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F 000	INITIAL COMMENTS The following citation represents the findings of complaint investigation #128939.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility census totaled 39 residents with 3 residents sampled for skin conditions not related to pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, interview, and record review, the facility failed to perform and document on-going assessments which included a description of the wound bed, type of wound, length and width of wound, and description of the wound margins for 3 of 3 residents reviewed. (#1, #2, and #3) The assessment would be utilized to monitor for wound healing or the need to modify the treatment plan. Findings included: - Resident #2's pertinent diagnoses from the Physician's Order Sheet dated 1/8/18 included edema (swelling resulting from an excessive	F 684		

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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accumulation of fluid in the body tissues).

Review of the quarterly minimum data set (MDS), dated 11/19/17, revealed the resident had moderately impaired daily decision-making skills. He/she had no documented wound except for 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) and did receive application of ointments to areas of his/her body other than his/her feet.

Review of the annual MDS dated 2/17/18 revealed no change from the prior assessment.

Review of the cognitive loss care area assessment (CAA), dated 2/22/18, revealed the resident had confusion but could make his/her wants/needs known. He/she could use the call light to request staff assistance. Resident #2 did recall staff names, location of his/her room, and some other resident names. He/she required reminders regarding the facility schedule.

Review of the pressure ulcer CAA, dated 2/22/18, revealed the resident used a wheelchair for locomotion and ambulated short distances with staff assistance and walker. He/she spent most of his/her time in a wheelchair and/or recliner, but could make position changes. He/she had edema with discoloration to both lower legs and was recently on antibiotic therapy for methicillin-resistant staphylococcus aureus (MRSA - a type of bacteria resistant to many antibiotics). He/she had bumped his/her leg causing a bruise and a large blood blister. He/she had an appointment scheduled with the wound clinic on 3/12/18.

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The resident's care plan, last revised 9/15/17, revealed the resident was at high risk for impaired skin integrity. He/she had frequent reoccurring cellulitis (skin infection caused by bacteria characterized by heat, redness and swelling) to both lower extremities. Staff were to perform skin audits weekly and as needed, while encouraging the resident to turn and reposition frequently and as needed (PRN).

Review of a nursing note, dated 2/16/18, revealed staff assisted the resident with a transfer from the toilet to his/her wheelchair and the resident lost his/her balance. Staff provided support for the resident to complete the transfer safely. During that time, the resident struck his/her right shin on the wheelchair causing a large purplish, raised bruise. The facility staff elevated the leg and applied ice to the area.

There was a physician order, dated 2/16/18, for staff to start the resident on an oral antibiotic and to apply dressings to the right lower leg daily and PRN after cleansing.

A nurse's note dated 2/16/18 revealed the antibiotic was started for the raised area on the right lower leg which was approximately 5 centimeters (cm) and described as a raised bruise which was the length and width of the lower leg from knee to ankle, filled with fluid and was bleeding. The wound was covered and wrapped per the physician's orders.

On 2/19/18, physician B ordered staff to change the resident's oral antibiotics based on a wound culture report indicating the wound contained a large amount of MRSA. Staff were to continue

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with the same daily dressing changes.

A nurse's note, dated 2/21/18, revealed the resident continued antibiotic therapy for the infection in his/her skin. He/she continued to have large amount of drainage from both legs.

Review of a physician's progress note, dated 2/22/18, revealed the resident developed MRSA in his/her leg. The resident had drainage to both legs and the left leg was about to open into a wound.

Review of a nurse's note, dated 2/26/18, revealed the resident continued antibiotics for MRSA to the right lower leg. He/she had bloody, foul, drainage which soaked through his/her dressings. Staff changed the dressings and documented they would continue to monitor.

The weekly skin assessment, dated 2/27/18, revealed the facility continued to monitor the resident's right lower leg and documented a dark, bloody, hard area to the right lower leg. There was no further documentation regarding the size of the area, how the wound bed appeared, the wound edges, or drainage.

Review of a wound report note, dated 3/1/18, revealed there was an unmeasurable wound to the resident's right lower leg. It was described as a blood clot and skin with a large amount of drainage.

On 3/1/18, physician B ordered the facility to obtain the resident an appointment at a wound clinic.

Review of a nurse's note, dated 3/3/18, revealed

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the resident continued antibiotics for the treatment of MRSA. The wound to the right calf was very large and necrotic (dead tissue) with flesh that was open and/or cracking on the medial (towards the center of the body) side of the necrotic area on the anterior (towards the front of the body) side.

On 3/4/18, a nurse note stated the wound started to smell "foul" and an order from the physician was obtained to change the type of dressing materials being utilized and a continuation of the oral antibiotic for another 10 days.

Review of the wound report, dated 3/8/18, revealed the resident's right lower leg had a hard, black area which measured 10.2 x 14 (measurement units not documented) with splitting around the wound bed. The licensed nurse described the wound as dark grey with a foul odor.

The resident was seen at a wound clinic on 3/12/18 and admitted to the hospital from the wound clinic due to the wound. Review of the wound clinic documentation, dated 3/12/18, revealed the wound to the right lower leg measured 14.3 cm x 8.5 cm x 0.9 cm, and was a full thickness (extending into the subcutaneous tissue or beyond) wound, was between 51-75% eschar (dead tissue) and 1-25% granulation (tissue formed during wound healing) tissue. During the resident's admission to the hospital, the resident's family elected comfort care for the resident instead of surgical intervention for the wound.

Interview with direct care staff D on 4/30/18 at 9:25 AM revealed the resident's leg initially

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appeared to be a blood blister and then started getting worse. He/she did not know what the wound appeared like prior to the resident being admitted to the hospital since the licensed nursing staff performed the dressing changes.

Interview with direct care staff F on 4/30/18 at 2:58 PM revealed he/she remembered the resident had MRSA to his/her leg, but he/she did not remember the wound itself since the licensed nursing staff performed the dressing changes.

Interview with licensed nurse C on 4/30/18 at 9:35 AM revealed he/she knew the resident had a wound on his/her other leg and when the licensed nursing staff was requesting the physician to look at the wound, staff C was shown the right lower leg and then had the physician come over to look at the wound. He/she did not know what date that occurred. Staff C reported the facility attempted to get the resident into a wound clinic, but were having difficulties getting an appointment. He/she stated the earliest they could get the resident into the wound clinic was on 3/12/18.

During an interview with administrative nursing staff E on 5/1/18 at 12:30 PM, he/she stated the facility administrative staff had identified the documentation of the wound assessments needed to be improved and new procedures and forms had been implemented since his/her arrival 2 weeks prior. He/she reported that he/she was not with the facility and could not explain why a detailed nursing wound assessment had not been completed.

Interview with physician B on 5/1/18 at 9:27 AM revealed the facility's nursing staff had updated him/her about the resident's wound quite often.

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He/she stated the wound initially started as a hematoma (bruise) and progressed very rapidly from the inside out. He/she had seen the wound just a week prior to the resident being admitted and it was not as bad as listed at the wound clinic. Physician B reported the licensed nursing staff at the facility have been very good about assessing wounds and notifying him/her of any changes in the way the wound appeared.

Review of the policy entitled Significant Skin Injury, approved 4/27/18, revealed the facility would closely monitor the skin conditions and identifying the physician if the condition became significant and that all injuries would be monitored routinely until resolved. Significant condition was defined as when there was an indication for the need for treatment.

The facility failed to ensure a comprehensive nursing assessment of resident #2's wound to the right lower leg which included measurements, description of the wound bed, description of the wound margins, type of wound, and drainage.

- Resident #3's pertinent diagnoses from the Physician's Order Sheet dated 1/31/18 included cellulitis (skin infection caused by bacteria characterized by heat, redness and swelling) and edema (swelling resulting from an excessive accumulation of fluid in the body tissues).

Review of the admission minimum data set (MDS) dated 1/25/18 revealed a brief interview for mental status (BIMS) score of 14, indicating no cognitive impairment. He/she was at risk for the development of pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or

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pressure in combination with shear and/or friction) but he/she did not have any pressure ulcers or other wounds except for 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).

Review of the pressure ulcer care area assessment (CAA) dated 1/25/18 revealed the resident had a decline in his/her mobility and used a wheelchair for locomotion throughout the facility. The resident did not make much effort during transfers and preferred to stay in bed. He/she had lymphedema (swelling caused by accumulation of lymph) to lower legs and wore leg wraps daily. He/she had excoriation (injury to the skin) in his/her abdominal area.

Review of the activities of daily living (ADL) CAA dated 1/25/18 revealed the resident had a decline in his/her status which led to him/her admitting to the facility to participate in the therapy program to increase strength and endurance so he/she could return home with his/her family.

Review of the resident's undated care plan revealed no interventions related to skin integrity.

Review of a weekly skin assessment, dated 2/2/18, did not identify any open areas on the resident's body.

The physician wrote an order on 2/6/18 for the staff to apply kerlix (rolled gauze) dressings to both resident's legs twice daily for edema and to then apply ACE wraps in the AM and remove the ACE wraps in the PM.

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Review of the weekly skin assessment, dated 2/6/18, revealed there was an open area to the resident's left calf. The facility staff documented it might have been potential pinching from the ACE wraps. There was no further documentation regarding the size of the area, how the wound bed appeared, the wound edges, or drainage.

Review of the physician progress note dated 2/8/18 revealed the resident was seen for increased edema. The resident's skin was warm, dry, with edema present. There was no documentation of any wounds or dressing orders for a wound.

Review of the wound report, dated 2/9/18, revealed the resident had a wound measuring 1.3 centimeters (cm) x 2.5 cm to the back of his/her left leg with clear drainage. There was no further description of the wound.

On 2/9/18, an order was obtained from the physician for staff to apply a Vaseline covered gauze type dressing to both lower extremities and then to cover with absorbent dressings. Staff were to change the dressings two times daily.

Review of the wound report dated 2/15/18 revealed the resident had 3 "slits" on the back of his/her left calf. One measured 0.2 cm x 5.5 cm, the 2nd measured 0.2 cm x 6 cm, and the 3rd measured 0.2 cm x 4 cm. All had drainage and bleeding was present.

Review of the wound report dated 2/22/18 listed one wound measuring 0.2 cm x 7 cm with no drainage.

The physician progress note dated 2/22/18

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revealed the resident had increased drainage from both legs, but overall there was less edema present.

The resident admitted to a hospital on 2/25/18 and returned to the facility on 3/6/18 for an unrelated condition.

Review of the licensed nurse's assessment, dated 3/6/18, revealed upon his/her return to the facility, the resident had a small split, approximately 3 cm in length, to the left inner calf. His/her lower legs were dark, leathery, thick skinned, and desensitized to touch.

Review of a nursing note dated 3/11/18 revealed the licensed nursing staff changed the dressings to the lower legs as ordered and the tissue continued to be leather-like and wrinkly. There was no further documentation regarding the size of the wound, how the wound bed appeared, the wound edges, or drainage.

A nursing note dated 3/13/18 revealed the left calf wound was almost healed. There were not any comprehensive nursing wound assessments since the resident's return from the hospital.

The resident discharged home with hospice care on 3/16/18.

Interview with direct care staff D on 4/30/18 at 9:25 AM revealed the resident's legs were very swollen and discolored. He/she did not get to see the resident's wounds since they were always wrapped and the licensed nursing staff provided the dressing changes.

Interview with direct care staff F on 4/30/18 at

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2:58 PM revealed he/she remembered the resident had a large amount of drainage from his/her legs and the licensed nursing staff would have to change the dressings several times during the day. He/she did not remember how the wounds looked since the licensed nursing staff performed all the wound care.

Interview with licensed nursing staff C on 4/30/18 at 9:30 AM revealed he/she was in a different position while the resident was in the facility and all he/she recalled about the resident's legs was they were very large, swollen, and wrapped whenever he/she provided care to the resident.

During an interview with administrative nursing staff E on 5/1/18 at 12:30 PM, he/she stated the facility administrative staff had identified the documentation of the wound assessments needed to be improved and new procedures and forms were implemented 2 weeks prior to his/her arrival. He/she reported he/she was not with the facility and could not explain why a detailed nursing wound assessment had not been completed.

Interview with physician B on 5/1/18 at 9:27 AM revealed the resident's wounds were related to his/her edema.

Review of the policy entitled Significant Skin Injury, approved 4/27/18, revealed the facility would closely monitor the skin conditions and identifying the physician if the condition became significant and that all injuries would be monitored routinely until resolved. Significant condition was defined as when there was an indication for the need for treatment.

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The facility failed to ensure a comprehensive nursing assessment of resident #3's wounds to the left lower leg which included measurements, description of the wound bed, description of the wound margins, type of wound, and drainage. This would allow for monitoring of the wound for improvements, declines, and/or if treatments/interventions needed to be adjusted.

- Resident #1's pertinent diagnoses from the physician's progress note dated 3/6/18 included dementia (progressive mental disorder characterized by failing memory, confusion).

Review of the admission minimum data set (MDS) dated 12/13/17 revealed he/she had severely impaired daily decision-making skills. He/she was not at risk for developing pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction) and did not currently have any wounds.

Review of the significant change MDS dated 4/17/18 revealed a brief interview for mental status (BIMS) score of 0, indicating severe cognitive impairment. He/she was at risk for the development of pressure ulcers and did not have any current wounds.

Review of the pressure ulcer care area assessment (CAA) dated 12/13/17 revealed the resident had episodes of incontinence related to dementia but could make position changes.

Review of the cognitive loss CAA dated 12/13/17 revealed the resident did not know the time, place, and situation. He/she did know his/her own

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name and recognized his/her family for the most part. He/she required cues and prompting and had a history of agitation during cares.

Review of the resident's care plan, revised 4/9/18, instructed staff to notify an administrative nurse and the physician of any red, discolored, or broken skin. Staff were to notify the physician and family of the progress of the resident's wound and perform skin audits weekly.

Review of a physician order, dated 2/22/18, revealed an order from the physician for a wound culture to the resident's right lower extremity inner ankle.

Review of the wound culture results dated 2/25/18, revealed the resident had methicillin-resistant staphylococcus aureus (MRSA - a type of bacteria resistant to many antibiotics) and the physician wrote to start the resident on an oral antibiotic to treat the infection.

A nurse's note dated 3/1/18 revealed the resident continued oral antibiotics for MRSA to the leg and the wound was covered and dry. There is no documentation as to when the wound developed. The last documentation was of a bruise.

Review of a nurse note dated 3/10/18 revealed the wound on the left leg continued to drain clear fluid and was less swollen. There was no description of the wound.

Review of a nursing note dated 3/31/18 revealed the resident had a 3 centimeters (cm) x 2 cm skin tear to the left shin with no further description or assessment of the wound.

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Review of the weekly skin assessment dated 4/5/18 revealed the resident had a skin tear to his/her right lower leg measuring 3 x 2.2 (undocumented measurement unit) and the wound bed was pink with red skin rolled. Staff were unable to approximate the skin.

Review of the wound report dated 4/5/18 revealed the resident had a skin tear to his/her right lower leg 3 x 2.2 (undocumented unit of measure). The wound bed was pink and red skin rolled and staff could not approximate (make the edges come together) the skin.

Review of the weekly skin assessment dated 4/12/18 revealed the resident had an old skin tear to the right lower leg which measured 3 x 2.8 (undocumented unit of measurement) with a pink wound bed and dark drainage.

Review of a clarification document provided by the facility on 5/3/18 revealed the resident had the following skin issues:
2/16/18- skin tear to the right inner ankle
2/20/18- small laceration to the back of the head
2/22/18- bruise to the inner left leg above the ankle. Wound culture done on right lower extremity.
4/5/18- skin tear to the right lower leg
4/12/18- pressure ulcers to both heels

Review of a nurse's note dated 4/15/18 revealed the resident obtained a half moon shaped skin tear to the left lower leg measuring 3 cm x 2 cm while transferring from bed to wheelchair.

A nurse's note dated 4/26/18 revealed wound rounds were completed with the wound nurse and the skin tears to the right shin were healing well

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	C 05/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY	445 N WESTVIEW DR DERBY, KS 67037

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and new orders obtained to apply skin prep (a solution when applied that forms a protective waterproof barrier on the skin) to all skin tears and leave open to air.

Observation on 4/30/18 at 4:19 PM revealed the resident lay in bed. Licensed nursing staff G lifted the resident's blanket over his/her legs showing 2 distinct wounds to the right lower leg. Both wounds were on the left anterior (towards the front) shin with the proximal (closest to the head) approximately 2.5 cm x 3 cm with eschar (dead tissue) to approximately 3% of the wound bed and the remainder of the wound bed approximately 30% epithelization (new tissue) and 67% granular (budding healing tissue). The distal (farthest from the head) wound with steri-strips in place and approximately 3 cm x 3 cm with the wound bed unable to be visualized due to the steri-strips. There were no dressings present to either wound. There were no wounds visualized on the left leg.

Interview with direct care staff D on 4/30/18 at 9:25 AM revealed he/she did not know how the resident obtained the skin tears to the left calf and nursing staff changed all the dressings.

Interview with direct care staff H on 4/30/18 at 3:04 PM revealed the resident's feet were really swollen and he/she made sure the resident's legs were elevated and pressure reduction boots were on while he/she lay in bed. He/she stated the nurses changed all the dressings and cleansed and wrapped the resident's legs daily for the skin tears.

Interview with licensed nursing staff C on 4/30/18 at 9:30 AM revealed the resident was declining

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and was on hospice care. He/she did not know how the resident obtained the wounds but believed they were from the foot pedals on the resident's wheelchair.

During an interview with administrative nursing staff E on 5/1/18 at 12:30 PM, he/she stated the facility administrative staff had identified the documentation of the wound assessments needed to be improved and new procedures and forms were implemented 2 weeks prior to his/her arrival. He/she reported he/she was not with the facility and could not explain why a detailed nursing wound assessment had not been completed. He/she had identified the discrepancies as to how the facility staff were documenting right and left.

Review of the policy entitled Significant Skin Injury, approved 4/27/18, revealed the facility would closely monitor the skin conditions and identifying the physician if the conditions became significant and that all injuries would be monitored routinely until resolved. Significant condition was defined as when there was an indication for the need for treatment.

The facility failed to ensure comprehensive on-going nursing assessments of resident #1's wounds to include measurements, description of the wound bed, description of the wound margins, type of wound, and drainage in order to ensure the resident received appropriate wound treatment with any changes in the wounds.