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	N089042	A. BUILDING: _____ B. WING _____	C 08/06/2019

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THE HOMESTEAD OF AUBURN	280 E VALLEY SPRINGS DR AUBURN, KS 66402

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with a complaint (#143951) at the above named assisted living facility conducted on 8/5,6/2019.	S 000		
S3155 SS=G	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (a) The facility reported a census of 30 residents. The sample included 3 residents. Based on observation, interview and record review of 2 (#805, #810) of 3 resident's the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that meet the needs of and were in accordance with the functional capacity screen and negotiated service agreement related to the identification of risk and development of impaired skin integrity. For resident #805 who wore oxygen continuous and glasses and slept in his/her recliner the licensed nurse failed to identify the residents risk for impaired skin integrity and when the resident developed pressure ulcers, failed to implement	S3155		

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

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measures for ongoing monitoring and interventions to promote healing and reduce the risk of further worsening or development of additional pressure ulcers.

Findings included:

- Review of resident #805's medical record revealed the resident admitted to the facility on 6-20-19 with diagnoses of heart failure, hypertension, edema and insomnia.

Review of the resident's functional capacity screen dated 6-20-19 revealed the resident required physical assistance with bathing, dressing, toileting, and supervision with eating. The resident also had frequent bladder incontinence and could not manage his/her medications or medical treatments. The screening identified the resident as cognitively intact.

Review of the negotiated service agreement/health care service plan (NSA/HCSP) dated 6-20-19 revealed the facility staff would provide assistance of 1 staff with bathing twice a week, dressing and help with toileting every 3 hours. Facility staff would also administer all medications and medical treatments. It identified that staff would monitor for skin changes with bathing and notify the nurse as appropriate. The facility staff would monitor skin during toileting and notify nurse of any changes. It identified the resident slept in a recliner, needed to elevate his/her legs related to edema and wore compression stockings.

Licensed nursing staff failed to review and revise the NSA/HCSP to identify the resident's risk for pressure ulcers, direct staff regarding the use of

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foam protective covers for oxygen tubing, and any additional interventions to promote healing and prevent further development of pressure ulcers.

Review of the physical evaluation dated 6-21-19 signed by licensed nursing staff A revealed the resident had "chaffing to the crevice between upper buttocks."

Review of the nurse's notes revealed the following:
7-17-19 -The resident complained of right ear hurting and observed an open area on top of the right ear ...padded with gauze and called the oxygen company for ear protectors ...Signed by licensed nursing staff B
8-1-19 - The resident is incontinent and sits in his/her recliner frequently. He/she is at risk for skin breakdown, preventative barrier cream applied. Signed by licensed nursing staff G

Review of the wound evaluation forms revealed the following:
7-17-19 Licensed nursing staff B documented: The resident complained of his/her right ear hurting and observed a small laceration to the top of the resident's right ear where his/her oxygen tubing sits. Resident had no ear protectors on the tubing at the time. Operator/licensed nursing staff C assisted to clean the area and place clean gauze padding to the ear to prevent further pain or rubbing. Nurse B notified the oxygen company and ordered ear protectors to be delivered. The wound measured 0.8 X 0.1 X 0 centimeters (cm).
7-24-19 licensed nursing staff B documented the same measurements with the difference being the surrounding tissue was light pink with a scab forming to the anterior side of wound.

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The record lacked additional wound evaluations of the resident's ears or buttocks.

Review of the physician's orders dated 8-1-19 directed staff to liberally apply barrier cream to buttocks twice a day and as needed, and notify nurse if area opens.

Observation on 8-5-19 at 1:03 PM with operator/licensed nursing staff C and licensed nursing staff B of the resident's pressure ulcers on his/her ears and on his/her buttocks revealed the right ear had an open area on the top with exposed areas of white that appeared to be cartilage. Licensed nursing staff B confirmed it was cartilage. The resident also had a red area further down on the back of the right ear. The left ear had a red divot area that was not open and a red area on the back of his/her ear. Licensed nursing staff B reported he/she had not seen the resident's bottom. When staff pulled the residents incontinent product down in the back it revealed 2 open areas on each buttock where the buttock cheeks come together. Licensed nursing staff B offered to give the resident a pillow to put under his/her bottom to help relieve the pressure and the resident did not respond.

During an interview on 8-6-19 at 10:50 AM operator/licensed nursing staff C reported he/she had spoken with the resident and family using a specialty bed that would allow the resident to adjust his/her head and feet but when the resident moved in he/she refused to use the bed and wanted to sleep in his/her recliner.

Observation on 8-5-10 at 2:01 PM with licensed nursing staff B and certified staff D revealed the resident's family had brought in a chair cushion that was foam and had lamb's wool on the top of

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it. Licensed nursing staff B and certified staff D proceeded to ask the resident to stand so they could check his/her bottom. The area now was covered with barrier cream which certified staff D reported he/she had applied. Licensed nursing staff B stated the darkened area around the edges was a scab as he/she cleaned off the barrier cream with alcohol pad. Staff cleaned the pressure ulcer with wound cleanser. The open area of the wound measured 1.5 X 1.2, without a measurement for depth. Licensed nursing staff B then covered with foam dressing and tape. Staff B then looked at the resident's right ear and confirmed he/she could see 3 white areas that appeared to be cartilage. Licensed nursing staff B reported the pressure ulcer started as a small cut and the tubing just rubbed on it making it worse. The pressure ulcer measured 1.2cm X .2 cm X .2 cm.

During an interview/observation with the resident on 8-5-19 at 11:30 AM the resident sat in his/her recliner with both feet touching the floor. The resident had his/her oxygen on with tubing over both ears without protective foam around the tubing. The resident stated that staff sometimes put a pad on the tubing and stated they hurt, especially the right one. The resident stated he did have a sore on his/her buttock and staff put a cream on it when he/she asked them to.

During an interview on 8-5-19 at 9:30 AM certified staff D reported resident #805 was at risk for pressure ulcers because he/she slept in the recliner and staff encourage him/her to get up to meals and things. Certified staff D stated staff kept a close eye on the skin of a resident at risk for pressure ulcers. Staff check resident's skin with bathing and toileting. If the staff see something, they let the nurse on call know and

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the nurse will decide what to do at that time.

During an interview on 8-5-19 at 9:50 AM certified staff E reported staff just watched their skin when providing cares. Staff E stated he/she thought resident #805 had some open spots on his/her bottom.

During an interview on 8-6-19 at 9:00 AM certified staff H reported the resident had slept in his/her recliner and had oxygen on all the time since admission. The resident needed staff assistance getting dressed and taking to the toilet. The resident also sat a lot and only got out of the recliner for meals and to use the bathroom. Certified staff H stated he/she knew the resident needed to wear something on the oxygen tubing because he/she had sores on his/her ears.

During an interview on 8-5-19 at 10:00 AM operator/licensed nursing staff C confirmed resident #805 currently had a pressure ulcer. Staff C knew the resident had an area on his/her coccyx but did not think it had ever opened and the resident also developed a superficial area on his/her ear from the oxygen tubing and staff put foam pads on the tubing and it is better now.

During an interview on 8-5-19 at 12:18 PM operator/ licensed nursing staff C reported if a resident developed a new concern and needed new interventions for care an addendum to the current NSA/HCSP would be completed.

During an interview on 8-5-19 at 12:55 PM operator/licensed nursing staff C reported non-ambulatory residents, residents that were incontinent and slept in recliners are residents at risk for pressure ulcers. The licensed nurse needed to complete a Braden Pressure Ulcer risk

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S3155	Continued From page 6 Assessment for residents that are at risk and the licensed nurse then put interventions in place and those interventions would be found in the NSA/HCSP. During an interview on 8-5-19 at 12:43 PM certified staff F reported staff usually checked resident's skin for any changes, any complaints of pain and make sure the residents are turned, not sitting in the same place or have their heels in the same place for "X" amount of time. Certified staff F reported he/she knew there were some gray pads for the residents tubing but the resident might take them off sometimes. There is also a cream that staff put on his/her bottom when taking him/her to the bathroom. Staff F reported the foam pads or other interventions would be in the resident's care plan. During an interview on 8-5-19 at 12:55 PM Operator/ licensed nursing staff C reported licensed nursing staff B had been coming in and doing the skin assessments. Operator/licensed nursing staff C reported a nurse left in the middle of July and they are starting from scratch with assessments. Licensed nursing staff C stated the resident was supposed to have on the foam ear protectors. During an interview on 8-5-19 at 2:53 PM the resident's family member reported today was the first time the staff had mentioned a cushion for the resident's recliner. The family member stated he/she had thought about bringing it up over the weekend because he/she knew he had a sore on his bottom. Review of the policy dated 12-2016 revealed residents identified to be at risk for impaired skin integrity will have interventions implemented for	S3155		

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S3155	Continued From page 7 repositioning needs and will be reflected on the care plan. The operator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of the resident who was at risk for skin impairment. The licensed nurse failed to identify the resident's risks for skin breakdown and implement measures to reduce the risk of skin breakdown. When the resident developed pressure wounds, the licensed nurse further failed to implement interventions to address resident's actual skin impairment in the negotiated service plan/health care service plan.	S3155		