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F 000	INITIAL COMMENTS The following citations are the result of abbreviated survey and complaint investigation KS00186047 and KS00185986. The 2567 was sent electronically on 03/05/24.	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 identified a census of 34 residents with three residents reviewed for care and treatment of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid). Based on record review, observation, and interview, the facility failed to ensure Resident (R) 2 received treatment and care in accordance with professional standards of practice related to CHF. This deficient practice placed R2 at risk for complications from congestive heart failure that included weight gain, edema (swelling), and difficulty breathing. Findings included: - R2's Electronic Medical Record (EMR) documented R1 had diagnoses of acute on	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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chronic diastolic congestive heart failure, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and atrial fibrillation (rapid, irregular heartbeat).

The "Quarterly Minimum Data Set (MDS)," dated 01/25/24, documented R2 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented R2 weighed 193 pounds and had a five percent weight gain in the last month; R2 was not on a physician-prescribed weight gain regimen. The MDS recorded R2 received a diuretic (medication to promote the formation and excretion of urine).

The "Activity of Daily Living (ADL)/Rehabilitation Potential Care Area Assessment (CAA)," dated 10/25/23, documented R2 required substantial assistance with ADL care, toileting, and mobility both with walking and wheelchair propulsion.

The "Pressure Ulcer/Injury CAA," dated 10/25/23, documented R2 was at risk for pressure ulcer due to immobility and incontinence. Staff monitored R2's skin when they provided care.

R1's "Care Plan," dated 01/26/24, documented R2 required maximum assistance from staff for bathing, bed mobility, dressing, personal hygiene, toilet use, and transfer. The plan directed staff to monitor, document, and report any signs and symptoms of CHF: dependent edema of legs and feet, periorbital (around the eyes) edema, shortness of breath upon exertion, weakness, weight gain, crackles, and wheezes upon auscultation (listening) of the lungs, and weakness or fatigue.

The "Weights and Vitals," dated 01/01/24

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documented R2 weighed 179.8 pounds.

The "Weights and Vitals," dated 02/06/24, documented R2 weighed 193.1 pounds which indicated a 13.3 pound weight gain. R2's clinical record lacked evidence staff notified R2's primary care physician.

The "Health Status Note," dated 02/10/24, documented R2 had audible expiratory wheezing at intervals.

The "Health Status Note," dated 02/12/24, documented R2 complained to a certified nurse aide (CNA) that he had a hard time breathing. When the nurse approached R2, he stated he was much better at that point. The note documented R2 had bilateral (both sides) lower extremity edema.

The "Alert Note," dated 02/13/24, documented a CNA notified the nurse R2 presented with new onset edema in his bilateral thighs going up to his hips. R2 had a baseline of chronic edema to his bilateral lower extremities due to CHF. The CNA notified the nurse R2 was wheezing while lying down in bed. R2's lung sounds were clear but diminished. R2 voiced pain, a 10 on a zero to ten scale (pain scale where zero equals no pain and 10 the worst pain imaginable) that felt like a stabbing ice pick to his right lateral (towards the side) abdomen. Staff administered R2 his as-needed albuterol (medication used to clear airways) inhaler for dyspnea (difficulty breathing). The note documented that staff would pass on to the day shift staff to notify R2's primary care physician of the 13.3-pound weight gain over a time period of one month, new onset edema to bilateral thighs, bilateral hips, and distention to

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the right lateral abdomen.

The "Health Status Note," dated 02/13/24, documented that R2's primary care physician was notified of his change in condition.

The "Health Status Note," dated 02/13/24, documented the facility received new orders to increase R2's Lasix (diuretic medication) to 40 milligrams (mg) twice a day for five days and give potassium 20 milliequivalents (mq) for five days. Staff were to obtain daily weights, and a Basic Metabolic Panel (BMP-laboratory blood test) on 02/19/24; and monitor for increased edema.

The "Health Status Note," dated 02/14/24, documented R2 had 2+ pitting edema (swelling resulting from an excessive accumulation of fluid in the body tissue demonstrated by the application of pressure to the swollen area with a finger which causes an indentation) to his left lower extremity and 3+ pitting edema to his right lower extremity. R2's right hip contained fluid pockets. R2's skin was tight and shiny in appearance. R2's lung sounds were clear but the left lobe was diminished. R2's respirations were even and unlabored.

A review of R2's clinical record revealed the facility failed to follow R2's primary care physician's orders to obtain a BMP on 02/19/24. The facility obtained the BMP on 02/21/24 and received the results on 02/26/24. The results of the BMP showed R2's potassium level was 3.8 millimoles per liter (mmol/L) and R2's sodium level was 140 milliequivalents per liter (mEq/L).

On 02/26/24 at 11:45 AM, observation revealed R2 sat in a chair in his room. R2's pajama pant

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legs were pulled up revealing his lower extremities. R2's had obvious edema to both legs with the right greater than the left. R2's right lower leg was taut and shiny. R2 rubbed his right lower leg.

On 02/26/24 at 11:45 AM, R2 stated his right leg was really swollen and it hurt. R2 stated no one had obtained his weight yet that day.

On 02/26/24 at 01:00 PM, Administrative Nurse E verified the lab was drawn on 02/21/24, not 02/19/24 as the doctor ordered it to be drawn. Administrative Nurse E verified she just received the results of the BMP back.

On 02/27/24 at 10:00 AM, Administrative Nurse D verified the staff had not identified R2's 13.3-pound weight gain and verified the staff did not notify R2's primary care physician.

The facility's undated "Quality Assurance Performance Improvement Policy," documented the facility would ensure that all staff will consistently develop processes and systems to provide safe, effective, and optimal care and services to each resident residing at or receiving services from the facility. The governing body of this facility understands and supports processes and systems of care that are coordinated and collaborative with the mission of continuously improving performance involving every department and discipline for every resident served.

The facility lacked a "Quality Care Policy."

The facility failed to ensure R2 received treatment and care in accordance with professional

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F 684	Continued From page 5 standards of practice related to CHF. This deficient practice placed R2 at risk for complications from congestive heart failure which placed him at risk for weight gain, edema, and difficulty breathing.	F 684		
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 34 residents with three residents 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 record review, observation, and interview, the facility failed to implement interventions to prevent a Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) pressure ulcer to Resident (R) 1's left buttock and then failed to provide routine treatment and nutritional interventions to promote healing of R1's pressure ulcer. This deficient practice placed R1 at risk for	F 686		

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pressure ulcer development, pain, infection, and complications from delayed healing.

Findings included:

- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of fracture (broken bone) of the left neck of the femur (thigh bone), weakness, and low back pain.

The "Quarterly Minimum Data Set (MDS)," dated 01/26/24, documented R1 had a Brief Interview for Mental Status score of 12 which indicated moderately impaired cognitive function. The MDS documented R1 did not have any pressure ulcers or skin alterations, R1 was at risk for developing pressure ulcers, and R1 had a pressure-reducing device for her chair and for her bed.

The "Medicare/5 Day MDS," dated 12/30/23 documented therapy GG codes dated 01/03/24. The GG codes documented R1 required substantial staff assistance with toileting, bathing, bed mobility, and transfer.

The "Pressure Ulcer/Injury Care Area Assessment (CAA)," dated 07/26/23, documented R1 required assistance with bed mobility, was at risk for friction (the mechanical force exerted when skin is dragged across a surface) and shearing (the separation of skin layers caused by friction or trauma) from sliding in bed, and was at risk for maceration (softening and breaking down of skin as a result from prolonged exposure to moisture, such as sweat, urine, or feces or wounds for extended periods) due to R1's increased incontinence events. The CAA documented pressure ulcers/injuries would be addressed in R1's "Care Plan" to avoid

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complications.

R1's "Care Plan," dated 01/21/24, documented R1 had the potential for pressure ulcer development due to dehydration and immobility. The care plan documented R1 would have intact skin, free of redness, blisters, or discoloration. The plan directed staff to ensure R1 had a pressure-reducing cushion in her recliner, monitor R1's nutritional status, and follow the facility policies for the prevention/treatment of skin breakdown.

The "Braden Scale for Predicting Pressure Ulcer Risk," dated 01/22/24, documented R1 was at risk for developing pressure ulcers with a score of 16. The assessment documented R1 was slightly limited in sensory perception (has some sensory impairment which limits the ability to feel pain or discomfort in one or two extremities); R1 was occasionally moist (requiring an extra linen change approximately once a day); R1 walked occasionally but spent most of her time in a chair or bed; and R1's nutritional intake was probably inadequate.

The "Skin Assessment," dated 01/17/24, documented R1's integumentary (skin) system was intact.

The "Skin Assessment," dated 01/26/24, documented R1's integumentary system was intact.

The "Skin Assessment," dated 01/31/24, documented R1's skin was intact, and lotion was applied.

The "Skin Assessment," dated 02/07/24,

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documented R1's integumentary system was intact.

The "Skin Assessment," dated 02/14/24, documented R1's integumentary system was intact.

The "Health Status Note," dated 02/16/24, documented the area to R1's coccyx (area over the tailbone) was cleaned with soap and water, and the dressing was changed. There was a foul smell noted. Staff faxed R1's primary care physician and requested a soft brace for R1's right wrist due to a nodule. The EMR lacked measurements of the wound, description of the wound, description of the peri-wound, and if there were any signs and symptoms of infection.

The "Health Status Note," dated 02/19/24, documented the bandage to R1's left buttock was changed and noted malodor. The EMR lacked measurements of the wound, description of the wound, description of the peri-wound, and if there were any signs and symptoms of infection.

The "Skin Assessment," dated 02/21/24, documented R1's skin was intact.

The "Health Status Note," dated 02/20/24, documented R1's dressing to her left buttock was clean, dry, and intact.

The "Health Status Note," dated 02/23/24 at 03:35 AM, documented R1's left buttock had an open area with purulent (producing or containing pus) drainage and the peri-wound (area around the wound) was pink and inflamed, with malodor noted. R1 denied pain in the area. The wound bed was surrounded by thick white drainage. The

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wound measured 0.8 centimeters (cm) by 1.4 cm. Staff updated R1's primary care physician and requested wound care orders.

The "Health Status Note," dated 02/23/24 at 04:35 PM, documented a new order to apply Santyl (a prescription enzyme used to help break up and remove dead skin and tissue of a wound) to the wound bed daily and cover with Optifoam; continue to monitor closely, and follow up in one week or sooner for concerns.

R1's "Treatment Administration Record" (TAR) dated February 2024 documented an order for Santyl to be placed in the wound bed and covered with Optifoam. The TAR documented the treatment was completed for 02/24/24 and 02/25/24. The facility did not receive the Santyl medication until the afternoon of 02/26/24.

On 02/26/24 at 09:00 AM, R1 sat in her wheelchair at the nurse's desk and asked someone to put her hearing aid in.

On 02/26/24 at 09:01 AM observation of R1's room revealed she had a Roho cushion (pressure relief cushion that is made of soft, flexible air cells) in the recliner in her room. Her bed had a regular mattress with no overlay.

On 02/26/24 at 09:30 AM, R1 observed self-propelling in her wheelchair around the facility.

On 02/26/24 from 10:00 AM to 11:00 AM, R1 sat in her wheelchair at a puzzle table and put a puzzle together with a friend.

On 02/26/24 at 11:00 AM, R1 sat in her

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wheelchair at the lunch table and drank coffee.

On 02/26/24 at 12:00 PM, R1 sat in her wheelchair and ate lunch. Staff had not repositioned R1 since 09:00 AM or offered toileting.

On 02/26/24 at 01:00 PM, R1 left the lunch table and went to her room.

On 02/26/24 at 01:10 PM, observation revealed Licensed Nurse (LN) G assisted R1 to the bathroom. R1's incontinence brief was soaked with urine. LN G then performed a dressing change to R1's left buttock. LN G removed the old dressing which had yellow drainage on it. LN G did not measure the wound. The wound was covered with yellow slough (dead tissue, usually cream or yellow in color) LN G cleansed the wound with wound cleanser and the yellow slough remained adhered to the wound. LN G applied Santyl to the wound bed and then covered the wound with an Optifoam dressing. Observation of R1's wheelchair where she sat all morning revealed a fabric pillow cushion and a zippered pouch that appeared to have items in it.

On 02/26/24 at 09:00 AM, R1 stated she thought she got the wound on her buttock from sliding up and down in bed. She said she was not able to scoot herself up in bed very well, so she thought she just wore the skin down.

On 02/26/24 at 10:30 AM, Administrative Nurse D stated the facility had not received the Santyl from the pharmacy yet, so staff waited to perform the dressing change to R1's left buttock until they received the medication. Administrative Nurse D stated the facility had been using the Optifoam

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dressing on the wound without the Santyl medication. Administrative Nurse D stated she thought R1 developed a pressure ulcer due to pain, R1 had a lot of lower back pain and was on opioid (narcotic) medication for pain. Administrative Nurse D stated R1 was thin and did not eat well all the time. Administrative Nurse D stated the registered dietitian had not been contacted regarding R1's wound.

On 02/26/24 at 11:30 AM, Certified Nurse Aide (CNA) M stated since R1 broke her left hip in December 2023, she spent all her time in her wheelchair. CNA M said that before R1's left hip fracture, R1 had spent most of her time in her recliner. CNA M stated R1 had been up in her wheelchair since 01:30 AM that morning per night shift report. CNA M stated R1 had a pillowed cushion in her wheelchair that her family brought in for her.

On 02/26/24 at 01:20 PM, LN G stated R1's wound was a pressure ulcer and had yellow slough in the wound bed.

The "Skin Integrity Policy," 02/26/24, documented based on the comprehensive assessment of the resident, facility staff will ensure that the resident who enters the facility without a pressure sore will not develop a pressure sore unless the resident's clinical condition demonstrates that the condition was unavoidable. Identification and evaluation of risk factors are decreased mobility and decreased functional ability, cognitive impairment, under-nutrition, and malnutrition including significant weight loss with mobility/positioning concerns, any decline in clinical status or co-morbid diagnoses affecting mobility/positioning or ability of the skin to endure effects of pressure.

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The nurse will conduct a full-body skin assessment for each resident to ensure no risks have developed.

The "Pressure Ulcer Policy," dated 01/26/24, documented all residents will be assessed for skin risk using the Braden Scale: upon admission or re-admission, weekly for the first four weeks, with an MDS significant change in condition, change in cognition, and with any acute medical condition. These residents will have a pressure-reducing device for their bed and/or chair. If the resident develops or has a pressure ulcer/wound, the nursing staff will document weekly on either the wound sheet or in the nurse's notes the status of the pressure sore/wound including size, depth, drainage, tunneling, odor, and degree of healing. For residents with wounds, the intactness of the dressing, skin around the wound, and any signs or symptoms of infection are noted on each shift. All residents at risk or with skin breakdown (wound or pressure ulcer) will have a dietary consult. Recommendations should include necessary laboratory data. Those residents to be found at risk are noted to be at risk on their care plan with individualized interventions. If the resident has a Stage II or higher, a significant change MDS will be completed. The nursing staff will be able to verbalize who they report skin issues to. Professional nursing staff should be aware of all wounds, treatment in use, and degree of healing.

The facility failed to implement interventions to prevent a Stage 3 pressure ulcer from developing to R1's left buttock and failed to provide the physician-ordered treatment and other routine interventions such as RD involvement to promote

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	C 02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	**105 N HIGHWAY 99 WESTMORELAND, KS 66549**

(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 the healing of R1's pressure ulcer. This deficient practice placed R1 at risk for pressure ulcer development, pain, infection, and complications from lack of healing.	F 686		