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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00120227	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 157		

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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(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 46 residents. Three residents were reviewed for pressure ulcers (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). Based on observation, interview and record review the facility failed to promptly notify the physician when 1 of 3 residents developed a reddened area to his/her left inner foot on 7/19/17 and the facility did not notify the physician until 7/28/17. (#3)

Findings included:

- Review of resident #3's quarterly minimum data set (MDS) dated 6/15/17 revealed a brief interview for mental status (BIMS) score of 15, indicating intact cognition. The resident required extensive assistance of 1 staff for bed mobility, transfers and dressing, toilet use and personal hygiene. The resident had impaired range of motion (ROM) to lower extremities on both sides and used a wheelchair for mobility. The resident

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had a risk of pressure ulcers (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) and no unhealed pressure ulcers.

Review of the significant change MDS dated 8/2/17 revealed a BIMS score of 14, which indicated intact cognition. The resident continued to require extensive assistance of 1 staff for bed mobility, transfers, locomotion, and toilet use. The resident had impaired ROM in both upper and lower extremities and used a wheelchair for mobility. The resident had a risk of pressure ulcers and had 1 or more unhealed pressure ulcers, stage 1 or higher. The resident had 1 unstageable (slough and/or eschar), 1 unstageable (deep tissue injury-purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of the underlying soft tissue from pressure and/or sheer) that measured 1 centimeter (cm) x 1 cm and had no epithelial (new skin growing in a superficial wound), granulation (tissue formed during wound healing), slough (dead tissue, usually cream or yellow in color), or eschar (dead tissue). The treatments included a pressure reducing device for the chair, pressure ulcer care, and application of dressings to his/her feet.

Review of the resident's care area assessments (CAAs) dated 8/11/17 revealed:
Pressure Ulcer: The resident had unstageable wounds, 1 to the left heel and 1 to the left lateral ankle. The resident explained that he/she tried blue foam boots during sleep and did not like them, so he/she did not wear them and he/she had a new pair of shoes. The resident received wound care per facility guidelines.

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The resident's care plan reviewed on 8/14/17 revealed the following interventions:
7/13/17: staff were to monitor the bony prominence to the resident's left inner foot and notify the charge nurse of redness or pain.
7/26/17: suspected deep tissue injury to the left foot inner aspect- staff were to monitor daily, ensure the resident wore ankle boots when in bed or the recliner and apply slip on shoes only with Kerrafoam (absorbent dressing pad) dressing on the resident's left foot inner aspect and left heel.

Review of the wound notes for the resident's left inner foot revealed the following:
7/19/17: Left Inner Foot: 0.4 cm x 0.5 cm x 0 cm the resident stated the bony area at inner arch of left foot bothered him/her. Upon inspection noted small red area which measured 0.4 cm x 0. 5 cm. Preventative dressing applied. Kerrafoam put in place at the time as preventative.
7/21/17: 0.4 cm x 0.5 cm x 0 cm
7/24/17: 0.4 cm x 0.5 cm x 0 cm
7/26/17: 1.0 cm x 1.0 cm x 0 cm. The resident stated his/her bony area at the inner arch of his/her left foot bothered him/her. Dark red, non-blanching area noted with persistent skin redness and surrounding skin red tender to touch.

Review of the treatment administration record (TAR) dated 7/15/17 - 8/14/17 revealed on 7/19/17 staff initiated checking the resident's left inner foot area daily and applied a preventative Kerafoam dressing and changing the dressing every 3-7 days. On 7/26/17 staff initiated checking the resident's left inner heel, applying Kerrafoam dressing and changing the dressing every 3-7 days.

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Physician orders lacked staff notification of these wounds and/or staff request for orders for treatment interventions for the wounds between 7/19/17 and 7/28/17.

Review of the signed physician order summary dated 7/26/17 revealed no supplements or pressure ulcer care ordered. The summary included on 7/19/17 the resident's left inner bony area of the inner arch of the left foot was bothering him/her and upon inspection revealed a small red area which measured 0.4 cm by 0.5 cm.

Review of the fax communication orders dated 7/28/17 (9 days after staff discovered a wound on the resident's inner left foot) revealed the resident had two dark red areas to his/her inner left foot and no open areas. The resident believed it was due to ill-fitting shoes. Staff noted suspected deep tissue injuries and requested to start multivitamin daily and Arginaid twice a day for wound healing which the physician approved on 7/31/17.

Observation on 9/7/17 at 7:30 a.m. revealed direct care staff F entered the resident's room and assisted the resident to the side of the bed. The resident wore white socks only and wore no protective heel boots.

During an interview on 9/7/17 at 1:08 p.m. administrative nursing staff A reported the wounds on the resident's left inner foot and left inner heel were completely separate wounds. In early June the resident reported pain to his/her inner foot. Staff A completed wound care on July 5, 12, 19, 2017 and then discontinued the

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dressing licensed nursing staff G put on the resident's left inner bony prominence and left it open to air. On 7/26/17 licensed nursing staff B found a suspected deep tissue injury (SDTI). Staff B stated the resident had 2 wounds then and confirmed there was a gap between a 7/19/17 left inner heel red area observation and nutrition interventions added on 7/31/17. Staff A stated the nursing staff initiated protective heel boots as an intervention and needed to encourage the resident to wear his/her protective heel boots. Staff A confirmed staff failed to notify the physician until 7/28/17, after a second wound appeared on the resident's left inner heel on 7/26/17.

Attempts were made to contact the physician on 9/8/17 at 9:03 a.m., on 9/11/17 at 8:31 a.m., and again on 9/18/17 at 4:18 PM without success.

Review of the facility policy titled Notification Parameters - primary care providers (PCP), revised 01/2016, revealed licensed nursing staff have the responsibility of contacting a PCP any time a resident had developed a clinical problem requiring PCP intervention. The policy directed staff to attempt to notify the attending PCP, then the attending PCP's designated alternate, and finally the medical director, in that order. Regarding pressure ulcers the physician would be notified for any new stage II and any stage pressure ulcer when current treatment was not effective.

The facility failed to promptly notify the physician when resident #3 developed a reddened area to his/her left inner foot on 7/19/17 and the facility did not notify the physician until 7/28/17, when the resident had two areas of concern to his/her left

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F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (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 46 residents. Three residents were reviewed for pressure ulcers (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). Based on observation, interview and record review the facility failed to provide appropriate care and services to prevent the development of or promote healing of pressure ulcers for 2 of 3 sampled residents. The facility failed to ensure the staff implemented timely interventions in the prevention two pressure ulcers for resident #3; one unstageable 1 unstageable deep tissue injury (DTI- a purple or maroon localized area of	F 314		

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discolored intact skin or blood-filled blister due to damage of the underlying soft tissue from pressure and/or sheer) and one which developed into a stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer) pressure ulcer which required wound care at a local wound clinic for the resident. The facility also failed to ensure staff repositioned resident #2 every hour while up in his/her chair as care planned and resident #2 developed a red area to his/her left buttock.

Findings included:

- Review of the signed physician orders dated 7/26/17 revealed resident #3's diagnoses included dementia (progressive mental disorder characterized by failing memory, confusion), pain in left knee, localized edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and pain in the right knee.

Review of the quarterly minimum data set (MDS) dated 6/15/17 revealed a brief interview for mental status (BIMS) score of 15, indicating intact cognition. The resident required extensive assistance of 1 staff for bed mobility, transfers and dressing, toilet use and personal hygiene. The resident had impaired range of motion (ROM) to lower extremities on both sides and used a wheelchair for mobility. The resident had moderate pain frequently and received scheduled pain medications for 7 of 7 days of the observation period. The resident had a risk of pressure ulcers and no unhealed pressure ulcers.

Review of the significant change MDS dated 8/2/17 revealed a BIMS score of 14, which indicated intact cognition. The resident continued

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to require extensive assistance of 1 staff for bed mobility, transfers, locomotion, and toilet use. The resident had impaired range of motion in both upper and lower extremities and used a wheelchair for mobility. The resident reported no pain. The resident had a risk of pressure ulcers and had 1 or more unhealed pressure ulcers, stage 1 or higher. The MDS revealed he/she had 1 unstageable [slough (dead tissue, usually cream or yellow in color) and/or eschar (dead tissue)], and 1 unstageable deep tissue injury-(DTI-a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of the underlying soft tissue from pressure and/or sheer) that measured 1 centimeter (cm) x 1 cm and had no epithelial (new skin growing in a superficial wound), granulation (tissue formed during wound healing), slough (dead tissue, usually cream or yellow in color), or eschar (dead tissue). The treatments included pressure reducing device for chair, pressure ulcer care, and application of dressings to his/her feet.

Review of the resident's care area assessments (CAAs) dated 8/11/17 revealed:

Activities of daily living (ADL)/Functional Rehabilitation potential: Resident #3 had arthritis in both knees with pain, which weight bearing activity increased. The resident no longer walked and used a sit-to-stand mechanical lift (transferring device) only, for transfers. The resident required extensive assistance of 1 with ADLs. He/she called for assistance to the bathroom, on and off the toilet, transfers in/out of the bed or wheelchair, and to the recliner. The resident could reposition him/herself and had a positioning bar on his/her bed to help with

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independent bed mobility. The resident was alert and oriented, made his/her own decisions regarding his/her care and used a call light to summon help, as needed (PRN). The resident's arthritis hindered his/her ADL ability.

Pressure Ulcer: The resident had unstageable wounds, 1 to the left heel and 1 to the left ankle. The resident explained that he/she tried blue foam boots during sleep and did not like them, so he/she did not wear them and he/she had a new pair of shoes. The resident received wound care per facility guidelines.

Review of the Braden Skin Assessment (tool used to assess the skin for sensitivity, moisture, and other categories of the skin's health) Scores dated 10/3/16 revealed a score of 15 and on 7/28/17 a score of 17, both indicating low risk.

Review of the resident's care plan reviewed on 8/14/17 revealed the following interventions:

7/13/17: staff were to monitor prominence to the resident's left inner foot and notify the charge nurse of redness or pain
7/26/17: suspected deep tissue injury to the left foot inner aspect- staff were to monitor daily, ensure the resident wore ankle boots when in bed or the recliner and apply slip on shoes only with Kerrafoam (absorbent dressing pad) dressing on the resident's left foot inner aspect and left heel.
7/31/17: physician ordered a multivitamin every day and Arginaid (a nutrition supplement to help support the nutritional needs of individuals with wounds) twice a day for wound healing.

On 8/14/17 staff initiated a new problem and goal for wounds identified as unstageable in the

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resident's 8/11/17 care area assessment to his/her left foot and heel.
Interventions dated 8/14/17 directed staff to:
Assist to reposition every 2 hours in bed and 1 hour in chair and PRN
Ensure the dietician completed an assessment every month and PRN
Evaluate positioning to determine if the resident needed an assistive device
Educate the resident on the importance of repositioning and any assistive devices used to assist with repositioning. The resident did not like the foam booties when tried and kicked them off.
Prop the resident's feet on a pillow support as he/she allowed. Use slip-on shoes only.
Place a dressing to the ankle and heel per wound treatment orders.
Licensed wound care nurse (LWCN) to assess weekly and update interdisciplinary team (IDT), physician (MD) and implement new wound treatment orders PRN.
8/22/17: Omnicef (antibiotic medication) for 10 days, twice a day (BID) for left heel wound - discontinued (DCd) 8/29/17
8/23/17: Provide wound care via the outpatient clinic.
8/24/17: Alleviate all pressure from the left foot. Assist with pushing the resident in the wheelchair and do not let the resident use his/her legs to mobilize the wheelchair.
8/28/17: Vancomycin and Cefepime (both antibiotic medications) intravenous (IV- external catheter used to allow a fluid to flow directly into a vein) started for left heel wound "cellulitis" (skin infection caused by bacteria characterized by heat, redness and swelling).

Review of the signed physician order summary dated 7/26/17 revealed no supplements or

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pressure ulcer care ordered. The summary included on 7/19/17 the resident's left inner bony area of the inner arch of the left foot was bothering him/her and upon inspection revealed a small red area which measured 0.4 cm by 0.5 cm.

Review of the fax communication orders dated 7/28/17 (9 days after staff discovered a wound on the resident's inner left foot) revealed the resident had two dark red areas to his/her inner left foot and no open areas. The resident believed it was due to ill-fitting shoes. Staff noted suspected deep tissue injuries and requested to start multivitamin daily and Arginaid twice a day for wound healing which the physician approved on 7/31/17.

Review of the wound notes revealed the following:
7/19/17: Left Inner Foot: 0.4 cm x 0.5 cm x 0 cm the resident stated the bony area at inner arch of left foot bothered him/her. Upon inspection noted small red area which measured 0.4 cm x 0. 5 cm. Preventative dressing applied. Kerrafoam put in place at the time as preventative.
7/21/17: Left Inner Foot: 0.4 cm x 0.5 cm x 0 cm
7/24/17: Left Inner Foot: 0.4 cm x 0.5 cm x 0 cm
7/26/17: Left Inner Foot: 1.0 cm x 1.0 cm x 0 cm. The resident stated his/her bony area at the inner arch of his/her left foot bothered him/her. Dark red, non-blanching area noted with persistent skin redness and surrounding skin red tender to touch.
On 7/26/17 a suspected DTI (sDTI) was found on the resident's left inner heel that measured 3.0 cm x 2.0 cm x (blank). The wound had epithelial tissue without drainage and had no interventions listed.

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F 314	Continued From page 12 7/28/17: Left inner heel: staff documented measurements 0.0 cm x 0.0 cm x (blank) with blanchable redness noted. Red and tender to touch. Tissue type: necrotic/eschar. Treatment; daily monitoring. Covered with Kerrafoam dressing. (No interventions listed) On 7/28/17 staff initiated an intervention on the treatment administration record (TAR) for the resident to wear heel boots on both feet when he/she lay in his/her bed or recliner until his/her wound heeled however staff failed to document the resident wore his/her heel boots. On 7/31/17 the physician signed an order approving a multivitamin every day and Arginaid twice a day for wound healing. 8/2/17: Left Inner foot: 1 cm x 1 cm x 1 cm - circular maroon discoloration to bony prominence on left inner foot. Kerrafoam to prevent friction and shear was applied to the affected area. Suspected deep tissue injury (DTI-purple or maroon localized area of intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear). Interventions included a turning repositioning program and protein supplement implemented 7/31/17. 8/2/17: Left inner heel: staff documented measurements 0 cm x 0 cm x 0 cm with persistent skin redness. Type Pressure ulcer - Suspected Deep Tissue Injury to left inner heel. Staff described wounds to the resident's left inner heel as 3 spots measuring 0.3 cm x 0.4 cm, 0.2 cm x 0.2 cm, and 0.4 cm x 0.4 cm. Daily monitoring of wound, and covered with Kerrafoam dressing to prevent friction and shear. Interventions included a turning and repositioning program, protein supplement, multi-vitamin, and ulcer care. 8/7/17: Left Inner Foot: 1 cm x 1 cm x 0 cm: circular maroon discoloration to bony prominence	F 314		

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pressure ulcer with persistent skin redness. Kerrafoam to prevent friction and shear placed to the affected area. Interventions included: Pressure reducing chair, Turning repositioning program, multivitamin, protein supplement, and ulcer care.
8/9/17: Left Inner foot: 0.6 cm x 0.5 cm x 0 cm: No change from the prior note.
8/9/17: Left inner heel: 3 cm x 2 cm x (blank) :persistent redness, wound edge pink in color - tissue type epithelial; description: DTI to left inner heel; staff described wounds as 3 maroon spots that became one big wound measuring 3 cm x 2 cm. Daily monitoring of wound, covered with Kerrafoam dressing to prevent friction and shear. Interventions included: turning and repositioning program, multivitamin, protein supplement, and ulcer care
8/12/17: Left inner heel 3 cm x 2 cm x (blank) - No change from the prior note.
The wound notes lacked further documentation about the left inner foot wound and continued documentation about the left inner heel wound.
8/14/17: Left Inner foot 0.6 cm x 0.5 cm x 0 cm. No change from the prior note.
8/14/17: Left inner heel 3 cm x 2 cm x (blank) No change from the prior note.
8/16/17: Left inner heel 3 cm x 2 cm x (blank) persistent skin redness; tissue type epithelial. Dead epithelial tissue came off. 1.4 cm x 1 cm maroon area visible underneath. Daily monitoring of wound. Covered with Kerrafoam dressing to prevent friction and shear. DTI interventions included: turning and repositioning program, multivitamin, protein supplement, and ulcer care. The Arginaid was not administered BID as ordered on 8/18/17, 8/20/17.
8/21/17: Left inner heel 3 cm x 2 cm x (blank) No change from the prior note.

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F 314	Continued From page 14 8/23/17: Left inner heel 3 cm x 2 cm x (blank) No change from the prior note. Arginaid not administered BID on 8/23/17. 8/26/17: Left inner heel 3 cm x 2 cm x (blank) No change from the prior note. Arginaid not administered BID on 8/26/17. 8/28/17: 3 cm x 2 cm x (blank): The resident received outpatient wound clinic treatment. Medi-honey (medical-grade honey product for the management of wounds) applied to wound bed, covered with gauze and secured by coban. Persistent skin redness - tissue type epithelial. Interventions included: turning and repositioning program, multivitamin, protein supplement, and ulcer care. On 8/28/17 a PICC (peripherally inserted central catheter: a form of intravenous access that can be used for prolonged period of time) line was placed to administer Vancomycin 1 gram IV daily and Cefepime 2 grams IV daily for 7 days for leg cellulitis. 8/30/17: left inner heel 3 cm x 2 cm x (blank). No change from the prior note. 9/4/17: left inner heel 3 cm x 2 cm x (blank). No change from the prior note. (no change in size from 8/9/17- 9/4/17) Arginaid not administered BID on 9/1/17 and 9/3/17. Review of the treatment administration record (TAR) dated 7/15/17- 8/14/17 revealed on 7/19/17 staff initiated checking the resident's left inner foot area daily and applied a preventative Kerafoam dressing and changing the dressing every 3-7 days. On 7/26/17 staff initiated checking the resident's left inner heel, applying kerrafoam dressing and changing the dressing every 3-7 days. Physician orders lacked staff notification of these wounds and/or staff request for orders for treatment interventions for the wounds between 7/19/17 and 7/28/17.	F 314		

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Review of the nutrition assessment dated 8/14/17 revealed the dietician noted the resident received treatment to his/her left inner foot and received a multivitamin with minerals daily and Arginaid BID as recommended and ordered on 7/31/17.

Review of the medication administration record 8/15/17- 9/7/17 revealed staff failed to administer Arginaid 4.5 gram oral powder for wound healing 8 of 48 possible administrations (17%).

Review of a physician order dated 8/28/17 revealed to place a PICC line for Vancomycin 1 gram IV daily and Cefepime 2 grams IV daily for 7 days for leg cellulitis.

Review of the nurse's notes revealed the following:

8/5/17: The resident complained of pain in his/her left foot. Staff applied a preventative dressing and administered 50 mg Ultram (pain medication).
8/19/17: the resident complained of left heel pain. Staff found the wound moist with a necrotic area and foul odor noted and administered Tramadol (Ultram) 50 mg for pain.
8/24/17: The resident went to wound clinic outpatient therapy for wound care. His/her wound measured 1.8 cm x 1.6 cm and had 90% necrosis (localized tissue death that occurred in a group of cells in response to disease or injury).
8/25/17: The resident returned from his/her appointment. He/she had significant necrosis and staff needed to alleviate pressure to his/her left heel at all times.
8/28/17: The resident returned from the wound clinic after he/she had necrosis debridement (medical removal of dead, damaged, or infected

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tissue to improve the healing potential for the remaining healthy tissue).
8/28/17: Staff received a new order for Vancomycin 1 gm IV daily and Cefepime (an antibiotic) 2 gm IV daily for 7 days.
8/30/17: A wound dressing appointment noted the resident's wound had eschar present and softening.
9/3/17: The resident complained of left heel pain. His/her wound had a necrotic middle noted with serous drainage and wore protective boots.

Review of the Physician visits regarding the resident's wound revealed:
8/21/17: A necrotic area to the resident's left heel noted and the resident complained of pain to left foot at night; left heel ulcer, stage 2
8/24/17: Left heel stage 2 ulcer: evaluation performed size of wound 1.8 cm x 1.6 cm. 90% necrosis. Concern with surrounding area of heel very soft/tender.
8/25/17: Left heel pressure ulcer - re-evaluate. No significant change since yesterday. Necrosis still significant.
8/28/17: wound treatment progress notes: some mild debridement of necrosis. No changes in size.
8/30/17: no significant change to wound. Eschar still present but softening
9/1/17: removed dressing and noted minimal serous/bloody drainage with eschar very dry and unable to debride.

Observation on 9/7/17 at 7:30 a.m. revealed direct care staff F entered the resident's room and assisted the resident to the side of the bed. The resident had on white socks and did not have on foot protectors.

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Observation on 9/7/17 at 2:20 PM revealed the resident wore fur-lined house slippers and sat in a wheelchair. Licensed nursing staff C removed the resident's dressing secured with self-adherent wrap off the resident's left foot which revealed a wound approximately 2 cm x 1.5 cm with circular eschar and reddish pink healing granulation tissue around it, and a small amount of dry brownish, yellow drainage. Staff C cleansed the area with normal saline. The resident's left inner foot had an approximate 1 cm circumference area, which looked like a blood blister over his/her bony prominence. Staff C put a small square of petroleum gauze over the wound then wrapped it in a gauze bandage, then an elastic bandage, per the wound clinic instructions prior to the resident leaving for his/her wound clinic appointment.

During an interview on 9/7/17 at 7:30 AM resident #3 stated he/she did not know how or when he/she acquired a wound on his/her heel and did not know why he/she wore protective boots. The resident stated the staff just kept it wrapped up and he/she did not know why he/she did not wear protective boots last night.

During an interview on 9/6/17 at 4:43 PM direct care staff E said the resident had a pressure ulcer on his/her left foot. Staff E stated when the resident sat in a recliner, staff kept the resident's legs elevated and his/her boots on to ensure the resident's heels were not pressing against anything. Staff E stated the resident wore both boots, but sometimes did not like the boots because the resident had problems with his/her knees. Staff E stated he/she had not seen the pressure ulcer because when he/she worked, it was covered. Staff E said staff kept 2 pillows

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under the resident's legs, a small pillow between his/her knees and then put the resident's boots on. Staff E stated the staff had to do everything for the resident. The resident used a sit-to-stand mechanical lift for all transfers and the staff assisted the resident in the bathroom.

Interview with direct care staff F on 9/7/17 at 8:04 a.m. revealed the resident needed to wear heel boots when in bed and in his/her recliner and staff F did not know why the resident did not have them on the morning of 9/7/17. Staff F stated the resident may have refused to let staff put on heel boots that night.

During an interview on 9/6/17 at 3:03 p.m. licensed nursing staff H reported the resident just finished an antibiotic for a left heel infection. Staff H reported staff put boots on the resident to relieve pressure. Staff H reported the resident had just finished antibiotics. The resident received dressing changes at the wound clinic. Staff put boots on the resident to relieve pressure and did not think he/she wore them all the time. The resident could not stand and wanted staff to propel him/her to keep pressure off the feet. Staff H thought licensed nursing staff B discovered the pressure ulcer, but did not know when. Staff H reported the resident received wound care at the local wound clinic 3 times a week. Staff did see the wound once and it was black and the physician decided the resident needed to go to the wound clinic.

During an interview on 9/7/17 at 1:08 p.m. administrative nursing staff A reported the wounds were completely separate wounds. In early June the resident reported pain to his/her inner foot. Staff A completed wound care on July

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5, 12, and 19, 2017 and then discontinued the dressing. On 7/26/17 licensed nursing staff B found a suspected DTI. Staff B stated the resident had 2 wounds then and thought his/her shoes might have caused them then changed his/her mind and thought he/she hit it. Staff A confirmed there was a gap between a 7/19/17 left inner heel red area observation and nutrition interventions added on 7/31/17. Staff A stated the nursing staff initiated protective heel boots as an intervention and needed to encourage the resident to wear his/her protective heel boots. Staff A confirmed staff failed to notify the physician until 7/28/17 after a second wound appeared on the resident's left inner heel on 7/26/17. At 5:28 PM staff A. reported he/she expected staff to offer and administer Arginaid as ordered for the resident and did not administer it twice daily as ordered.

Attempts were made to contact the physician on 9/8/17 at 9:03 a.m., on 9/11/17 at 8:31 a.m., and again on 9/18/17 at 4:18 PM without success.

Review of the facility policy Skin Integrity: Nursing intervention and wound treatment guidelines for health care center revised 8/10/16 revealed to initiate and implement wound treatment orders when pressure ulcer wounds were acquired.

Review of the facility policy on Order Guidelines revised 01/2016, instructed the staff to sign off on the MAR after the administration of each drug to a resident if using the EMAR (electronic medication administration record - also used to document administration of nutritionl supplement Arginaid).

The facility failed to prevent resident #3 from

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developing two pressure ulcers while a resident in the facility; one unstageable DTI and one stage 2 pressure ulcer, and failed to implement timely and effective interventions to aid wound healing.

- Review of resident #2's signed physician orders dated 8/14/17 revealed the resident's diagnoses included congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), neuropathy (a result of damage to peripheral nerves, often causes weakness, numbness and pain), left heel infection, pain, and type II diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).

Review of the admission 5 day minimum data set (MDS) dated 8/20/17 revealed a brief interview for mental status (BIMS) score of 14, which indicated intact cognition. The resident required extensive assistance from 2 staff for bed mobility and transfers and extensive assistance from 1 staff for locomotion on the unit and dressing. The resident had impaired range of motion on both sides of his/her lower extremities and used a wheelchair for mobility. The resident had moderate pain frequently, received scheduled pain medication and had a risk of developing pressure ulcers (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). The resident had 1 or more unhealed pressure ulcers: 1 stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer) pressure ulcer present on admission with a tissue type of slough (dead tissue in the process of separating from the viable portions of the body and is usually light colored, soft, moist, and stringy). Skin and

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ulcer treatments included pressure reducing device for chair and bed, nutrition or hydration interventions, pressure ulcer care and application of ointments/medications other than to his/her feet.

Review of the resident's care area assessment (CAA) dated 8/26/17 revealed:

Activities of daily living (ADL)/Functional rehabilitation potential: The resident required extensive assistance with ADLs of 1 to 2 staff, used a sit-to-stand lift (assistive device used to transfer residents) for transfers, most often. The resident used a wheelchair only for mobility and the resident only slept in his/her recliner due to the need for comfort, related to a fracture in his/her pelvis and hip hardware in the resident's left hip.

Pressure Ulcer: The resident had a stage 2 pressure ulcer to the left lateral (outside) heel, present on admission, and admitted with cellulitis (skin infection caused by bacteria characterized by heat, redness and swelling) to upper left thigh. The resident received skilled nursing services to monitor improvement to infection and sepsis (a systemic reaction that develops when the chemicals in the immune system release into the blood stream to fight an infections which cause inflammation throughout the entire body instead. Severe cases of sepsis can lead to the medical emergency, septic shock). The resident had a preventative dressing to the coccyx/left buttock and used a gel cushions to his/her wheelchair and recliner, and a low air loss mattress (LAL) mattress on his/her bed. Staff were to assist with turning and repositioning the resident as he/she allowed. The resident wore foam heel boots to

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the left foot, staff offloaded heels at all times and ensured the resident did not wear shoes.

Review of the Braden Skin assessment from admission dated 8/13/17, revealed a score of 16 indicating low risk.

Review of the resident's care plan dated 8/26/17 revealed the following:
8/16/17: Remind/Assist the resident to reposition every 2 hours while in bed and every 1 hour while in his/her chair and as needed (PRN).

Review of the left heel wound charting revealed:

8/13/17: pressure ulcer stage 2 to the lateral aspect of the resident's left heel measured 1.6 centimeters (cm) x 1.2 cm x 0.3 cm, with a red and bloody wound bed. Interventions included: turning and repositioning program, pressure reducing chair, nutrition/hydration, multivitamin, zinc, ulcer care, dressing with or without topical medications, and protective skincare. Staff noted no other skin issues.

8/14/17: pressure ulcer stage 2 to the lateral aspect of the resident's left heel measured 1.6 cm x 1.3 cm x 0.2 cm, with a pink and moist wound bed and yellowish epithelial (thin tissue forming the outer layer of a body's surface) tissue noted to the wound edges. Interventions included turning and repositioning program, pressure reducing chair, ulcer care, dressing with or without topical medications, and preventative protective skincare. Staff noted no other skin issues.

8/16/17: pressure ulcer stage 2 to the lateral aspect of the resident's left heel measured 1.6

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centimeters (cm) x 1.2 cm x 0.2 cm, with a pink and moist wound bed, and thick macerated, yellowish epithelial tissue noted to wound edges. The surrounding skin remained clean, dry, intact and pink in color. No change from the prior interventions. Staff noted no other skin issues.

Review of the left buttock wound charting revealed the following:

8/24/17: The resident had a blanchable (to press on a person's skin to push blood away and wait for return to determine blood circulation) red spot to his/her left buttock which was not-painful and had no signs of swelling or heat. The area measured 2 cm x 2 cm. Interventions included a turning and repositioning program, pressure reducing chair, pressure reducing bed, nutrition hydration intervention, nutrition shakes, nutrition protein supplement, nutrition multi-vitamin, and zinc.

8/31/17: the resident had a blanchable red spot to his/her left buttock which was not painful and had no signs of swelling or heat, and measured 2 cm x 2 cm. Interventions included no change from the prior interventions.

Observation on 9/7/17 at 7:05 a.m. revealed the resident sat in his/her overstuffed chair asleep with the footrest elevated. No change in the residents' position at 7:15 a.m., 7:30 a.m., 7:45 a.m. or at 8:00 a.m. At 8:16 a.m. observation revealed the resident sat in his/her overstuffed chair awake with staff in the room talking to the resident and family member entered the room, in the same position. At 8:20 a.m. the resident remained in the same position. At 8:32 a.m. licensed nursing staff C and the resident's family

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member were in the resident's room and the resident remained in the same position. At 9:00 a.m. the resident remained in the same position. No change in the resident's position at 9:15 a.m. At 9:26 a.m. (after the resident sat 2 hours and 21 minutes in the same position) therapy staff I transferred the resident from his/her wheelchair to a standing position in the bathroom. Licensed nursing staff J removed a large sacral occlusive dressing affixed over the resident's coccyx area to reveal a reddened area approximately 2 cm on his/her left buttock that had intact skin, no drainage, and the dressing did not cover it. Staff J reported he/she thought the bandage served to protect the resident's coccyx only and stated the red area on the resident's buttock had been discovered the day before. At 9:35 a.m. staff J changed the resident's dressing and applied wound gel to the wound on his/her left heel and covered with gauze and wrapped with soft gauze to secure. Licensed nursing staff J cleansed the resident's buttocks then sprayed zinc oxide protectant spray and affixed a new sacral occlusive dressing on the resident's coccyx. Staff J reported the staff applied ointment on the resident's coccyx and also to the left buttock wound also.

During an interview on 9/6/17 at 5:02 p.m. resident #2 reported he/she had a sore on his/her heel when he/she lived in independent living which caused him/her to have an infection that put him/her in the hospital for a week and he/she sat in his/her chair most of the time because he/she could only take one or two steps. The resident stated he/she had a sore on his/her bottom on the left side which did not hurt and he/she did not remember the last time staff treated the wound but the nurse treated his/her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175306	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR OF THE PLAINS	200 CAMPUS DRIVE DODGE CITY, KS 67801

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foot one time daily and the time varied. The resident stated he/she sat in his/her chair during the day.

During an interview on 9/7/17 at 6:10 p.m. administrative nursing staff A reported he/she expected staff to prompt the resident to reposition every hour when resident sat in his/her chair as care planned.

Review of the facility policy on Skin Integrity: Nursing Intervention and Wound Treatment Guidelines for Health Care Center, revised 8/10/16, instructed staff to reposition a resident at least every hour when in a chair and directed staff to teach the resident to shift his or her weight every 15 minutes while in a chair if the resident was alert and capable.

The facility failed to assist and remind resident #2 to reposition while he/she sat in his/her chair every hour as care planned and the resident developed a red area on his/her buttock.