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F 000	INITIAL COMMENTS The following citations are the result of abbreviated survey and complaint investigation KS00182969. The 2567 was sent electronically on 10/30/23.	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 identified a census of 36 residents with three residents reviewed for pressure ulcers. Based on record review, observation, and interview, the facility failed to provide Resident (R) 1 with care consistent with professional standards of practice to prevent pressure ulcer development. R1 admitted to the facility on 03/13/23 without any skin issues to her buttock but had crevices to her bilateral heels from previous pressure ulcers. The facility failed to initiate a turning/repositioning program, cushion for wheelchair, or bilateral heel protectors/offloading to prevent R1 from	F 686		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/30/2023

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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developing pressure ulcers. On 03/27/23 R1 obtained suspected deep tissue injuries to her left sacrum and bilateral heels. R1's left sacrum wound later progressed into a Stage 4 pressure ulcer (a deep wound that reaches the muscles, ligaments, or even bone) and R1's right heel ulcers progressed to Stage 3 (full thickness pressure injury extending through the skin into the tissue below). This deficient practice also placed R1 at risk for further skin breakdown, delayed healing, and infection.

Findings included:

- R1's Electronic Medical Record (EMR) documented diagnoses of muscle weakness, diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), and hypertension (high blood pressure).

The "Admission Minimum Data Set (MDS)," dated 03/20/23, documented R1 had a "Brief Interview for Mental Status" (BIMS) score of 15, which indicated intact cognition. The MDS documented R1 required extensive assistance of one to two staff for all activities of daily living (ADLs) except eating. The MDS further documented R1 had intact skin with no pressure ulcers, was at risk for developing pressure ulcers, did not have a pressure reducing device for her chair or bed, and was not on a turning/repositioning program.

The "Significant Change MDS," dated 05/03/23, documented R1 had a BIMS score of 15, which

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indicated intact cognition. The MDS documented R1 required extensive assistance of one to two staff for all AMDS. The MDS further documented R1 had a Stage 4 (a deep wound that reaches the muscles, ligaments, or even bone) pressure ulcer (localized injury to the skin and/or underlying as a result of pressure, or pressure in combination with shear and/or friction). The MDS recorded R1 did not have a pressure relieving device for her chair or bed; R1 was not on a turning/repositioning program, was not receiving a nutrition or hydration interventions to manage skin problems and was not receiving pressure ulcer care.

R1's "Care Plan," initiated on 03/13/23, directed staff that R1 required assistance of one to two staff for turning/repositioning and required maximum assistance with transfer. The care plan directed staff R1 was incontinent of bowel and directed staff to provide peri care after each incontinent episode.

The "Care Plan" dated 04/06/23 documented R1 had impairment to her skin as evidenced by wounds to her sacral area and bilateral heels. The care plan interventions dated 04/26/23 directed staff to reposition R1 every two hours from side to side while in bed and check R1 for incontinence at turn times, monitor/document location, size and treatment of skin injury and report any abnormalities or failure to heal to R1's primary care physician. The staff were to encourage good nutrition and hydration in order to promote healthier skin for R1 and change out her bed/mattress. The intervention dated 04/11/23 directed staff to refer R1 to a wound care clinic. The intervention dated 04/27/23 directed staff to change R1's foam cushion in her

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wheelchair to a ROHO cushion (pressure relief cushion that is made of soft, flexible air cells). The interventions dated 05/03/23 directed staff that R1 required an air mattress, as needed pain medication prior to wound treatments, and initiate a wound-vac (a vacuum-assisted wound treatment that applies gentle suction to a wound to help it heal). The intervention dated 05/12/23 directed staff to provide R1 with 30 milliliters (ml) of liquid protein twice a day and a multivitamin with minerals to assist R1 with wound healing.

The "ADL/Rehabilitation Potential Care Area Assessment (CAA)," dated 03/20/23, documented R1 required extensive assistance with bed mobility, transfer, locomotion on and off the unit, dressing, and toileting. Possible underlying problems that may have affected R1's functioning was changing cognitive status, communication problems, mood decline, and recent hospitalization.

The "Pressure Ulcer/Injury CAA," dated 03/20/23, documented R1 was at risk for pressure ulcer injury due to requiring extensive assistance for bed mobility, R1 was frequently incontinent of urine and always incontinent of bowel and had a recent hospitalization. The CAA documented pressure ulcer/injury would be addressed on R1's care plan. The facility failed to address pressure ulcer/injury on R1's care plan until after she had obtained pressure ulcers.

The "ADL/Functional Rehabilitation Potential CAA," dated 05/03/23, documented R1 required extensive assistance with bed mobility, transfer, locomotion on and off the unit, dressing, and toileting. Possible underlying problems that may have affected R1's functioning was changing

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cognitive status, communication problems, and mood decline.

The "Pressure Ulcer/Injury CAA," dated 05/03/23, documented R1 was at risk for pressure ulcer injury due to requiring extensive assistance for bed mobility, R1 was frequently incontinent of urine, always incontinent of bowel, and R1 had a one Stage 4 pressure ulcer.

The "Health Status Note," dated 03/13/23, documented R1 admitted to the facility at 12:15 PM. A skin assessment revealed R1's sacrum had no redness or open areas. The assessment noted right lateral heel indentions from previous pressure areas and left lateral heel indentions from previous pressure areas.

The "Braden Scale Assessment", dated 03/13/23, documented R1 had a score of sixteen which indicated R1 was at risk for developing pressure ulcers.

The "Skin/Wound Note" dated 03/27/23, documented the Certified Medication Aide (CMA), reported to the charge nurse that R1 had blisters to her buttocks. An assessment revealed three open areas where blisters had opened. The area was firm and measured 5.6 centimeters (cm) by 6.2 cm with purple bruising to the peri wound (area around the wound). R1 complained of tenderness to the area when touched. R1 was alert but unable to notify staff in time when she needs to use the toilet. A bordered foam was applied to the area for protection and added the task to reposition every two hours and check for incontinence. The staff notified R1's primary care physician who told the facility wound nurse to let him know if wound care was needed.

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The "Task History" in R1's EMR documented a pressure relieving cushion in R1's wheelchair at all times was initiated on 03/27/23. The Task History also documented R1 required turning and repositioning and staff were to check for incontinence, initiated on 03/27/23.

The "Task History" lacked a task for heel protectors to R1's bilateral heels.

The "Skin/Wound Assessment" dated 03/31/23, documented R1 had pressure injuries to her left buttock, right heel, and left heel that were all suspected deep tissue injuries. The assessment lacked any measurements and/or description.

The "Health Status Note," dated 03/31/23, documented R1's primary care physician ordered wound care to evaluate and treat the open sore to R1's buttock.

The "Plan of Care Note" dated 04/03/23, documented staff placed shepherd's hooks (device to assist with turning and repositioning in bed) to R1's bed to increase bed mobility with turning/repositioning.

The "Skin/Wound Note" dated 04/06/23, documented the open area to R1's sacrum measured 5.6 cm by 6.2 cm with a depth of 0.4 cm at the 5 to 6 o'clock area. The wound bed consisted of 75 percent (%) red granulation (new tissue formed during wound healing) and 25% of yellowish brown thick adherent slough (dead tissue, usually cream or yellow in color) with moderate amount of serosanguineous (semi-thick, blood-tinged drainage) to purulent (producing or containing pus) drainage, and slight

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odor. R1 complained of tenderness to the area when touched. Interventions noted: changed out bed/mattress, remind staff to report to charge nurse if dressing was soiled or off, so it could be replaced, continue to reposition every two hours from side to side when in bed and check for incontinence, and continue with cushion to her wheelchair. New concern to R1's right lateral heel noted, with red drainage noted on R1's sock and bed. R1 had a blood blister to the right lateral heel that was draining by a 0.3 cm slit and entire area measured 2.5 cm by 1.7 cm, dark red in color and tender to touch. The staff cleansed the area and applied skin prep (liquid skin protectant) and covered with a foam dressing.

The "Health Status Note" dated 04/06/23, documented the wound nurse notified Administrative Nurse D and R1's responsible party of the new area to R1's right heel. The staff sent a request for a wound clinic referral to R1's primary care physician. The staff educated R1's responsible party on R1 no longer using Prevalon boots (special pressure reducing heel protectors) and would start using a foot cushion, and the facility changed out R1's mattress. R1's responsible party voiced understanding.

The "Skin/Wound Note" dated 04/07/23, documented the facility received new orders from R1's primary care physician regarding R1's wound including to start Clindamycin (antibiotic) 300 milligrams (mg) by mouth, three times a day for seven days, and for the wound care clinic to evaluate and treat.

R1's "Electronic Medication Administration Record" (EMAR) for April of 2023 documented the administration of Clindamycin 300 mg, three

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time a day for seven days for R1's wound infection.

The "Health Status Note" dated 04/11/23, documented R1 returned from an appointment at the wound care clinic with orders to place Santyl (a prescription enzyme used to help break up and remove dead skin and tissue of a wound) to the wound beds of R1's right heel and left buttock, then cover with Mepilex (absorbent, bordered foam dressing) foam; apply Sorbact (a bacteria and fungi binding wound dressing) to the wound bed of the left heel, then cover with Mepilex foam, and change every twenty-four hours. The note documented R1 had a Stage 2 pressure ulcer (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) to her left heel and Stage 3 pressure ulcers to her right heel and left buttock. R1 would have a return appointment in one week and noted wound cultures were obtained from all wounds.

The "Skin/Wound Note" dated 04/13/23, documented the completion of R1's wound treatment that morning. R1's left sacral area was a Stage 3 pressure ulcer that measured 5.6 cm by 5.5 cm with an open area with eschar (dead tissue) at one o'clock with a depth of 0.7 cm. A large amount of red to purulent drainage expressed from the wound with foul odor. 75% of the wound consisted of dry eschar and the peri wound was reddened. R1 complained of discomfort with cleansing of the wound. R1's right lateral heel Stage 3 pressure ulcer, that started out as a blood blister, measured 3.5 cm by 3.3 cm with moderate amount of serosanguineous drainage, and no redness to the peri wound. R1 had no complaints of discomfort. R1's left medial heel Stage 2 pressure ulcer, that started out as a

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blood blister, measured 1.5 cm by 1.6 cm. The wound bed consisted of granulation tissue and the peri wound was without redness. R1 had no complaints of discomfort. Interventions: R1 to be repositioned every two hours, use foot/leg cushion to offload pressure to heels, cushion in wheelchair, and antibiotic therapy. Staff notified the wound care clinic was on R1's sacral wound drainage.

The "Health Status Note" dated 04/14/23, documented R1's primary care physician ordered Augmentin (antibiotic) 875 mg by mouth twice a day for ten days for wound infection.

The "Infection Note" dated 04/15/23, documented R1 received Augmentin for her left buttock wound infection and R1 complained about pain at the site.

The "Health Status Note" dated 04/18/23, documented R1 returned from her wound care clinic appointment. The wound care clinic ordered the facility to continue with the same dressing to R1's bilateral heels but changed the dressing to R1's left buttock to Santyl in the wound bed followed by saline moistened gauze, followed by dry gauze, and then placed a sacral border dressing. The facility was ordered to change the dressings daily.

The "Infection Note" dated 04/24/23, documented R1 received her last dose of Augmentin for her wound infection.

The "Health Status Note" dated 04/27/23, documented R1 had returned from the wound care clinic appointments. The wound care clinic notes documented R1's coccyx (area at the base

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of the spine) wound extended to the fascia (a thin sheath of fibrous tissue enclosing a muscle or other organ). New orders included Santyl to coccyx wound covered with moist gauze and then covered with ABD (large pad to absorb drainage) and place barrier cream to peri wound and change dressing daily. The orders for R1's right heel wound included to apply Santyl to the wound bed then Adaptic (a non-adhering dressing that helps protect regenerating skin), ABD, and wrapped with roll gauze with daily dressing change. The order continued to direct the facility to ensure Prevalon boots were on to bilateral heels at all times unless transferring or weight bearing, position R1 off of her back in bed at all times, and limit R1's time up in her wheelchair for meals to no longer than forty-five minutes. The wound care clinic directed the facility to apply a wound vac (a vacuum-assisted wound treatment that applies gentle suction to a wound to help it heal) for R1's coccyx wound and bring to the next appointment. The wound care clinic directed the facility to place a foam dressing to R1's left heel and change Monday, Wednesday, and Friday. R1 would return the wound care clinic in one week.

The "Skin/Wound Note" dated 04/28/23, documented the Stage 4 pressure ulcer to R1's left sacral area measured 4.9 cm by 6.5 cm with a depth of 2.5 cm and tunneling (an opening underneath the surface of the skin) of 1.7 cm at eight o'clock. The wound was noted to have 90% red granulation tissue with moderate serosanguineous drainage without odor and the peri wound was without redness. The Stage 3 pressure area to R1's right heel measured 1.1 cm by 0.9 cm by 0.1 cm with 90% slough, scant drainage, and peri wound without redness. The Stage 2 pressure ulcer to R1's left heel measured

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0.6 cm by 0.2 cm. The area was dry without drainage or redness to the peri wound. R1 was limited at forty-five-minute intervals up in her wheelchair, repositioned side to side when in bed, and Prevalon boots on at all times.

The "Skin/Wound Note" dated 05/01/23, documented staff notified R1's primary care physician regarding R1 having a second open area on her coccyx to the right of the larger wound, that measured 0.5 cm by 1 cm. The physician ordered to continue R1's dressing as ordered.

The "Communication with Family/NOK/POA Note" dated 05/02/23 documented staff notified R1's responsible party the facility would place an air mattress to R1's bed that evening when R1 was up for supper. On 04/27/23 therapy changed out the foam cushion in R1's wheelchair to a Roho cushion. The facility nurse relayed to R1's responsible party staff were repositioning R1 every two hours while in bed, Prevalon boots to her heels at all times while in bed and would only up for forty-five minutes at a time to off load pressure to the coccyx area. As needed Tramadol (pain medication) was administered to R1 prior to dressing changes. R1's responsible party expressed concern that R1 would need all forty-five minutes to eat as she was a slow eater. R1's responsible party voiced concern the Tramadol was not helping much with pain as R1 complained to her about pain. R1's responsible part stated he would be at R1's wound care clinic appointment the next day for the wound vac placement.

The "Communication Note" dated 05/03/23, documented the facility requested orders for a

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protein supplement to promote wound healing process.

The "Nutrition/Dietary Note" dated 05/03/23, documented due to R1 having pressure areas on her coccyx and heels, the dietitian suggested a multi-vitamin with minerals daily and one ounce of Prostat (protein supplement) twice a day to aid in wound healing. The Prostat will provide R1 an additional thirty grams of protein and two hundred calories daily.

The "Health Status Note" dated 05/03/23, documented R1 had returned from the wound care clinic with wound vac in place to left sacrum, change Monday, Wednesday, and Friday. The wound care clinic ordered the facility not to change the dressing to R1's right heel and to continue a bordered foam dressing to R1's left heel and change weekly or as needed. The wound care clinic also ordered the facility to continue to have R1 only up thirty to forty-five minutes for meals and then back to bed side to side with heel protectors on.

The "Health Status Note" dated 05/04/23, documented R1's wound vac was in place and working properly. Serosanguineous drainage was noted in the wound vac tubing and negative pressure was set at 120 millimeters of mercury (mm/Hg). R1 complained of pain and staff administered Tramadol.

The "Health Status Note" dated 05/08/23, documented R1's wound vac dressing was changed and R1 received as needed Tramadol prior to the dressing change. During treatment R1 complained of pain when her wound was being cleansed. The treatment to her bilateral heels

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would be completed by the wound care clinic on 05/10/23.

The "Health Status Note" dated 05/18/23, documented R1 returned from the wound care clinic. The wound care clinic noted R1's wound to her sacrum was improving. The wound care clinic directed the facility to place moist Prisma (wound dressing) over the fascia and cover with Adaptic spiral cut wound vacuum black foam to fill the depths and tunnels as well as the entire wound and increase the suction to 150 mm/Hg and change the wound vac dressing on Tuesday, Thursday, and Saturday. Place Prisma, foam and drape to the sacral satellite wound. R1's right heel wound was improving and new orders to place Sorbact to the wound bed and cover with foam, with a barrier cream to the peri wound, and dressing changes on Tuesday, Thursday, and Saturday.

The "Health Status Note" dated 05/23/23, documented the completion of R1's wound vacuum dressing change. When removing the old dressing, the nurse noted the drape was not placed on the skin when channeling the tubing up R1's right hip. Skin irritation noted where the black foam was on R1's skin. R1's wound bed odorous after removing the old dressing but after cleansing the wound, noted no odor. R1's sacral wound bed was beefy red and moist, with a moderate amount of drainage in the cannister. R1 received Tramadol forty-five minutes prior to the dressing change.

The "Health Status Note" dated 06/15/23, documented R1 had returned to the facility from the wound care clinic with new orders to place Duoderm (wafer type moisture-retentive wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

(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 686	Continued From page 13	F 686		

dressing used for partial and full-thickness wounds leaking fluids) to the peri wound around the sacral wound, place moist Prisma to the undermining of the wound and over the bone with Adaptic spiral cut black foam to tuck into the tunnel undermining and then apply foam over the undermining area over draped skin and continue the wound vacuum at 150 mm/Hg and change Tuesday, Thursday, and Saturday. Upon dismissal from the nursing facility place saline moist gauze to wound and cover with ABD with barrier cream to peri wound.

The "Health Status Note" dated 06/16/23, documented the healed Stage 3 pressure ulcer to R1's right heel. The Stage 4 pressure ulcer to R1's sacrum, measured 4.2 cm by 3.5 cm by 2.2 cm, had improvement, and a moderate amount of serosanguineous drainage noted with no odor, peri wound flesh toned, and the satellite wound continued to show signs of healing. R1 would be going home next week, and Home Health would perform wound care.

The "Discharge Not," dated 06/20/23, documented R1 discharged from the facility with her responsible party.

On 10/19/23 at 10:00 AM, Licensed Nurse (LN) G verified R1 did not have a turning repositioning program, a pressure reducing mattress or wheelchair cushion until after she obtained wounds to her left sacrum and bilateral heels.

On 10/19/23 at 10:45 AM, Certified Nurses Aide (CNA) M stated she R1 had not been on a turning/repositioning program prior to her acquired pressure ulcer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	C 10/19/2023

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F 686	Continued From page 14	F 686		

On 10/19/23 at 11:15 AM, Administrative Nurse D stated she did not feel the initial skin assessment was completed correctly, because the wounds just popped up out of nowhere and there had to be underlying skin issues on admission to the facility.

The facility's undated "Pressure Ulcer Management Policy" documented it is the policy of the facility that all residents are considered to have some risk for the development of pressure ulcers. A licensed nurse will perform a full body assessment on the day of admission to the facility and then weekly thereafter. For the purpose of this policy, a skin assessment utilizes the Braden Scale. After conducting an inspection of the resident's skin, the nurse will review the resident assessment protocol for pressure ulcers to identify risk factors for the development of pressure ulcers. An immediate plan to reduce a residents' risk of pressure ulcers or to treat an existing pressure ulcer will be developed and implemented.

The facility failed to initiate a turning/repositioning program, cushion for wheelchair, or bilateral heel protectors to prevent R1 from developing pressure ulcers which resulted in R1 developed pressure injuries which evolved into Stage 3 and 4 wounds. This deficient practice also placed R1 at risk for further skin breakdown, delayed healing, and infection.