound vac in place on his buttock wound but, there was no documentation regarding if the wound vac had been changed as ordered.

Review of the "Daily Skilled Nurse's Notes" dated 04/12/21 lacked documentation the wound vac had been changed as ordered.

Review of the facility's Medication and Treatment Administration (MAR/TAR) in-service on 04/13/21 revealed an in-service was attended by 12 nurses for discussion of the need for the completion of the MAR/TAR documentation to be completed prior to the nurse leaving for the end of his/her

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shift.

On 04/19/21 at 09:10 AM R2 rested in bed. He had a low air loss mattress on his bed and a wound vac was in place. R2 stated the wound care physician had been assessing the wound and thought it was getting better the last time he assessed the wound.

On 04/19/21 at 03:49 PM Licensed Nurse (LN) G stated skin assessments were done by the nursing staff weekly. The wounds were measured weekly by the Wound Care Nurse. The Wound Care Physician assessed wounds on Fridays. The nursing staff documented wound care treatments on the TARS. R2's wound vac dressings had come loose in the past and the wound care was sometimes done on a different day but, if the care was not completed a nursing progress note was documented. LN G did not find documentation for the reason why the 04/07/21 and 04/12/21 wound care was not completed.

On 04/19/21 at 04:00 PM Administrative Nurse (AN) E stated the Wound Care Physician assessed pressure wounds weekly and sent the reports to the facility to be scanned to the residents' EMRs. The Administrative Staff had been reviewing the residents' EMRs to check for documentation on the TARs. R2's wound vac dressings had been coming off at times due to bowel incontinence issues and the placement of the wound. When the wound care was not completed, the reason for the incompletion was documented in the EMRs. AN E was unable to find documentation for the reason why the 04/07/21 and 04/12/21 wound care was not completed.

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{F 686}	Continued From page 4 On 04/19/21 at 04:12 PM AN D stated the Administrative Staff reviewed the residents' TARS during the morning meetings. The reason for the inability to complete wound care should be documented in the residents' EMRs by the nursing staff. AN D was unable to find documentation for the reason why the 04/07/21 and 04/12/21 wound care was not completed. The facility's "Pressure Ulcer/Pressure Injury Prevention and Healing Program" policy, dated April 2018, documented treatments were completed as ordered by the physician. The facility failed to ensure R2 received wound care consistent with professional standards of practice when physician ordered wound care treatments were not documented. This had the potential for a deterioration of the wound or increased healing time.	{F 686}		
{F 880} SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	{F 880}		

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reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the

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corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 39 residents, with 10 residents in the sample. Based on observations, interviews, and record reviews the facility failed to ensure staff followed standard of infection control practices regarding appropriate hand hygiene, handling of linens, use of personal protective equipment (PPE- gloves, gowns, masks, eye protection, or face shield) and infection control precautions for isolation (transition) rooms (rooms 200-208) used to reduce the prevention and spread of disease including Covid-19 (an infectious disease caused by a severe acute respiratory syndrome which caused an ongoing world-wide pandemic). This deficient practice placed residents at increased risk for infectious disease including Covid-19.

Findings included:

- An observation on 04/19/21 at 09:17 AM revealed Licensed Nurse (LN) I exited room 210, without performing hand hygiene. LN I closed the door upon exiting room 210, walked down hall, and opened the medication cart without performing hand hygiene.

An observation on 04/19/21 at 09:39 AM revealed

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Certified Nurse Aide (CNA) R gathered dirty linen in room 212 and placed in a bag. CNA R exited the room with the dirty linen bag, walked down hallway, and placed in the dirty utility room. CNA R then walked back to room 212, wrote on a paper outside of door though she did not perform hand hygiene after collecting and disposing of the dirty linen.

An observation on 04/19/21 at 2:11 PM revealed CNA N knocked then entered room 211 to assist CNA R with resident care. CNA N entered the room and donned gloves without performing hand hygiene.

An observation on 04/19/21 at 09:43 AM revealed CNA M carried clean linens under her left arm with linens close to her body and touching her clothing into a resident's room.

An observation on 04/19/21 at 2:33 PM revealed CNA N in a Covid-19 transition isolation room. CNA N did not have gown on. CNA N then came out of the room with an ice water cup from the room and filled the cup from the community ice chest with scoop. CNA N wore a KN95 (disposable filtering facepiece), upon exiting room. Upon re-entering room, CNA N donned a gown, did not perform hand hygiene, and took the cup of ice back into the isolation room. CNA N did not have on a face shield or goggles while in the isolation room. The sign on the room door indicated face shield or goggles was required.

An observation on 04/19/21 at 10:13 AM revealed CNA M wore a N95 (disposable filtering facepiece), donned gown and entered Covid-19 isolation room 203. CNA M did not don a face shield or goggles before entering the isolation

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room. The sign on the room door indicated face shield or goggles was required.

An observation on 04/19/21 at 10:09 AM revealed CNA R wore a N95, donned a gown, performed hand hygiene and donned gloves before entering Covid-19 isolation room 204. CNA R did not don a face shield or goggle before entering the isolation room. The sign on the door indicated face shield or goggles was required.

The facility's "Hand Hygiene" policy date January 2017, documented appropriate hand hygiene is essential in preventing transmission of infectious agents. The purpose is to cleanse hands to prevent the spread of potentially deadly infections; provide a clean and healthy environment to staff, residents and visitors; to reduce the risk of healthcare provider of colonization or infections acquired from a resident. Hand hygiene continue to be the primary means of preventing transmission of infection. Hand hygiene (e.g., hand washing and/or ABHR): consistent with accepted standards of practice such as the use of ABHR instead of soap and water in all clinical situations except when: hands are visibly soiled (e.g., blood body fluids) or after caring for a resident with known or suspected communicable disease or before eating and after using the restroom.

The facility's "COVID Isolation PPE" policy date December 2020, documented that person to person transmission most commonly occurs during close exposure to a person infected with COVID-19, primarily via respiratory droplets produced when the infected person coughs or sneezes. Droplet can land in the mouths, nose or eyes of people who are nearby or possibly

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{F 880}	Continued From page 9 inhaled into the lungs of those in proximity. The isolation (transition) room every time staff enters or exit, they should perform hand hygiene. Ensure N95 is properly on face covering mouth and nose. Practice social distancing six feet between persons when not performing personal cares. Appropriate use of PPE: eye protection (goggle or face shield), gowns and gloves. Follow instructional signage throughout facility regarding COVID-19. Clean and disinfect contaminated or touched surfaces and equipment using approved disinfectant. The facility failed ensure staff practiced appropriate hand hygiene, and appropriate handling of clean linen. The facility further failed to ensure staff used appropriate PPE and infection control precautions when providing care for residents in Covid-19 isolation rooms The deficient practice placed residents at increased risk for transmission of infectious disease, including Covid-19.	{F 880}		