STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	C 01/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #159086 and #159100. The 2567 was electronically sent to the facility on 01/07/21.	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 had a census of 39 residents. The sample included seven residents with two reviewed for pressure ulcers. Based on observation, record review, and interview, the facility failed to implement pressure relieving interventions upon admission to the facility to prevent Resident (R) 3 from developing unstageable pressure ulcers (full thickness skin and tissue loss obscured by slough or eschar, dead tissue) to her bilateral heels. Findings included: - R3's "Electronic Medical Record" documented	F 686		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/07/2021

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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the facility admitted the resident on 12/24/20.

R3's "Physician Order Sheet," dated 12/30/20, documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), and malaise (vague uneasy feeling of body weakness, distress or discomfort.

R3's "Admission Minimum Data Set" (MDS) had not been completed yet.

R3's "Braden Scale Assessment," (predicts risk for pressure ulcers) dated 12/24/20, recorded a score of 14 (moderate risk).

R3's "Skin Assessments," dated 12/24/20 and 12/29/20, recorded redness to her coccyx, a skin tear to her right hand, and a skin tear to her left hand. The assessments lacked documentation regarding the resident's heels.

The resident's "Baseline Care Plan," dated 12/24/20, recorded R3 easily communicated with staff and understood direction and goal was to strengthen and go back to Assisted Living. The care plan recorded she was alert with cognitive impairment, required setup help only for eating and personal hygiene, one staff assistance with dressing and transfers, and two staff assistance with toileting and bed mobility. The care plan recorded the resident ambulated with a walker and a wheelchair, occasionally incontinent of urine, and always continent of bowel. The care plan recorded R3 admitted with redness to her coccyx, and skin tears on the tops of her bilateral hands. The care plan lacked interventions for

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pressure relief devices.

An "Admission Note," dated 12/24/20 at 02:02 PM, documented the facility admitted R3 from the hospital with a diagnosis of a urinary tract infection (UTI) and skilled care for strengthening so R3 could return to Assisted Living. The note recorded R3 had redness to her coccyx and skin tears to both hands. Staff applied TED hose (compression socks) to R3's bilateral lower extremities, Calmoseptine (barrier cream) for R3's red coccyx, and applied Optifoam (foam dressing) to the bilateral skin tears on her hands.

R3's "Daily Skilled Nursing Assessments," dated 12/25/20 - 12/29/20, documented R3 had late loss Activities of Daily Living (ADLs) and now required assistance with bed mobility, transfers, toileting, and eating, and no new changes to her skin integrity.

The "Registered Dietitian (RD) Note," dated 12/28/20 at 07:43 AM, documented the facility admitted the resident from Assisted Living with colon cancer, history of falls, and dementia. RD was currently unable to meet with the resident due to isolation precautions in the facility. The resident was able to state needs, speech clear, and diet regular with poor intakes. She weighed 160 pounds (lb), weight was skewed due to edema in bilateral lower extremities (BLE). The resident worked with therapies. Interventions included shakes three times a day (TID) with meals, staff to encourage intake of food/fluids throughout the day, and recommended to start a snack of resident's choice in the evening and at bedtime. Staff to monitor weight weekly and notify RD for nutritional concerns.

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The "Nurse's Note," dated 12/29/20 at 10:37 AM, documented the resident continued to be weak and fatigued, with loss of appetite, frequent nausea, and difficulty swallowing. Therapy did not feel like skilled care was benefiting the resident and planned to discharge her today per request from resident's representative so hospice orders could be pursued. The note documented therapy staff lowered the resident to the floor during therapy earlier that day due to her legs giving out. The note documented the resident did not want to continue with therapy and her representative felt hospice was in the resident's best interest as she was a Do Not Resuscitate (DNR) and had declined to treat the colon cancer. Staff requested an order for hospice to evaluate and admit the resident if appropriate.

The "Hospice Initial Assessment," dated 12/30/20, documented the resident's skin pale, warm, dry, fragile and intact. Deep Tissue Injury (persistent non-blanchable deep red, purple or maroon areas of intact skin) to bilateral heels, heels dark red with black centers. The note documented no slough, granulation, drainage, or odor. Peri wound healthy, intact, and pink. Staff to float the resident's heels, use heel protectors in bed, apply skin prep twice a day, discontinue TED hose, and elevate legs.

The "Nurse's Note," dated 12/30/20 at 04:12 PM, documented hospice staff was at the facility and admitted the resident, would like to have heel boots on resident while in bed, skin prep to heels due to them being boggy (soft and mushy), and to discontinue the TED hose.

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On 01/04/21 at 03:05 PM, observation revealed Certified Nurse Aide (CNA) M and CNA N repositioned and checked the resident for incontinence, coccyx light pink in color, and skin intact. CNAs applied Calmoseptine to the coccyx and peri area, pressure relieving boots in place, and no skin issues noted to legs.

On 01/04/21 at 04:55 PM, observation revealed heel protectors on the resident's bilateral heels. Licensed Nurse (LN) G removed the heel protectors revealing dry black areas to bilateral heels that measured approximately 3 centimeters (cm) by 5 cm, and LN G reapplied the heel protectors.

On 01/04/21 at 12:50 PM, CNA P stated she had not noticed any issues with R3's heels.

On 01/04/21 at 01:45 PM, LN H stated R3's hospice admission assessment recorded the resident had 2+ pitting edema (slight pitting, no visible distortion, disappears rapidly) in her bilateral lower extremities and deep indentions on the resident's bilateral calves and ankles from the TED hose. LN H stated there were no open areas, but the redness remained in the indentions the TED hose made after they were removed. LN H stated R3 had DTI's to her bilateral heels that were dark red with black centers (no measurements) and hospice started heel protectors and skin prep to bilateral heels twice a day.

On 01/04/21 at 02:00 PM, LN G stated R3's legs were swollen so she put the TED hose on the resident because LN G thought it would help the swelling. LN G stated she did not notice anything going on with R3's heels.

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On 01/04/21 at 04:20 PM, Administrative Nurse D stated she performed R3's admission assessment, noted the bilateral skin tears to the tops of R3's hand and started Optifoam dressings to them, also noted R3's coccyx was reddened, and started Calmoseptine to the coccyx. Administrative Nurse D stated she did not see any areas of concern on R3's bilateral heels, TED hose were initiated on admission due to edema, and went on easily. Administrative Nurse D stated there were no interventions put in place to prevent pressure ulcers from forming on R3's bilateral heels.

On 01/04/21 at 04:55 PM, LN G stated that R3 declined very quickly. The facility did not have any interventions in place to prevent the pressure ulcers from occurring.

01/06/21 at 11:00 AM, Physician GG stated, in general, the resident's condition rapidly deteriorated, her general moving ability declined due to the metastatic cancer to her colon which would make it easier for skin issues to occur.

The facility's revised "Prevention of Pressure Ulcers/Injuries" policy, dated July 2017, documented to prevent pressure ulcers - keep the skin clean and free of exposure to urine and fecal matter. Monitor the resident for weight loss and intake of food and fluids. Include nutritional supplements in the resident's diet to increase calories and protein, as indicated in the care plan. Choose a frequency for repositioning based on the resident's mobility, the support surface in use, skin condition and tolerance, and the resident's stated preferences. At least every hour, reposition residents who are chair-bound or bed-bound with

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F 686	Continued From page 6 the head of the bed elevated 30 degrees or more. At lease every two hours, reposition residents who are reclining and dependent on staff for repositioning. Reposition more frequently as needed, based on the condition of the skin and the resident's comfort. Teach residents who can change positions independently the importance of repositioning. Provide support devices and assistance as needed. Remind and encourage resident to change positions. Evaluate, report and document potential changes in the skin. Review the interventions and strategies for effectiveness on an ongoing basis. The facility failed to implement pressure relieving interventions upon R3's admission to the facility and the resident developed bilateral unstageable pressure ulcers to her heels, placing the resident at risk for worsening pressure ulcers.	F 686		