STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175332	A. BUILDING _____ B. WING _____	C 08/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK OF OTTAWA	1100 W 15TH STREET OTTAWA, KS 66067

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00144022. The 2567 was electronically sent to the facility on 08/21/19.	F 000		
F 686 SS=G	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 reported a census of 71 residents. The sample included three residents reviewed for pressure ulcers. Based on observation, interview, and record review, the facility failed to timely implement appropriate interventions to prevent a pressure ulcer from reoccuring for one Resident (R) 3 of the three residents reviewed. On 07/26/19, following healing of a prior ulceration on 07/10/19, facility staff identified a hard lump in the prior wound bed of the healed ulcer. Facility staff failed to implement an intervention to reduce pressure or prevent skin breakdown until 08/01/19, after the wound reopened as an	F 686		

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

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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unstageable pressure ulcer.

Findings included:

- Resident (R) 3's signed "Order Recap Report", dated 07/19/19, documented the resident admitted to the facility on 07/03/16, with diagnoses including dementia with behavioral disturbance (chronic brain disease, resulting in loss of independence and ability to care for one's self), Alzheimer's disease (progressive dementia, resulting in loss of memory and independence), and need for assistance with personal care.

Review of the R3's "Minimum Data Set" (MDS) assessment, dated 04/03/19, assessed the resident with a "Brief Interview for Mental Status (BIMS)" score of five, indicating severe cognitive impairment. The resident required extensive assistance from one staff person with transferring, bed mobility, and her other activities of daily living (ADLs), but required supervision with eating. The resident was occasionally incontinent of urine, and was not incontinent of bowel. The resident was at risk for developing pressure ulcers, had no unhealed pressure ulcers, but did experience moisture-associated skin damage (MASD). Facility staff applied ointments or medications to areas other than the resident's feet.

Review of the Pressure Ulcer "Care Area Assessment" (CAA), dated 04/16/19, revealed that facility staff documented the resident was at risk for pressure ulcers, due to her weakness and need for assistance with ADLs. Facility staff provided the resident with a pressure-reducing mattress and a pressure-reducing cushion for her wheelchair.

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The resident's care plan for pressure ulcers, updated 08/01/19, documented the resident was at risk for developing pressure ulcers due to immobility. Facility staff must administer any treatments as ordered by her physician, and monitor for effectiveness. On 04/16/19, facility staff placed a pressure-reducing cushion in the resident's wheelchair, and placed a pressure-reducing mattress on her bed. On 07/31/19, the resident developed an unstageable pressure ulcer, which required treatment per physician's orders. Facility staff must monitor and report any changes in the resident's wound to her physician as needed. On 08/01/19, facility staff provided a low-air-loss mattress (a type of specialized pressure-relieving mattress) to the resident.

Review of "Skin Assessments" revealed the following:

05/29/19; 06/05/19; and 06/11/19: documented the resident was free of skin issues on her coccyx (tailbone).

06/19/19: revealed the resident developed a rash to her perineal area (area between the genitals and the coccyx), which staff cleansed with soap and water. Facility staff notified the resident's physician.

06/25/19: revealed facility staff documented the resident's buttocks appeared to be healing.

07/02/19: revealed facility staff noted blanching redness to the resident's coccyx, and applied barrier cream.

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07/05/19: revealed facility staff noted a small open area to the resident's buttocks, measuring 0.5 centimeters (cm) by 0.4 cm by 0.1 cm.

07/10/19: revealed that facility staff documented in a Nursing Note at 03:54 PM that the resident's wound resolved.

07/12/19: revealed the facility wound physician assessed the wound site and noted the area to be covered with 100% epithelialization tissue (skin), indicating the wound resolved. Facility staff must apply protective ointment each shift.

07/17/19: revealed facility staff documented the resident's skin continued to improve.

07/19/19: revealed facility staff noted no skin issues.

07/26/19: revealed facility staff noted a hardened area when touching the resident's healed pressure ulcer site. The skin assessment failed to document implementation of an intervention to prevent skin breakdown from occurring.

07/31/19: revealed facility staff noted an unstageable pressure ulcer to the resident's prior wound site, measuring 2.5 cm by 1.4 cm by 0.2 cm. The facility wound physician observed the wound. Facility staff obtained orders to cleanse the wound with wound cleanser, apply Santyl (a chemical debriding agent) to the wound bed, cover with petrolatum gauze, cover with bordered gauze, change the dressing daily and as needed. Facility staff documented that the resident's physician and family were made aware of the wound.

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An "Interdisciplinary Team" (IDT) note, dated 07/31/19 at 02:06 PM, documented that a low-air-loss mattress would be provided to the resident.

A Skin Assessment, dated 08/07/19, revealed facility staff measured the resident's unstageable wound, and found that it measured 4 cm by 4.2 cm by 0.1 cm.

Review of a Nursing Note, dated 08/09/19 at 11:25 AM, revealed that the resident returned from an appointment with her primary care physician, who documented that she had a severe, full-thickness, necrotic pressure ulcer on her sacrum. The resident's physician ordered Bactrim (an antibiotic) DS (double strength), 1 tablet, by mouth, twice daily, for ten days; and Tramadol (a pain reliever), 50 milligrams (mg), by mouth, every six hours, as needed, for pain.

Review of a skin assessment, dated 08/14/19, revealed the facility wound physician debrided the resident's unstageable pressure ulcer. The wound measured 4 cm by 4 cm by 3.5 cm, and had 3.5 cm of undermining surrounding the edges of the wound. The wound had foul-smelling drainage.

On 08/15/19 at 09:50 AM, Licensed Nurse (LN) H and Administrative Nurse E changed the resident's dressing. The resident rested on an air mattress. The resident's wound measured approximately 4 cm by 4 cm by 3.5 cm, and undermining could be seen. A foul odor could be detected in the room during the dressing change. LN H and Administrative Nurse E repositioned the resident following the dressing change.

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On 08/15/19 at 11:00 AM, facility staff repositioned the resident. At 12:55 PM, facility staff repositioned the resident. At 03:00 PM, the resident rested in a different position. The resident's air mattress was in place and functioning appropriately.

On 08/16/19 at 09:27 AM, Consultant GG confirmed the resident's prior pressure wound healed, and that she developed a new wound. Consultant GG stated that the resident began experiencing a recent functional decline, due to her disease processes, and earlier interventions such as the air mattress may have been beneficial for the resident.

On 08/19/19 at 08:57 AM, the resident slept on her air mattress, and wore protective pillow booties on her feet.

On 08/19/19 at 09:41 AM, Certified Nurse Aide (CNA) O stated the resident had a pressure ulcer on her tailbone. CNA O stated that the resident required frequent repositioning, and following the development of the ulcer, got an air mattress.

On 08/19/19 at 10:30 AM, Certified Medication Aide (CMA) R stated the resident developed a pressure ulcer on her tailbone. CMA R stated that the resident had an air mattress, but that he/she was not sure when facility staff provided the air mattress to the resident.

On 08/19/19 at 12:45 PM, Administrative Nurse E stated the resident had a pressure ulcer on her coccyx, that developed after a previous ulcer healed. Administrative Nurse E stated the facility placed a low-air-loss mattress as an intervention for the wound, on either 07/31/19 or 08/01/19,

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after the wound reopened.

On 08/19/19 at 01:30 PM, Administrative Nurse D stated that facility staff provided the air mattress on 08/01/19.

On 08/19/19 at 03:30 PM, Administrative Nurse D confirmed that the facility failed to timely implement an intervention following the identification of the hardness to the resident's prior wound site on 07/26/19.

Review of the facility's policy titled, "Pressure Ulcer Management," revised 09/2018, documented that preventative measures for pressure ulcer development included pressure reduction.

The facility failed to timely implement an intervention to reduce pressure to a previously healed pressure ulcer, when facility staff identified a hardened area to the site on 07/26/19. Facility staff failed to implement an intervention to reduce pressure or prevent skin breakdown until 08/01/19, after the wound reopened as an unstageable pressure ulcer.