STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41121 The facility reported a census of 58 residents with five residents selected for review. Based on observation, interview, and record review, the facility failed to revise the care plan for Resident (R)1 for his pressure ulcer (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) to his buttocks and placement of a urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag), for R2 for her right foot wound, and for R5 for catheter management. This deficient practice placed these three residents at risk to not receive appropriate cares and treatments. Findings included: - The Medical Diagnosis tab for Resident (R)1 included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), Down's Syndrome (chromosomal abnormality characterized by varying degrees of mental retardation and multiple defects), and muscle weakness. The Significant Change Minimum Data Set (MDS) dated [DATE], assessed R1 with a short-term and long-term memory loss and impaired decision making. He did not reject care and was dependent on staff for bed mobility, transfers, and toileting, and required a wheelchair for mobility. R1 was always incontinent of bowel and bladder and at risk for developing pressure ulcers/injuries. He had two Stage 2 pressure areas (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) that were not present on admission and/or reentry. R1 required a pressure reducing device for his chair and bed and was not on a turning/repositioning program. He received nutrition or hydration interventions to manage skin problems, application of nonsurgical dressings and ointments/medications other than to his feet. R1 received hospice services. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 01/12/24, revealed R1 had a memory problem making his decisions regarding tasks of daily life severely impaired. The Urinary Incontinence and Indwelling Catheter CAA dated 01/12/24, revealed R1 was incontinent of bowel and bladder, wore incontinent products, and was dependent on staff for all aspects of toileting needs. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Pressure Ulcer/Injury CAA dated 01/12/24, revealed R1 was at risk for skin breakdown and had two stage two pressure ulcers to his left hip. R1 was dependent on staff for all aspects of bed mobility and had a pressure relieving mattress on his bed and a pressure relieving cushion to his chair. R1 required pressure relieving boots while in bed. The Licensed Nurse (LN) was to do a weekly/PRN (as needed) skin assessment and certified staff were to observe skin daily with cares. The staff were to report any new skin areas to the primary care provider for review. R1 recently changed hospice providers and was back on hospice services. The Quarterly MDS dated [DATE], for R1 revealed no change to his memory recall or decision making. R1 did not reject care and continued to be dependent on staff for bed mobility, transfers, toileting, and required a wheelchair for mobility, and had no range of motion impairments, and was frequently incontinent of bladder and always incontinent of bowel. R1 continued to be at risk for developing pressure ulcers/injuries and had one stage two pressure area which was not present on admission/reentry, and one unstageable pressure ulcer (depth of the wound is unknown due to the wound bed is covered by a thick layer of other tissue and pus) which was not present on admission/reentry. R1 required a pressure reducing device for his chair and bed and was not on a turning/repositioning program. He received nutrition or hydration interventions to manage skin problems, required pressure ulcer/injury care, and application of nonsurgical dressings and ointments/medications other than to feet. R1 continued to receive hospice care. The Care Plan dated 07/25/24, for R1 revealed R1 had a pressure ulcer, stage two (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters), to his right rear iliac crest (the curved area at the top of the hip bone) and left outer ankle related to his diagnosis of terminal illness. The plan further revealed R1 was incontinent of bowel and bladder and the staff were to check him every two hours and provide peri-care immediately after incontinence. The care plan lacked R1 had an indwelling urinary catheter. The hospice Skilled Nursing Visit Note dated 06/24/24, revealed R1's upper medial buttock pressure ulcer, now labeled as a stage four (a deep pressure wound that reaches the muscles, ligaments, or even bone). The facility failed to revise the care plan to a stage four pressure ulcer. The hospice Skilled Nursing Visit Note dated 07/12/24, revealed Consultant Staff MM arrived at 03:40 PM and staff reported R1's dressing was coming off and saturated before lunch, so hospice staff changed it. The note included orders received to insert a 16 French urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) to dependent drainage to assist with wound healing. Consultant Staff MM inserted the urinary catheter. The Orders tab revealed a new order dated 07/13/24 for the staff to obtain urinary output every shift. The facility failed to revise R1's care plan to reveal he had a urinary catheter placed. On 07/29/24 at 12:26 PM, observation revealed a large pressure ulcer to R1's upper medial buttocks. Consultant Staff GG measure the ulcer which was 7.8 cm by 5.0 cm by 1.2 cm with undermining of 4.0 cm at 12 o'clock, 3.2 cm at nine o'clock, and 2.8 cm at seven o'clock. The wound tissue was beefy red in color with some areas of slough noted. On 07/30/24 at 02:05 PM, Licensed Nurse (LN) I stated the charge nurse should update the care plan with changes in resident condition, new skin issues should be added as well as if a urinary catheter had been inserted. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Care Plans - Comprehensive Person - Centered dated March 2022, revealed assessments of residents are ongoing and care plans were to be revised as information about the residents and the residents' conditions change. The facility failed to revise R1's care plan when his pressure ulcer declined to a stage four pressure ulcer and failed to revise the care plan when the urinary catheter had been inserted. and insertion of a urinary catheter. - The Medical Diagnosis tab for Resident (R)2 included diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) with neuropathy (weakness, numbness and pain from nerve damage, usually in the hands and feet), hemiplegia (paralysis of one side of the body) affecting right dominant side, dementia (progressive mental disorder characterized by failing memory, confusion), muscle weakness, and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) to bilateral (both) knees. The Quarterly Minimum Data Set (MDS) dated [DATE], assessed R2 with a Brief Interview of Mental Status (BIMS) score of 14, indicating intact cognition and she did not reject care. R2 had a range of motion impairment to one side of her upper and lower extremities and used a wheelchair for mobility. R2 was dependent on staff for bed mobility and taking off and putting on footwear. R2 was at risk 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) and did not have any type of ulcers present, had a pressure reducing device to her bed and chair, and was not on a turning/repositioning program. The Annual MDS dated [DATE], assessed R2 with a BIMS score of 10, indicating moderate cognitive impairment and she did not reject care. R2 continued to have a range of motion impairment to one side of her upper and lower extremities and used a wheelchair for mobility. R2 was totally dependent on staff for taking off and putting on footwear and required substantial/maximal assistance with bed mobility. R2 continued to be at risk for pressure ulcers, did not have any type of ulcers, continued to require a pressure reducing device to bed and chair, and was not on a turning/repositioning program. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 06/13/24, revealed R2 had a cognitive impairment, and was alert and oriented with confusion. The Functional Abilities CAA dated 06/13/24, revealed R2 had limitations to her range of motion on one side, was able to make her wants/needs known to staff, and the staff also anticipated her needs. R2 was dependent on staff for all aspects of dressing and required substantial/maximal assistance with rolling left and right. The Pressure Ulcer/Injury CAA dated 06/13/24, revealed R2 was at risk for skin breakdown and required substantial/maximal assistance for bed mobility. The staff reposition her every two hours while in bed and every one-hour while in the chair and the Licensed Nurse (LN) does weekly and PRN (as needed) skin assessments. The certified staff observe R2's skin daily with cares. R2 had a pressure relieving mattress on her bed and wore moon boots (orthopedic device) while in bed to offload heels. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan dated 06/18/24, revealed R2 was at risk for impaired skin integrity, skin/tissue color changes, and pressure ulcers related to her diagnoses of hemiplegia (paralysis of one side of the body), obesity, and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). The Care Plan lacked presence of any wounds or staff guidance to care for the wounds. The Weekly Nursing Skin assessment dated [DATE], revealed R2 had a callus to her right foot and was to be seen by the wound center as ordered. The facility failed to revise R2's care plan. The Progress Note dated 06/24/24 revealed Administrative Staff B notified Licensed Nurse (LN) I of an area to R2's right foot. R2 had a pink/black area that measured 6.0 centimeters (cm) by 3.0 cm to the lateral (pertaining to the side, away from the middle) edge of her right foot and the resident reported pain of a 10 on the zero to 10 pain scale, with 10 indicating the highest amount of pain, when touched. LN I notified Administrative Staff A of the area. LN I received a new order for R2 to be seen by the wound center to evaluate and treat the area. The facility failed to revise R2's care plan. The Weekly Nursing Skin assessment dated [DATE], revealed the lateral front edge of R2's right foot had a 6. 0 centimeter (cm) by 3.0 cm pink/black area that was new. The facility failed to revise R2's care plan. The Weekly Non-Pressure Wound assessment dated [DATE], revealed R2 had an arterial wound, a deep dark-colored area on her right lateral foot including her fifth toe, with an onset date of 06/19/24. The area did not blanch and was not open and measured 6.0 cm by 4.0 cm. The surrounding skin appeared dark/discolored on the right lateral foot. The treatment was for skin prep (protective wipe) to the area daily. The facility failed to update R2's care plan. The Weekly Nursing Skin assessment dated [DATE], revealed the lateral front edge of R2's right foot, onset date of 06/19/24, would be seen in house by the wound care team on 07/03/24. The facility failed to revise R2's care plan. The Weekly Non-Pressure Wound assessment dated [DATE], revealed R2 had a discoloration to her right lateral foot, and the treatment was to monitor. The assessment lacked measurements or a description of the area. The facility failed to revise R2's care plan. The Weekly Nursing Skin assessment dated [DATE], revealed the wound center removed the hard outer layer of skin to her right foot, received new treatment orders, and the wound center would see R2 the next in house visit on 07/10/24. The facility failed to revise R2's care plan. The Weekly Non-Pressure Wound assessment dated [DATE], revealed R2 had a discoloration to her right later foot, and the treatment was to monitor. The facility failed to revise R2's care plan. The Order tab for R2 revealed a treatment order to the open area to right lateral foot, dated 07/11/24, for the staff to remove the dressing, cleanse with wound cleanser, pat dry with clean dry gauze, place derma blue (highly absorbent vertically wicking foam primary dressing embedded with three proven antimicrobials) over the open area, and cover with a silicone dressing. The staff were to change the dressing on Monday, Wednesday, and Friday on the day shift, and as needed if the dressing became dislodged. The facility failed to revise R2's care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Weekly Non-Pressure Wound assessment dated [DATE], revealed R2 had an arterial ulcer to her right lateral foot that measured 2.02 cm by 1.49 cm, and was without drainage or odor. The ulcer had 76 to 100 percent (%) eschar (dead tissue), and the staff documented the wound as improved. The treatment was to clean with wound wash for mechanical debridement, apply Hydrofera blue (a type of moist wound dressing which provides wound protection and addresses bacteria and yeast) or derma blue, and cover with bordered gauze. The facility failed to revise R2's care plan. The Weekly Non-Pressure Wound assessment dated [DATE], revealed R2 had an arterial ulcer to her right foot that measured 0.5 cm by 0.2 cm, with 76 to 100% eschar, treatment same as the last assessment and wound improved. The facility failed to revise R2's care plan. On 07/29/24 at 02:15 PM, observation revealed a dressing in place to R2's right outer foot dated 07/24/24. On 07/30/24 at 02:05 PM, Licensed Nurse (LN) I stated the charge nurse should update the care plan with changes in resident condition, new skin issues should be added as well as if a urinary catheter had been inserted. The facility policy Care Plans - Comprehensive Person - Centered dated March 2022, revealed assessments of residents are ongoing and care plans were to be revised as information about the residents and the residents' conditions change. The facility failed to revise R2's care plan to include the ulcer to her right foot. - The Medical Diagnosis tab for Resident (R)5 included diagnoses of need for assistance with personal care, urinary tract infection, and benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections). The Admission Minimum Data Set, dated dated dated [DATE] assessed R5 with a Brief Interview of Mental Status (BIMS) score of 14, indicating intact cognition. R5 did not reject care and had an indwelling catheter. The Urinary Incontinence and Indwelling Catheter Care Area assessment dated [DATE], revealed R5 had an indwelling catheter for bladder elimination and catheter cares were provided every shift and as needed. The Care Plan dated 05/07/24, for R5 revealed he had an indwelling urinary catheter and the staff provided catheter cares every shift. The care plan lacked R5 would empty the catheter on his own at times. The Order tab included orders dated 07/26/24 for the staff to flush the catheter with 100 cubic centimeters (cc) of normal saline as needed to prevent clogging every eight hours as needed for catheter care. The staff were to straight catheter as needed and monitor bladder volume, change the catheter every 30 days or as needed, and to provide catheter care every shift. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/30/24 at 08:33 AM, revealed R5 propelling his wheelchair down a hallway. R5's urinary catheter tubing exited from the bottom of his pant leg then up and across a lap tray in front of him to the drainage bag that was hanging on the side of the wheelchair just below the armrest and above the wheelchair seat level. The urinary drainage bag lacked a cover bag. On 07/30/24 at 02:05 PM, Licensed Nurse (LN) I stated the charge nurse should update the care plan with changes in resident condition, new skin issues should be added as well as if a urinary catheter had been inserted. On 07/30/24 at 04:33 PM, CNA M stated the staff drain his urinary catheter bag, and the tubing should not come out of the bottom of his pant leg and up across the table, the bag should be under his wheelchair. On 07/30/24 at 04:46 PM, Administrative Nurse D stated R5 had just returned to the facility and R2 does empty his own bag sometimes and measures and shows the CNA's how much he has had out. Administrative D stated she thought the care plan outlined about him emptying his own drainage bag and him trying to handmake his own cover bags. The facility policy Care Plans - Comprehensive Person - Centered dated March 2022, revealed assessments of residents are ongoing and care plans were to be revised as information about the residents and the residents' conditions change. The facility failed to revise R5's care plan regarding management of the catheter, including keeping below bladder level.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41121 The facility reported a census of 68 residents with three sampled residents for skin conditions. Based on observation, interview, and record review, the facility failed to ensure the staff provided treatments as ordered to Resident (R)2, who had an ulcer to her right foot, monitor her wound status weekly, and ensure she had pressure relieving boots in place when in bed. Findings included: - The Medical Diagnosis tab for R2 included diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) with neuropathy (weakness, numbness and pain from nerve damage, usually in the hands and feet), hemiplegia (paralysis of one side of the body) affecting right dominant side, dementia (progressive mental disorder characterized by failing memory, confusion), muscle weakness, and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) to bilateral (both) knees. The Quarterly Minimum Data Set (MDS) dated [DATE], assessed R2 with a Brief Interview of Mental Status (BIMS) score of 14, indicating intact cognition and she did not reject care. R2 had a range of motion impairment to one side of her upper and lower extremities and used a wheelchair for mobility. R2 was dependent on staff for bed mobility and taking off and putting on footwear. R2 was at risk 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) and did not have any type of ulcers present, had a pressure reducing device to her bed and chair, and was not on a turning/repositioning program. The Annual MDS dated [DATE], assessed R2 with a BIMS score of 10, indicating moderate cognitive impairment and she did not reject care. R2 continued to have a range of motion impairment to one side of her upper and lower extremities and used a wheelchair for mobility. R2 was totally dependent on staff for taking off and putting on footwear and required substantial/maximal assistance with bed mobility. R2 continued to be at risk for pressure ulcers, did not have any type of ulcers, continued to require a pressure reducing device to bed and chair, and was not on a turning/repositioning program. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 06/13/24, revealed R2 had a cognitive impairment, and was alert and oriented with confusion. The Functional Abilities CAA dated 06/13/24, revealed R2 had limitations to her range of motion on one side, was able to make her wants/needs known to staff, and the staff also anticipated her needs. R2 was dependent on staff for all aspects of dressing and required substantial/maximal assistance with rolling left and right. The Pressure Ulcer/Injury CAA dated 06/13/24, revealed R2 was at risk for skin breakdown and required substantial/maximal assistance for bed mobility. The staff reposition her every two hours while in bed and every one-hour while in the chair and the Licensed Nurse (LN) does weekly and PRN (as needed) skin assessments. The certified staff observe R2's skin daily with cares. R2 had a pressure relieving mattress on her bed and wore moon boots (orthopedic device) while in bed to offload heels. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan dated 06/18/24, revealed R2 required one person assistance for bed mobility and EZ boots (protective/pressure reducing boot) on while in bed. R2 was at risk for impaired skin integrity, skin/tissue color changes, and pressure ulcers related to diagnosis of hemiplegia, obesity, and diabetes mellitus. Staff were to monitor/document location, size, and treatment of any skin injuries, and report any abnormalities, failure to heal, signs and symptoms of infection, 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), etc. to the physician as indicated, and provide any treatments as ordered. The staff were to perform weekly skin/treatment documentation in accordance with the wound nurse assessment and plan of care recommended. The Care Plan lacked presence of any wounds. The physician Progress Notes located under the miscellaneous tab dated 06/18/24, revealed R2 had a callus (area of thickened and sometimes hardened skin that forms as a response to repeated friction, pressure, or other irritation) to the sole of her right foot and plan was to consult the wound center. The Weekly Nursing Skin assessment dated [DATE], revealed R2 had a callus to her right foot and was to be seen by the wound center as ordered. The Progress Note dated 06/24/24 revealed Administrative Staff B notified Licensed Nurse (LN) I of an area to R2's right foot. R2 had a pink/black area that measured 6.0 centimeters (cm) by 3.0 cm to the lateral (pertaining to the side, away from the middle) edge of her right foot and the resident reported pain of a 10 on the zero to 10 pain scale, with 10 indicating the highest amount of pain, when touched. LN I notified Administrative Staff A of the area. LN I received a new order for R2 to be seen by the wound center to evaluate and treat the area. The Weekly Nursing Skin assessment dated [DATE], revealed the lateral front edge of R2's right foot had a 6. 0 centimeter (cm) by 3.0 cm pink/black area that was new. The physician Progress Notes located under the miscellaneous tab dated 06/25/24, revealed R2 had been evaluated last week, had reported pain to her right foot, and presented with a callus. During assessment, she presented with a pressure deep tissue injury (DTI- purple or maroon localized area of discolored intact skin or blood?filled blister due to damage of underlying soft tissue from pressure and/or shear). R2 scheduled to be evaluated by the wound center tomorrow (06/26/24), may use Unna boot (a compressive dressing to aid in circulation and wound healing) to assist with relieving pressure. The wound center Progress Note dated 06/26/24, revealed vascular (vessels which carry blood) disease, and the staff were to use Skin-prep (liquid skin protectant) to stabilize the eschar (dead tissue). The Assessment tab for R2 lacked a Weekly Non-Pressure Wound Assessment until 06/26/24. On 06/26/24, the assessment revealed R2 had an arterial wound, a deep dark-colored area on her right lateral foot including her fifth toe, with an onset date of 06/19/24. The area did not blanch and was not open and measured 6.0 cm by 4.0 cm. The surrounding skin appeared dark/discolored on the right lateral foot. The treatment was for skin prep (protective wipe) to the area daily. Documentation revealed the wound improved. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Treatment Administration Record (TAR) dated June 2024, lacked any treatment interventions for R2's right foot. The podiatry Order Sheet dated 06/26/24, revealed the house physician was to evaluate, R2 had a possible diabetic pressure sore and ordered non-invasive arterial studies of the right lower extremity. The Progress Note dated 06/26/24, revealed R2 was seen by the wound care center for the dark colored, non -blanchable area to her lateral right foot including her 5th toe. The area measured approximately 6.0 cm by 4.0 cm and was not open and was boggy in texture with palpation (a physical examination using touch). R2 received a new order for an x-ray of the right lateral foot and arterial doppler of her right lower extremity. The right foot x-ray Final Report dated 06/26/24 for R2 revealed the reason for the exam was large bruise on foot and soft tissue swelling present. The Weekly Nursing Skin assessment dated [DATE], revealed the lateral front edge of R2's right foot, onset date of 06/19/24, would be seen in house by the wound care team on 07/03/24. The wound center Progress Note dated 07/03/24, revealed wound debrided (medical removal of dead, damaged, or infected tissue to improve the healing potential for the remaining healthy tissue), hold off on a vascular consult due to negative testing and wound improvement, and continue with dressing change every other day. The physician Progress Note dated 07/02/24 revealed an arterial doppler (ultrasonography used to evaluate the direction and pattern of blood flow) had been obtained and revealed no findings and results sent to the wound center. Diagnosis continued to be pressure injury of deep tissue of right foot. The Weekly Non-Pressure Wound assessment dated [DATE], revealed R2 had a discoloration to her right lateral foot, and the treatment was to monitor. The assessment lacked measurements or a description of the area. The Weekly Nursing Skin assessment dated [DATE], revealed the wound center removed the hard outer layer of skin to her right foot, received new treatment orders, and the wound center would see R2 the next in house visit on 07/10/24. The wound center Progress Note dated 07/10/24 revealed a diagnosis of arterial or pressure wound, debrided wound, and switched the dressing to Hydrofera Blue (highly absorbent vertically wicking foam primary dressing embedded with three proven antimicrobials) because the alginate (dressing which forms a soft, gel that absorbs when it comes into contact with wound exudate) was sticking. The staff were to change the new dressing every two to three days. The Weekly Non-Pressure Wound assessment dated [DATE], revealed R2 had a discoloration to her right later foot, and the treatment was to monitor. The assessment lacked measurements or a description of the area. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Order tab for R2 revealed a treatment order to the open area to right lateral foot, dated 07/11/24, for the staff to remove the dressing, cleanse with wound cleanser, pat dry with clean dry gauze, place derma blue (highly absorbent vertically wicking foam primary dressing embedded with three proven antimicrobials) over the open area, and cover with a silicone dressing. The staff were to change the dressing on Monday, Wednesday, and Friday on the day shift, and as needed if the dressing became dislodged. The facility lacked treatment orders to R2's right foot until this date (23 days later) from when the facility noted the callus area and planned to consult the wound center. The Weekly Non-Pressure Wound assessment dated [DATE], revealed R2 had an arterial ulcer to her right lateral foot that measured 2.02 cm by 1.49 cm, and was without drainage or odor. The ulcer had 76 to 100 percent (%) eschar (dead tissue), and the staff documented the wound as improved. The treatment was to clean with wound wash for mechanical debridement, apply Hydrofera blue (a type of moist wound dressing which provides wound protection and addresses bacteria and yeast) or derma blue, and cover with bordered gauze. The wound center Progress Note dated 07/24/24 for R2 revealed wound debrided and continue with the Hyrdofera Blue and a border dressing. There were no signs of infection, and the staff were to continue with the same dressing orders and continue to offload appropriately. The Weekly Non-Pressure Wound assessment dated [DATE], revealed R2 had an arterial ulcer to her right foot that measured 0.5 cm by 0.2 cm, with 76 to 100% eschar, treatment same as the last assessment and wound improved. The TAR dated July 2024, revealed the staff changed R2's dressing to her right foot on Friday, 07/26/24. On 07/29/24 at 10:00 AM, observation revealed R2 in bed with the head of the bed elevated approximately 90 degrees and she was eating breakfast. R2 had covers over her and her bed had an air mattress in place. On 07/29/24 at 10:02 AM, R2 stated she had a wound to the little toe of her right foot, and it was elevated on a pillow. R2 stated the staff do a dressing change to the area weekly on Wednesdays. R2 stated she has had the area for about three months and the area was getting better. R2 stated about a month ago the wound really stared to bother her, and the foot doctor came and seen it, the nurse in the facility took pictures and referred her to another doctor, then another guy who looked at it and said to prop it up and see where it would go from there and wrapped it up. That doctor comes on Wednesday, and he pulls part of the scab off so it can breathe, changes the dressings, and the nurses check on it too and change the dressing. On 07/29/24 at 11:46 AM, LN G stated she had not seen R2's foot yet her shift which began at 06:00 AM, and LN I would complete the dressing change unless it came off. On 07/29/24 at 11:52 AM, observation revealed R2 continued to be in her bed in the same position as she was at 10:00 AM, with her breakfast tray in front of her and had a family member in her room with her. Directly on the floor under a folding chair was a pressure reducing boot. On 07/29/24 at 12:01 PM, LN G removed the breakfast tray from R2's table and stated the wound care nurse was on her way into the facility. R2 remained in the same position as she was at 10:00 AM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/29/24 at 02:09 PM, observation revealed R2 in her bed with the head of the bed elevated and there continued to be a pressure reducing boot directly on the floor under a folding chair. On 07/29/24 at 02:15 PM, Certified Nurses Aide (CNA) M and CNA Q entered the resident's room to provide cares. When they moved the covers off her, she lacked a pressure relieving boot to her left and right foot and a pillow was in place under her right leg. R2's right leg was extremely dry and flaky, and a dressing was in place to her right outer foot. CNA Q stated the dressing had a date of 07/24 and surveyor observation revealed date of 07/24 (Wednesday), indicating staff failed to change the dressing on Friday, 07/26/24. The dressing to her foot was loose in one of the corners. After finishing cares, staff covered her up and did not place any pressure reducing boots to her feet and did not offload her foot with the pillow. When the surveyor asked about when R2 was to have the pressure reducing boots in place, CNA Q picked up the boot off the floor and stated she wore it a night for a wound and to keep her heel off the mattress. On 07/29/24 at 02:20 PM, CNA M stated R2 was to wear the boot at night and during the day the staff were to float her heel on a pillow, and she as not sure if R2 had a wound on her heel or not. On 07/29/24 at 04:04 PM, LN H stated R2 had a wound on the bottom of her foot and the staff on the morning shift was responsible to care for the wound. LN H stated the staff were to put a pillow underneath to offload the foot to make sure R2's right foot did not touch the footboard because she had a habit of sliding down in the bed. LN H stated she had seen the boot on R2 but did not know when it was to be in place and R2's medical record lacked a physician order for the boot. LN H was not sure the cause of the foot ulcer and recalled they called it a diabetic ulcer. On 07/30/24 at 07:56 AM, R2 observed laying in the bed on her back, covered up and a pressure relieving boot was directly on the floor under a folding chair. On 07/30/24 at 08:03 AM, observed R2's dressing to her right foot with LN G, which had a date of 07/29/24. R2 had socks on her feet and lacked a pillow to offload, however the area where the dressing was did not have contact with the bed. LN G stated R2 was to have the boot on when in bed. LN G then picked the boot up which was in direct contact with the floor and preceded to put the boot on R2's right foot when surveyor questioned if the boot should be used, she stated she would find another EZ boot. On 07/30/24 at 02:25 PM, Administrative Nurse D stated she did the weekly wound assessments for pressure and non-pressure wounds, and the assessment should include measurements, current treatments, tissue types, wound appearance, and any interventions in place. Administrative Nurse D stated the facility had problems getting wound center notes when questioned what was being done for R2's foot wound prior to 07/11/24. Administrative Nurse D stated R2 did not have an open wound, so there was not a trigger that a treatment should have been in place. Administrative Nurse D stated the EZ boot was a little soft boot for protection, thought it was in case R2's foot had pressure at the end of the bed, and R2 was to have the boot on while in bed. Administrative Nurse D stated the staff should not document in the TAR if a dressing had been changed when it had not been changed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Pressure Ulcers/Skin Breakdown - Clinical Protocol dated April 2018, revealed the nurse shall describe and document/report the following: full assessment of pressure sore including location, stage, length, width, and depth, presence of exudates or necrotic tissue, pain assessment, mobility status, current treatments including support surfaces, and all active diagnoses. The policy lacked the frequency of the assessment. The facility failed to ensure the staff provided treatments as ordered to Resident (R)2, who had an ulcer to her right foot, monitor her wound status weekly, she had pressure relieving boots in place when in bed.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41121 The facility reported a census of 68 residents, with five sampled, including 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 observation, interview, and record review, the facility failed to ensure Resident (R)1, who was totally dependent on staff for cares, had been repositioned timely and his brief changed timely after bowel and/or bladder incontinent episodes. Furthermore, the facility failed to monitor R1's skin weekly, conduct weekly wound assessments, and provide wound treatments as ordered. R1 developed an unstageable pressure ulcer (depth of the wound is unknown due to the wound bed is covered by a thick layer of other tissue and pus) on 05/20/24. The facility did not identify the wound until 06/03/24 and failed to assess the wound until 06/05/24. R1's wound progressed to a stage four pressure ulcer (a deep pressure wound that reaches the muscles, ligaments, or even bone). R1 developed additional skin issues to his left outer ankle, left ear, upper right abdomen, and second and third digit of his right hand. Findings included: - The Medical Diagnosis tab for R1 included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), Down's Syndrome (chromosomal abnormality characterized by varying degrees of mental retardation and multiple defects), and muscle weakness. The Significant Change Minimum Data Set (MDS) dated [DATE], assessed R1 with a short-term and long-term memory loss and impaired decision making. He did not reject care and was dependent on staff for bed mobility, transfers, and toileting, and required a wheelchair for mobility. R1 was always incontinent of bowel and bladder and at risk for developing pressure ulcers/injuries. He had two Stage 2 pressure areas (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) that were not present on admission and/or reentry. R1 required a pressure reducing device for his chair and bed and was not on a turning/repositioning program. He received nutrition or hydration interventions to manage skin problems, application of nonsurgical dressings and ointments/medications other than to his feet. R1 received hospice services. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 01/12/24, revealed R1 had a memory problem making his decisions regarding tasks of daily life severely impaired. The Urinary Incontinence and Indwelling Catheter CAA dated 01/12/24, revealed R1 was incontinent of bowel and bladder, wore incontinent products, and was dependent on staff for all aspects of toileting needs. The Pressure Ulcer/Injury CAA dated 01/12/24, revealed R1 was at risk for skin breakdown and had two stage two pressure ulcers to his left hip. R1 was dependent on staff for all aspects of bed mobility and had a pressure relieving mattress on his bed and a pressure relieving cushion to his chair. R1 required pressure relieving boots while in bed. The Licensed Nurse (LN) was to do a weekly/PRN (as needed) skin assessment and certified staff were to observe skin daily with cares. The staff were to report any new skin areas to the primary care provider for review. R1 recently changed hospice providers and was back on hospice services. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Quarterly MDS dated [DATE], for R1 revealed no change to his memory recall or decision making. R1 did not reject care and continued to be dependent on staff for bed mobility, transfers, toileting, and required a wheelchair for mobility, and had no range of motion impairments, and was frequently incontinent of bladder and always incontinent of bowel. R1 continued to be at risk for developing pressure ulcers/injuries and had one stage two pressure area which was not present on admission/reentry, and one unstageable pressure ulcer (depth of the wound is unknown due to the wound bed is covered by a thick layer of other tissue and pus) which was not present on admission/reentry. R1 required a pressure reducing device for his chair and bed and was not on a turning/repositioning program. He received nutrition or hydration interventions to manage skin problems, required pressure ulcer/injury care, and application of nonsurgical dressings and ointments/medications other than to feet. R1 continued to receive hospice care. The Care Plan dated 07/25/24 for R1 revealed the following: On 11/21/23 the plan revealed R1 had a potential for impaired skin integrity and was at risk for pressure ulcers. The staff were to utilize pressure reduction equipment, turn and reposition R1, used a cushion in his wheelchair/recliner, specialty mattress to the bed and utilized a ROHO cushion (pressure relief cushion that is made of soft, flexible air cells). Staff were to monitor and document location, size and treatment of skin injury and report any abnormalities, failure to heal, signs and symptoms of infection, maceration (softening and breaking down of skin as a result from prolonged exposure to moisture, such as sweat, urine or feces), to the physician as indicated. The plan further revealed R1 was incontinent of bowel and a risk for impaired skin, rashes and irritation to the peri-area. The staff were to check R1 every two hours and assist with toileting as needed and provide peri-care immediately after incontinent episodes. R1 was totally dependent on staff for bed mobility, required a mechanical lift and two staff to assist with all transfers. R1 required staff to check and change his brief and provide peri-care with every incontinent episode as he allowed. An update on 06/17/24, revealed R1 had a pressure ulcer, stage two, to his right rear iliac crest (the curved area at the top of the hip bone) and left outer ankle related to his diagnosis of terminal illness. The goal was for his pressure ulcer to heal without complications through the end of the next review date. The Registered Dietician was to consult with any ongoing skin concerns and the staff were to encourage good nutrition/hydration to promote healing and follow the dietary interventions as recommended/ordered. The staff were to perform weekly skin/treatment documentation in accordance to the wound nurse assessment and plan of care recommended, and R1 was to be seen by the wound clinic as ordered. An update on 06/19/24, revealed R1 had an acute wound infection and staff were to administer antibiotics as ordered, treatments as ordered, and encourage dietary/fluid intake. The Orders tab included an order dated 04/30/24, instructing staff to assess R1's skin assessed weekly and obtain a set of vital signs for R1, on the day shift on Monday. The staff were to chart the assessment under the weekly skin evaluation. The hospice Skilled Nursing Visit Note dated 05/17/24 at 09:15 AM, revealed Consultant II documented there was a urine odor and R1's brief, gown, bed pad, and linens were all saturated with urine. R1 had a concerning area to his buttocks and a foam dressing applied to protect the skin and prevent breakdown. The visit note included Consultant Staff II communicated with Administrative Nurse D and CNA's regarding the condition of R1. The Assessments tab for R1 lacked a Weekly Nursing Skin Assessment on 05/20/24, the scheduled date the staff were to complete it. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The hospice Skilled Nursing Visit Note dated 05/20/24 at 11:10 AM by Consultant Staff II, revealed R1 had an unstageable pressure ulcer to his upper medial buttocks. The wound bed was 50 percent (%) black, 15% yellow, and 35% red in color and measured 4.5 centimeters (cm) length, by 2.0 cm width, by 0.2 cm deep with a moderate amount of serosanguinous (semi-thick blood-tinged drainage) drainage. The note revealed the wound was new and appeared to be unstageable, the physician consulted and advised a treatment, and Consultant Staff II provided the care per orders. Consultant Staff II communicated with the facility nurse (did not specify name) and R1's durable power of attorney regarding his condition. The Progress Notes dated 05/21/24 at 03:27 PM, for R1 revealed a nutrition/dietary note by Dietary Staff BB. The note revealed per Administrative Nurse D, R1's skin had healed and currently intact, no order changes. The facility failed to notify Dietary Staff BB of R1's pressure area. The Weekly Nursing Skin assessment dated [DATE], documented R1 had no alterations in skin integrity. (This was seven days after the hospice identified an unstageable wound to R1's upper medial buttocks.) The hospice Skilled Nursing Visit Note dated 05/27/24, revealed R1 lacked a dressing to his wound and Consultant Staff II provided wound care as ordered and communicated with the facility staff nurse (name not specified) regarding his condition. The hospice Skilled Nursing Visit Note dated 05/30/24, revealed Consultant Staff II provided wound care as ordered to R1 and coordinated care with LN G. LN G discussed her frustration with Consultant Staff II about staff not communicating if R1's dressing had become dislodged and left open to air. Consultant Staff II provided education to facility staff to frequently reposition and provide peri-care. Consultant Staff II confirmed with LN G that the facility nurse would replace R1's dressing if it should be dislodged or the facility would call hospice to take care of it. The Weekly Nursing Skin assessment dated [DATE], revealed R1 had an unstageable pressure area to right iliac crest (rear) and Administrative Nurse D and hospice were notified. The assessment lacked measurements and characteristics of the pressure area. The hospice Aide Visit Note dated 06/03/24, revealed the aide notified Consultant Staff II that R1's entire brief, outfit, linens, and mattress were soaked with urine when the aide arrived at 10:11 AM. The hospice Skilled Nursing Visit Note dated 06/03/24, revealed the upper medial buttocks wound was 10% red, 80% yellow, and 10% black, measured 3.5 cm by 2.5 cm by 0.1 cm, and the wound had declined in appearance since the last visit. Consultant Nurse II continued to educate staff (lacked names) to frequently reposition R1 and provide peri-care to prevent further skin breakdown and improve skin integrity. The Treatment Administration Record (TAR) dated June 2024 included a treatment order for R1's lower medial back region on 06/04/24. The facility failed to have a treatment order in place for R1's pressure area until 15 days after onset of the area on 05/20/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Weekly Pressure Wound assessment dated [DATE] (two days after the facility identified the pressure area, however hospice had identified on 05/20/24), revealed R1 had an unstageable pressure ulcer to his right iliac crest (rear) which measured 4.0 cm by 2.0 cm by 0.1 cm, had a moderate amount of serosanguineous and purulent drainage with slight odor. The wound was covered with 100% slough (dead tissue, usually cream or yellow in color), the surrounding skin macerated (softening and breaking down of skin as a result from prolonged exposure to moisture, such as sweat, urine, or feces), the wound had deteriorated, and lacked an onset date. The facility failed to document wound characteristics until two days after they had identified the area. The hospice Skilled Nursing Visit Note dated 06/06/24, revealed R1's wound had 85% eschar and 15% slough, with a large amount on sanguineous (bloody) drainage with mild odor. R1 was lying on his back upon arrival at 10:40 AM, saturated with urine, and his wound to the lower medial back significantly declined. The staff had been educated extensively by Consultant Staff II on importance of changing and repositioning R1 every two hours being careful to offload the wound, but unsure of how well this is being carried out. Consultant Staff II consulted with the physician and sent a picture of the wound progression, who then changed the treatment orders to the wound. The hospice Chaplain Visit Note dated 06/07/24 revealed Consultant Staff JJ spoke with members of the hospice team [specified names] about the issue of neglect from the facility. The hospice Medical Social Worker Note dated 06/07/24, revealed R1's durable power of attorney (DPOA) posted several signs in R1's room reminding staff to reposition him, change any wet briefs, and offer him drinks when they were in his room. R1's DPOA noticed a new open area to his outer left ankle, photographed the area, and forwarded it to a hospice nurse for review and follow up. The Weekly Nursing Skin assessment dated [DATE], revealed R1 had a pressure area to his right iliac crest measuring 5.5 cm by 3.5 cm. The assessment lacked documentation of any skin issues to R1's left outer ankle, which R1's DPOA had discovered three days prior. The Progress Note dated 06/11/24 at 02:06 PM, by Administrative Nurse D revealed there was a meeting held on 06/11/24 regarding care concerns. Hospice voiced concerns with him being changed on a regular basis and laying on his back too often. R1 had a current wound on the rear ischium (part of the hip bone or over the hip bone area). The facility assured hospice that R1 was on a current every two-hour repositioning schedule and on an air mattress. New hourly checks to be completed for R1 to prevent him from becoming soiled or saturated in his brief and the staff would ensure facility staff repositioned R1 hourly. The Weekly Pressure Wound assessment dated [DATE], revealed R1 had a right iliac crest (rear) unstageable pressure ulcer, lacked onset date, and measured 5.5 cm by 3.5 cm by 0.1 cm, continued to be covered with 100% slough, had moderate amount of purulent (producing or containing pus) and serosanguineous drainage with slight odor, with surrounding skin macerated. This was an increase in size from the prior assessment on 06/05/24. The assessment lacked documentation about R1's left outer ankle, discovered by R1's DPOA five days prior. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Progress Note dated 06/14/24 at 03:26 PM, revealed R1 had a new open area found on his left outer ankle, which was an old pressure area that re-opened. The staff cleaned the area, applied triple antibiotic ointment, and covered with a border gauze dressing. A new wound care order was in place for daily wound care. The facility failed to identify the area until seven days after R1's DPOA discovered the area. The Weekly Pressure Wound assessment dated [DATE] revealed the same measurements and wound assessment as 06/05/24 of the right iliac crest (rear) unstageable pressure ulcer. The assessment revealed a new stage two pressure ulcer to R1's outer left ankle, a previous area which reopened, and measured 0.3 cm by 0.3 cm by 0.1 cm. The hospice Skilled Nursing Visit Note dated 06/16/24 revealed Consultant Staff GG arrived at facility at 11:04 AM, the facility requested a visit due to an increased odor coming from R1's wound. The facility nurse (lacked name) accompanied Consultant Staff GG to R1's room. The old dressing had a moderate amount of serosanguineous fluid, and the wound had an increased amount of necrotic (pertaining to the death of tissue in response to disease or injury) tissue compared to two days ago. Consultant Nurse GG contacted the physician and received new orders for wound treatment, change dressing daily, and start Cipro (antibiotic), 500 milligrams (mg), by mouth, twice daily, for two weeks. The hospice Skilled Nursing Visit Note dated 06/17/24 with arrival time of 04:30 PM, revealed Consultant Staff II attempted to coordinate care with LN J, who said she did not have time to talk, when trying to inquire if R1's wound care had been done as R1 was eating supper. LN J then stated it had been done. LN J admitted that she knew her, and the staff, must do better with changing and checking R1 routinely. Consultant Staff II discussed R1's care with Administrative Nurse D, who believed R1 was doing well. Consultant Nurse II showed Administrative Nurse D image of wound from the previous day, discussed status of it, and having the provider that comes to the facility debride (medical removal of dead, damaged, or infected tissue to improve the healing potential for the remaining healthy tissue) the wound if the physician would give the order for it. Consultant Staff II consulted with the physician and R1's DPOA who agreed with the plan, and orders received. The hospice Skilled Nursing Visit Note dated 06/18/24 revealed Consultant Staff II assessed R1's upper medial buttock wound which was covered with 90% eschar (dead tissue) and 10% slough (dead tissue, usually cream or yellow in color). The wound measured 6.5 cm by 5.0 cm. The wound center Progress Note dated 06/19/24 revealed R1 had a pressure ulcer to the right inferior buttock, wound debrided with post debridement measurements of 3.57 cm by 2.95 cm by 0.3 cm, and the post debridement wound stage was a stage three pressure injury (full thickness pressure injury extending through the skin into the tissue below). The hospice Skilled Nursing Visit Note dated 06/19/24 revealed Consultant Staff II arrived as the practitioner just finished debridement of R1's wound, obtained image of wound, and sent to provider for orders since eschar removed. Orders received and Consultant Staff II relayed visit information to LN G, then visited with Administrative Nurse D. Consultant Staff II had visited with R1's DPOA about staff concerns and agreed the implemented checklist should be revised to be done every two hours and plan solidified with Administrative Nurse D for revision to reflect documentation of care to every two hours. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility failed to provide checklists prior to 06/19/24. The Hourly/Frequent Checks log for 06/19/24 revealed R1 was on his right side at 08:00 AM until turned to left side at 11:00 AM (three hours), where he remained on his left side until he was turned to his back at 02:00 PM (three hours). R1 was on his left side for three hours from 10:00 PM to 01:00 AM when turned to his right side, where he remained until 04:00 AM (three hours) when staff turned him to his left side. The facility failed to reposition R1 every two hours. The hospice Skilled Nursing Visit Note dated 06/20/24 revealed R1's wound care was now three times weekly, and no daily visits warranted. R1 was wet and Consultant Staff II provided peri-care, changed brief, and provided wound care. The Weekly Pressure Wound assessment dated [DATE] revealed the same measurements and wound assessment as 6/12/24 and 06/14/24 for R1's unstageable pressure ulcer to right iliac crest (rear). The facility failed to document current wound characteristics. The Hourly Frequent Checks for R1 dated 06/21/24 revealed R1 was on his right side at 11:00 AM and on his left side at 02:00 PM (three hours). R1 was on his right side at 01:00 AM and the log lacked documentation until 04:00 AM (three hours) to indicate he was on his left side. The facility failed to reposition R1 every two hours. The hospice Skilled Nursing Visit Note dated 06/22/24, revealed Consultant Staff II did an as needed (PRN) visit due to R1's dressing on his wound being saturated. The dressing changed yesterday afternoon for R1 had become completely saturated with wound drainage. Consultant Staff II contacted the physician and orders changed to daily until the wound improved. Consultant Staff II provided wound care per orders and communicated the new change to the DPOA and the facility. The Hourly Frequent Checks for R1 dated 06/22/24 revealed he was on his left side at 11:00 AM and every hour after that until 04:00 PM (five hours) when he was on his right side. R1 was on his right side at 09:00 PM and on his left side at 12:00 AM (three hours later). The facility failed to reposition R1 every two hours. The hospice Skilled Nursing Visit Note dated 06/23/24 revealed Consultant Staff GG arrived at the facility at 06:29 PM and returned to R1's room with an aide from the facility. R1 laid on his back with his brief saturated with urine. The Hourly Frequent Checks for R1 dated 06/23/24, revealed the staff documented he was on his left side at 08:00 PM, 09:00 PM, 10:00 PM, 11:00 PM lacked documentation, and at 12:00 AM. The log lacked R1 moved to right side until 01:00 AM (five hours later). The facility failed to reposition R1 every two hours. The hospice Skilled Nursing Visit Note dated 06/24/24, revealed R1's upper medial buttock pressure ulcer, now labeled as a stage four (a deep pressure wound that reaches the muscles, ligaments, or even bone), included an assessment of the wound to have a large amount of yellow-green drainage with a foul odor and measured 5.5 cm by 4.0 cm by 0.5 cm. Consultant Staff II arrived at the facility at 02:30 PM and noted R1's protective underwear saturated with urine. Consultant Staff II noted wound malodorous after doing peri-care, brief change, and wound care, and contacted the physician regarding this with new orders received for wound care. (continued on next page)

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	175078	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	The Hourly Frequent Checks for R1 dated 06/24/24 revealed R1 was on his left side at 08:00 AM, 09:00 AM, and 10:00 AM (three hours), and on right side at 11:00 AM, 12:00 PM, and 01:00 PM (three hours). R1 was on his left side at 04:00 PM, 05:00 PM, and 06:00 PM (three hours) and on his right side at 07:00 PM, 08:00 PM, and 09:00 PM (three hours), and on his back at 10:00 PM, 11:00 PM, and 12:00 AM (three hours). At 01:00 AM, 02:00 AM, and 03:00 AM (three hours) R1 was on his left side. The facility failed to reposition R1 every two hours. The hospice Skilled Nursing Visit Note dated 06/25/24 revealed Consultant Staff II arrived at facility at 04:30 PM and facility LN K came into the room to look at R1's wound because she had not seen it. The note revealed the upper medial buttocks wound had tunneling (a portion of a wound that extends deeper into the tissue than the surface creating a channel or tunnel) at 11 o'clock position at 0.6 cm, and at six o'clock position that measured 0.4 cm. The tunneling had not been present on the prior assessments. The hospice Skilled Nursing Visit Note dated 06/26/24, revealed Consultant Staff II arrived at 01:50 PM, facility staff finished feeding him lunch, she then conducted her assessment and provided wound care. The note revealed odor continued to be faint but improved. LN G reported the dressing had come off the evening shift and they had only applied a wet-to-dry dressing, which was still intact upon arrival, and had some strikethrough from drainage. Further skin assessment showed a new area to the inner aspect of the left elbow that measured 0.6 cm by 0.4 cm by 0.1 cm, and a new area to his left ear wound measured 0.9 cm by 0.5 cm by 0.1 cm with blood drainage, which appeared to be associated with some pressure from the oxygen tubing in combination with him resting on the left side of his face. The physician advised treatments to the areas. Consultant Staff II labeled both areas as stage two pressure areas. Consultant Staff II communicated with staff nurse (lacked name) regarding R1's condition. The Hourly Frequent Checks dated 06/26/24, revealed R1 was on his right side at 06:00 AM, 07:00 AM, 08:00 AM, 09:00 AM (four hours) until he was on his left side at 10:00 AM. He remained on his left side at 11:00 AM, 12:00 PM, 01:00 PM (three hours) until he was on his right side at 02:00 PM. R1 was on his right side 11:00 PM through 01:00 PM (three hours) and on his left side at 02:00 AM, 03:00 AM, and 04:00 AM (three hours) until 05:00 AM when he was on his right side. The facility failed to reposition R1 every two hours. The hospice Skilled Nursing Visit Note dated 06/27/24 revealed Consultant Staff II the dressing to R1's inner aspect of his left elbow dislodged. The facility failed to identify R1's dressing was not intact. The Weekly Pressure Wound assessment dated [DATE] for R1 revealed unstageable pressure area to right iliac crest with the same measurements and wound characteristics as the assessment on 06/12/24, 06/14/24, and 06/21/24. The left ankle had the same measurements as the assessment on 06/14/24 and 06/21/24. The facility failed to document R1's current wound characteristics. The TAR dated June 2024 for R1 revealed documentation of 9 indicating other, see progress note for the wound care to right buttock on 06/28/24. The Progress Notes lacked an entry for 06/28/24 to indicate why the staff did not provide wound care to the right buttock. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Hourly Frequent Checks dated 06/28/24 for R1 revealed he was on his right side at 06:00 AM, 07:00 AM, 08:00 AM, and 09:00 AM (four hours) on his left side at 01:00 PM until 04:00 PM when on his right side (three hours). The log revealed R1 was on his right side at 11:00 PM, 12:00 AM, and 01:00 AM (three hours), and on his left side at 02:00 AM, 03:00 AM, and 04:00 AM (three hours). On 06/29/24 the log revealed R1 was on his left side at 11:00 PM, 12:00 AM, and 01:00 AM (three hours), and on his right side at 02:00 AM, 03:00 AM, and 04:00 AM (three hours). The facility failed to reposition R1 every two hours. The hospice Skilled Nursing Visit Note dated 06/30/24, revealed Consultant Staff MM arrived at the facility at 01:40 PM and R1 was lying flat on his back, his brief very saturated in urine. The Hourly Frequent Checks dated 06/30/24 for R1 revealed he was on his left or right side for three hours at a time on five different occasions. The facility failed to reposition R1 every two hours. The Weekly Nursing Skin assessment dated [DATE] for R1 revealed he had a pressure area to his right iliac crest and left outer ankle. The assessment lacked any areas to his left ear or the inner aspect of his left elbow. The hospice Skilled Nursing Visit Note dated 07/01/24 revealed R1's wound to his left ear had scabbed over, and Consultant Staff II had concern that the wound to his lower back was tunneling. The upper medial buttock wound measured 6.0 cm by 3.0 cm by 0.5 cm, with tunneling 1.5 cm at nine o'clock and ten o'clock and 3.5 cm tunneling to 11 o'clock and twelve o'clock. The wound had large amount of serosanguineous and yellow-green drainage with mild odor. The inner elbow stage two pressure area measured 0.8 cm by 0.5 cm by 0.1 cm and improved. The Hourly Frequent Checks dated 07/01/24 revealed R1 was up for supper at 05:00 PM, 06:00 PM, and 07:00 PM (three hours). R1 was on his right side at 01:00 AM, 02:00 AM, 03:00 AM (three hours). The facility failed to reposition R1 every two hours. The facility lacked Hourly Frequent Checks for R1 on 07/02/24. The TAR dated July 2024 lacked documentation the staff provided wound care to R1's right buttock on 07/02/24 per physician order. The Hourly Frequent Checks dated 07/03/24, which was on the blank backside of another log, revealed R1 was on his left side for three hours on three occasions, and on his right side for three hours on one occasion. The facility failed to reposition R1 every two hours. The Weekly Pressure Wound assessment dated [DATE], for R1 revealed no changes in the measurements for the right iliac crest and the left ankle. The wound characteristics for the right iliac crest had not changed since 06/05/24. The wound assessment lacked the wound to the inner aspect of the left elbow. The facility failed to document current wound characteristics. The hospice Skilled Nursing Visit Note dated 07/07/24, revealed Consultant Staff MM arrived at 04:30 PM and R1 was lying in bed on his back, incontinent of bowel and bladder and his brief saturated with urine. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The TAR dated July 2024 revealed R1 had a weekly skin assessment performed on 07/08/24. However, the Assessment tab lacked a Weekly Nursing Skin Assessment for 07/08/24. The facility failed to perform a weekly skin assessment per physician order. The Weekly Pressure Wound assessment dated [DATE] revealed no changes in the measurements for the right iliac crest and the left ankle. The wound characteristics for the right iliac crest had not changed since 06/05/24. The facility failed to document current characteristics of R1's wounds. The hospice Medical Social Worker Visit Note dated 07/12/24, revealed Consultant Staff KK arrived at 10:50 AM, revealed R1's DPOA also present during visit. R1 found in a soiled brief, and his bedding and pads soiled with wound drainage. The hospice Skilled Nursing Visit Note dated 07/12/24, revealed Consultant Staff MM arrived at 03:40 PM and staff reported R1's dressing was coming off and saturated before lunch today, so they changed it. The note included orders received to insert a 16 French urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) to dependent drainage to assist with wound healing. Consultant Staff MM inserted the urinary catheter. The hospice Skilled Nursing Visit Note dated 07/14/24, revealed Consultant Staff HH arrived at 09:55 AM for R1's visit. Consultant Staff HH provided wound care. The old dressing had drainage that saturated the dressing with a copious (large) amount of purulent drainage with foul odor. Consultant Staff HH updated the facility staff nurse, LN L, on R1's wound care. The Weekly Pressure Wound assessment dated [DATE], revealed R1 had one wound present to his sacral area that was unstageable and measured 6.0 cm by 3.0 cm by 0.5 cm with prior measurements of 5.5 cm by 3.5 cm. The wound had serosanguineous and purulent drainage of a large amount and with slight odor. The wound bed was covered with 25% slough and had 76 to 100 % granulation tissue (new tissue formed during wound healing) with the surrounding skin macerated. The wound had tunneling/undermining of 1.5 cm at nine and ten o'clock, and 3.5 cm and 11 and 12 o'clock, the wound had deteriorated. The assessment lacked any other wounds. The hospice Skilled Nursing Visit Note dated 07/23/24, revealed R1's stage four pressure ulcer to his upper medial buttock measured 8.0 cm by 5.8 cm by 0.5 cm with 3.0 cm undermining at 12 o'clock and 3.5 cm at seven and nine o'clock, with a large amount of serosanguineous drainage. The Weekly Pressure Wound assessment dated [DATE], for R1 revealed the same measurements to the unstageable sacrum pressure ulcer as the week prior with no changes to the wound characteristic assessment. The assessment revealed wound deteriorated and lacked any other pressure wounds. The facility failed to document current wound characteristics. The hospice Skilled Nursing Visit Note dated 07/27/24, revealed Consultant Staff HH arrived at 08:55 AM and checked in with LN NN, who voiced no concerns. The note revealed new skin issues identified of a stage one pressure ulcer (pressure wound which appears reddened, does not blanche, and may be painful but is not open) to his second finger of his right hand with an onset date of 07/25/24 and a pressure ulcer, lacked stage, to his third finger of his right hand with an onset date of 07/25/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 07/29/24 at 11:10 AM, observation revealed R1 laid in bed on an air mattress tilted to his right side with the head of the bed elevated approximately 45 degrees, lacked clothing to upper body and lower body covered with a sheet, hands appeared contracted (abnormal permanent fixation of a joint or muscle), and a urinary catheter drainage bag hung from the right side of the bed frame. From the light fixture in the room above R1's bed were two notes. The first note read DO NOT LEAVE [specified resident] ON HIS BACK! Please, he has a buttock wound. Per his family - contact them for concerns. Thank you for helping us take good care of [specified name]. The second note revealed Check and change my brief regularly, also turning me often, do not let me set in urine or feces as this breaks down my fragile skin and it's pretty disgusting. Observation on 07/29/24 at 11:25 AM, revealed CNA N, CNA P, and CNA O entered R1's room to provide cares and get him up in the high back wheelchair. CNA N moved R1's high back wheelchair into the room, which has a pommel cushion (cushion with a raised section to assist in preventing a pe[TRUNCATED]

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41121 The facility reported a census of 68 residents with five residents reviewed, including three residents reviewed for urinary incontinence management. Based on observation, record review, and interview, the facility failed to provide timely incontinence care to Resident (R)1 and R2. Findings included: - The Medical Diagnosis tab for R1 included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), Down's Syndrome (chromosomal abnormality characterized by varying degrees of mental retardation and multiple defects), and muscle weakness. The Significant Change Minimum Data Set (MDS) dated [DATE], assessed R1 with a short-term and long-term memory loss and impaired decision making. He did not reject care and was dependent on staff for toileting. R1 was always incontinent of bowel and bladder. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 01/12/24, revealed R1 had a memory problem making his decisions regarding tasks of daily life severely impaired. The Urinary Incontinence and Indwelling Catheter CAA dated 01/12/24, revealed R1 was incontinent of bowel and bladder, wore incontinent products, and was dependent on staff for all aspects of toileting needs. The Quarterly MDS dated [DATE], for R1 revealed no change to his memory recall or decision making. R1 did not reject care, continued to be dependent on staff for toileting, and was frequently incontinent of bladder and always incontinent of bowel. The Care Plan dated 07/25/24 for R1 revealed he was incontinent of bladder and bowels and the staff were to check him every two hours and assist with toileting as needed and provide peri-care immediately after incontinence. R1 did not use a toilet, bed pan, or bed side commode, and the staff were to check and change brief and provide peri-care with every incontinent episode and as necessary. The care plan lacked use of a urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag). The hospice Skilled Nursing Visit Note dated 05/17/24 at 09:15 AM, revealed Consultant II documented there was a urine odor and R1's brief, gown, bed pad, and linens were all saturated with urine. The hospice Skilled Nursing Visit Note dated 05/30/24, revealed Consultant Staff II provided education to facility staff to frequently reposition and provide peri-care. The hospice Aide Visit Note dated 06/03/24, revealed the aide notified Consultant Staff II that R1's entire brief, outfit, linens, and mattress were soaked with urine when the aide arrived at 10:11 AM. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The hospice Skilled Nursing Visit Note dated 06/03/24, revealed Consultant Nurse II continued to educate staff (lacked names) to frequently reposition R1 and provide peri-care to prevent further skin breakdown and improve skin integrity. The hospice Skilled Nursing Visit Note dated 06/06/24 revealed upon arrival at 10:40 AM, R1 was on his back and saturated with urine. The staff had been educated extensively by Consultant Staff II on the importance of changing and repositioning R1 every two hours being careful to offload the wound, but unsure of how well this is being carried out. The hospice Chaplain Visit Note dated 06/07/24 revealed Consultant Staff JJ spoke with members of the hospice team [specified names] about the issue of neglect from the facility. The Progress Note dated 06/11/24 at 02:06 PM, by Administrative Nurse D revealed there was a meeting held on 06/11/24 regarding care concerns. Hospice voiced concerns with him being changed on a regular basis and laying on his back too often. R1 had a current wound on the rear ischium (part of the hip bone or over the hip bone area). The facility assured hospice that R1 was on a current every two-hour repositioning schedule and on an air mattress. New hourly checks to be completed for R1 to prevent him from becoming soiled or saturated in his brief and the staff would ensure facility staff repositioned R1 hourly. The hospice Skilled Nursing Visit Note dated 06/23/24, revealed Consultant Staff GG arrived at the facility at 06:29 PM and returned to R1's room with an aide from the facility. R1 laid on his back with his brief saturated with urine. The hospice Skilled Nursing Visit Note dated 06/30/24, revealed Consultant Staff MM arrived at the facility at 01:40 PM and R1 was lying flat on his back, his brief very saturated in urine. The hospice Skilled Nursing Visit Note dated 07/07/24, revealed Consultant Staff MM arrived at 04:30 PM and R1 was lying in bed on his back, incontinent of bowel and bladder and his brief saturated with urine. The hospice Medical Social Worker Visit Note dated 07/12/24, revealed Consultant Staff KK arrived at 10:50 AM, revealed R1's durable power of attorney (DPOA) also present during the visit. R1 was in a soiled brief, and his bedding and pads soiled with wound drainage. The hospice Skilled Nursing Visit Note dated 07/12/24, revealed Consultant Staff MM arrived at 03:40 PM and staff reported R1's dressing was coming off and saturated before lunch today, so they changed it. The note included orders received to insert a 16 French urinary catheter to dependent drainage to assist with wound healing. Consultant Staff MM inserted the urinary catheter. The Orders tab for R1 revealed an order dated 07/13/24, the staff were to report urinary output every shift. The order lacked indication for the catheter use. On 07/29/24 at 11:10 AM, observation revealed R1 laid in bed on an air mattress tilted to his right side with the head of the bed elevated approximately 45 degrees, and a urinary catheter drainage bag hung from the right side of the bed frame. From the light fixture in the room above R1's bed revealed a note Check and change my brief regularly, also turning me often, do not let me set in urine or feces as this breaks down my fragile skin and it's pretty disgusting. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/29/24 at 12:25 PM, Consultant Staff GG stated normally they do not like to insert urinary catheters for wounds, but with R1, it was felt the facility were not changing him appropriately. On 07/30/24 at 12:10 PM, LN G stated she had asked for the urinary catheter to be placed due to urine incontinence getting on R1's dressing and the family agreed. On 07/40/24 at 02:25 PM, Administrative Nurse D stated there had been a meeting with the hospice staff on 06/11/24 about R1's wound and about him being wet when they came to visit, and that was when we put an intervention in place to for one hour checks as the hospice team accused the facility of not doing our check and change per our schedule, and Administrative Nurse D implanted the one-hour patient check form. The from was for the staff to chart R1's position and if he was wet or dirty at that time. The facility policy Urinary Continence and Incontinence - Assessment and Management dated August 2022 revealed as appropriate the staff will provide scheduled toileting, prompted voiding, or other interventions to try and manage incontinence. Indwelling catheters shall not be used as a substitute for nursing care of the resident with urinary incontinence. If a catheter is used, the physician and staff will document the clinical indication for use of the catheter. The facility failed to provide timely incontinence care to R1 resulting in saturated briefs and urine-soaked linens upon arrival of the hospice staff to the facility. - The Medical Diagnosis tab for Resident (R)2 included diagnoses of hemiplegia (paralysis of one side of the body) affecting right dominant side, dementia (progressive mental disorder characterized by failing memory, confusion), muscle weakness, and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) to bilateral (both) knees. The Quarterly Minimum Data Set (MDS) dated [DATE], assessed R2 with a Brief Interview of Mental Status (BIMS) score of 14, indicating intact cognition, she did not reject care, was dependent on staff for toileting, and was always incontinent of bowel and bladder. The Annual MDS dated [DATE], assessed R2 with a BIMS score of 10, indicating moderate cognitive impairment, she did not reject care, was totally dependent on staff for toileting, and continued to be always incontinent of bowel and bladder. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 06/13/24, revealed R2 had a cognitive impairment, and was alert and oriented with confusion. The Functional Abilities CAA dated 06/13/24, revealed R2 had limitations to her range of motion on one side, was able to make her wants/needs known to staff, and the staff also anticipated her needs. R2 was dependent on staff for toileting hygiene. The Urinary Incontinence and Indwelling Catheter CAA dated 06/13/24, revealed R2 was incontinent of bowel and bladder and wore incontinent products for protection/dignity. R2 was dependent on staff for toileting cares and staff were to provide good peri-care with each incontinent episode. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan dated 06/18/24, revealed R2 was incontinent of bowel and bladder and did not use a toilet, bedpan, or bedside commode. The staff were to check and change her brief and provide peri-care with every incontinent episode and as necessary as she allowed. The staff were to provide a bedpan or bedside commode as R2 requested. On 07/29/24 at 10:00 AM, observation revealed R2 in bed with the head of the bed elevated approximately 90 degrees and she was eating breakfast. On 07/29/24 at 11:52 AM, observation revealed R2 was in bed in the same position as she was at 10:00 AM and had a family member in her room, her breakfast tray remained in front of her. On 07/29/24 at 12:01 PM, Licensed Nurse (LN) G entered room and removed R2's breakfast tray from her overbed table. LN G did not check R2's brief at that time. On 07/29/24 at 12:04 PM, R2 stated the staff had not checked her brief since they brought her breakfast, saying she was last changed at 05:00 AM. Her family member remains in room at this time. On 07/29/24 at 12:09 PM, Certified Mediation Aide (CMA) T entered the room to see if R2 was okay with getting up for a shower then exited the room. On 07/29/24 at 12:14 PM, CMA stated she was not responsible for taking care of residents on this hall, she was the bath aide, and R2 stated she would take a shower after lunch time. On 07/29/24 at 01:19 PM, R2 was in room eating lunch. R2 stated she would like to be changed, she felt wet, and had not told the staff yet. R2 then stated she was eating, and the staff were going to shower her after she ate so she would wait until then. At that time the family member moved R2's call light from the side of the bed to where it would be in R2's reach. The family member stated the staff had not been in to check or change her yet since she arrived. On 07/29/24 at 02:05 PM, R2 remained in bed on her back, family no longer at bedside. R2 stated she had not had a shower yet and had not been changed. On 07/29/24 at 02:09 PM, Certified Nurse Aide (CNA) M entered R2's room and R2 stated she had not been changed since five o'clock and the lady that was in here said I needed to be changed. CNA M told R2 she needed to get help and exited the room. On 07/29/24 at 02:15 PM, CNA M and CNA Q entered the room to provide cares. R2's brief was wet and the cloth pad under R2 was wet. On 07/29/24 at 02:25 PM, CNA M stated the staff were supposed to be changed every two hours, however, she did not think it had been since five o'clock when the staff changed her last, as the brief was still warm like she just went. CNA M stated she did not know when the staff changed R2 last. On 07/29/24 at 04:04 PM, LN H stated the staff were to check R2 and change her every two hours. The facility policy Urinary Continence and Incontinence - Assessment and Management dated August 2022 revealed as appropriate the staff will provide scheduled toileting, prompted voiding, or other interventions to try and manage incontinence. (continued on next page)

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	175078	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/29/24 the facility failed to check R2's brief, who was always incontinent of urine, per the care plan, instructing the staff to check and change her every two hours.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41121 The facility reported a census of 68 residents with five residents reviewed, with one resident reviewed for pharmacy services, Resident (R)4. Based on observation, interview, and record review, the facility failed to ensure the staff ordered R4's medication timely, resulting in her missing eight doses of her scheduled Norco (narcotic pain medication) and one dose of her scheduled Fentanyl (narcotic pain medication) patch. Findings included: - The Medical Diagnosis tab for R4 included diagnoses of pain and restless leg syndrome. The Quarterly Minimum Data Set (MDS) dated [DATE], assessed R4 with a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. She required scheduled pain medication and received or offered and declined as needed (PRN) pain medication, had frequent pain or hurting in the past five days of the assessment period which effected sleep frequently and day-to-day activities at a level four on the zero to 10 pain scale, with 10 being the worst amount of pain. The Annual MDS dated [DATE], assessed R4 with a BIMS score of 14, indicating intact cognition. R4 continued to receive scheduled pain medication and received or offered and declined PRN pain medication. She had frequent pain or hurting in the past five days of the assessment period which effected sleep frequently and day-to-day activities at a level 7 on the zero to ten pain scale. The Pain Care Area assessment dated [DATE], revealed R4 reported pain/discomfort of seven out of ten frequently and the pain made it hard for her to sleep at night and she had limited her day-to-day activities related to the pain. R4 received schedule/PRN pain relievers per orders. The staff monitor her pain every shift and as needed and record in the electronic medical record. The nursing staff were to notify the physician of any unrelieved pain and reposition her for maximum comfort. The Care Plan dated 07/23/24, revealed R4 had a diagnosis of restless leg syndrome and was at risk for tingling/burning/itching, painful cramping in her legs, a throbbing sensation in her calf area, and leg jerking. R4 had chronic pain and required scheduled pain medication. The staff were to administer her medications as ordered and monitor for effectiveness and side effects, notify the physician if interventions were unsuccessful, and notify the physician if her current complaint of pain had significantly increased from baseline. The Orders tab, included physician orders for the following medications: 1. On 10/21/23, Voltaren (anti-inflammatory medication used to treat pain) External Gel, one percent, apply to bilateral (both) lower extremities, topically, twice daily for pain. Apply four grams to each lower extremity, not to exceed 32 grams a day in all areas, and apply four grams, to bilateral lower extremities topically, every six hours, as needed for pain. 2. On 04/09/24, acetaminophen (analgesic), 500 milligrams (mg), one tab, by mouth, every four hours, PRN pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 07/11/24, Fentanyl transdermal patch, 72 -hour, 12 microgram (mcg)/hour, apply one patch transdermally, one time a day, every three days, for pain. 4. On 07/17/24, Norco, oral tablet, 10-325 mg, give one tablet, by mouth, every six hours, for pain. The Medication Administration Record (MAR) dated July 2024, revealed R4's Fentanyl patch was due to be replaced on 07/27/24 and the staff documented an 11 indicating medication unavailable. The MAR revealed the staff documented a 11 for the scheduled Norco on 07/27/24 (Saturday) at 06:00 PM, 07/28/24 (Sunday) at 12:00 AM, 06:00 AM, 12:00 PM, 06:00 PM, and 07/29/24 (Monday) at 12:00 AM, 06:00 AM, and 12:00 PM. R4 missed one dose of her Fentanyl patch and eight doses of her Norco. The facility provided the PRN Tylenol on 07/27/24 at 09:02 PM for pain level of 5 and documented ineffective, on 07/28/24 at 12:59 AM for pain level 7, and documented effective, and 07/29/24 for pain level 7 and documented effective. The staff did not document the Voltaren external gel had been administered PRN for pain from 07/27/24 through 07/29/24. The Progress Notes dated 07/27/24 at 09:02 PM, revealed R4 complained of feet pain and staff administered acetaminophen. The Progress Notes dated 07/28/24 at 12:01 AM, revealed the acetaminophen administered to R4 on 07/27/24 at 09:02 PM was ineffective and follow up pain score was a 7. The Progress Notes dated 07/28/24 at 12:59 AM, revealed staff administered R4 acetaminophen per R4's request for pain to bilateral feet. The Progress Notes dated 07/28/24 at 02:20 PM, revealed the staff were to check R4 for placement of the Fentanyl patch, however there was no patch available. Review of the Progress Notes dated 07/27/24 through 07/30/24 lacked documentation of R4 being out of her scheduled Norco and Fentanyl and lacked documentation if the staff notified the physician and/or the pharmacy to attempt to obtain the medications for R4. On 07/29/24 at 09:44 AM, observed R4 sitting in a hallway other than the one she resided on in her wheelchair. R4's bilateral feet rested on her foot pedals, and she had wraps in place. On 07/29/24 at 09:45 AM, R4 stated her feet hurt, she did not sleep well, and had been out of her pain medication which she last had on Friday (07/26/24). R4 stated the facility has run out of her medication a couple of times in the past. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/30/24 at 11:17 AM, R4 stated her current pain level was between a seven and eight' and she had received pain medication at 04:00 AM. R4 stated she could have her pain medication every six hours scheduled and it would get it again at noon. R4 stated she thought her last dose before she ran out was around noon on Friday (07/26/24) and her pain level was at an eight or nine over the weekend without it. R4 stated the facility medication aides did not reorder, or they waited too long to reorder, and the doctor needed to write a script, the doctor was gone by the time the pharmacy called, and it was the weekend. R4 stated her feet get to hurting so bad that she cannot go to sleep and if she does, the pain wakes her up. R4 stated she had that problem on Friday (07/26/24), Saturday (07/27/24), and Sunday (07/28/24). R4 stated she asked for Tylenol (acetaminophen) and the staff brought it. R4 stated the acetaminophen helped a little. R4 stated she let Administrative Nurse D about running out of her medication and she called the pharmacy right away. R4 stated I hope they will be on top of it, so it does not happen again. On 07/30/24 at 04:37 PM Certified Medication Aide (CMA) R stated the process for reordering medication was done by reordering in the electronic system or by pulling a sticker from the medication card and faxing it to the pharmacy. CMA R stated when the medication left is in the blue slot of the card, which is seven or 10 pills left, then the staff reorder the medication. CMA R stated if a resident ran out of their medication, she would see if the nurse could get it from the emergency kit or maybe provide a PRN medication. On 07/30/24 at 04:48 PM, Administrative Nurse D stated the process for reordering medication was through the electronic record by selecting a reorder option from the MAR which goes straight to the pharmacy. Administrative Nurse D stated on the medication card, there is an outline on when to reorder and thought it was around when there were seven doses left. Administrative Nurse D stated if a resident runs out of medication, the staff need to get the medication out of the emergency kit if available and if not, call the pharmacy and check the status. Administrative Nurse D stated she was not aware until yesterday R4 had ran out of her medication. On 07/30/24 at 04:50 PM Administrative Staff A stated she was aware R4 had ran out of her medication and there was a big mess up. Administrative Staff A stated we notified the pain clinic, R4's pain medication orders came from there, and had requested a script several times. Administrative Staff A stated when she called the pain clinic yesterday, they reported they received the facility request last Wednesday, and the pharmacy sent the script to the wrong doctor. The facility policy Documentation of Medication Administration dated November 2022 lacked instructions for staff for reordering medication and/or staff follow-up to ensure pharmacy fills the reorder request. The facility failed to ensure the staff reordered R4's medication timely, resulting in her missing eight doses of her scheduled Norco from 07/27/28 24 through 07/29/24 and one dose of her scheduled Fentanyl patch on 07/27/24.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41121 The facility reported a census of 68 residents. Based on observation, record review, and interview, the facility failed to maintain an effective prevention and control program with failure to perform appropriate glove removal and hand hygiene during after a disposable brief removal and during a dressing change for Resident (R)3 on 07/29/24, lacked hand hygiene during peri-care for R2, stored R2's pressure reducing boot directly on the floor, and failed to ensure R5's catheter drainage bag positioned appropriately to ensure proper urine flow. Findings included: - The following observations revealed the following areas of concern: 1. On 07/29/24 at 01:28 PM, Certified Nurse Aide (CNA) N removed Resident (R)3's wet disposable brief with her gloved hands and picked up a new brief from an overbed table with the same gloved hands. LN I was in the room to perform wound care to R3's right gluteal (buttocks) pressure ulcer (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), stage three (full thickness pressure injury extending through the skin into the tissue below). LN I cleansed R3's wound, removed her gloves, and failed to perform hand hygiene before applying a new pair of gloves. LN I then used scissors to cut a foam piece from a package placed on a cloth straight back chair in the room and placed the foam on top of the outer package after cutting it. LN I then applied a transparent dressing to R3's intact skin on his leg. CNA N moved the trash can, touching the inside surface with her gloved hands she had handled the wet brief with, to be closer to LN I. After applying a transparent dressing to the resident's leg and over a wound, LN I cut an opening to expose the wound opening, removed her gloves, then applied a new pair without performing hand hygiene. LN I took the foam piece she had cut and placed it on the inside of R3's wound and had CNA N hold another piece of foam over the transparent dressing to R3's leg. CNA N had the same gloves on she had on when handling the wet brief and the trash can. On 07/29/24 at 02:01 PM, LN I stated gloves should be changed after pulling a dressing off or moving to a different task and hand hygiene should be performed before donning gloves and when taking them off every time but stated that would make staff be in the room for a long time. LN I stated she needed to put hand sanitizer in R3's room. LN I stated gloves should be removed when moving from dirty to clean, and after moving the trash can. LN I stated CNA N should have changed her gloves before touching the foam dressing piece and after moving the trash can. 2. On 07/29/24 at 02:15 PM, CNA M provided peri-care to R2 after urine and bowel incontinence. With the same gloved hands, CNA M placed a clean sheet and two cloth pads under R2 and then a clean brief. CNA M pulled R2's gown down and covered her up with the same gloved hands, then removed the gloves and sacked up the soiled linens and the trash and took the bagged items to the utility room. On 07/29/24 at 02:25 PM, CNA M stated she should change her gloves between changing the brief and putting on clean bedding. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Observation on 07/30/24 at 08:33 AM, revealed R5 propelled his wheelchair down a hallway. R5's urinary catheter tubing exited from the bottom of his pant leg then up and across a lap tray in front of him to the drainage bag that hung on the side of the wheelchair just below the armrest and above the wheelchair seat level, which was above the resident's bladder. Observation on 07/30/24 at 04:31 PM, revealed R5 in his wheelchair in the front lobby living room area with other residents. The urinary catheter tubing exited the bottom of his pant leg, up and across a lap tray (which had two drinking cups on it), and to the drainage bag that hung from the side of the wheelchair just below the arm rest and above the wheelchair seat level. On 07/30/24 at 04:33 PM, CNA M stated the staff drain his urinary catheter bag, and the tubing should not come out of the bottom of his pant leg and up across the table, the bag should be under his wheelchair. On 07/30/24 at 02:25 PM, Administrative Nurse D stated gloves should be removed before leaving a room unless the staff were carrying a bag of soiled something. Administrative Nurse D stated hand hygiene should be performed before and after patient care, when taking gloves off and hygiene should be performed before putting a new pair on and at any point gloves should be changed if they become soiled. On 07/30/24 at 04:46 PM, Administrative Nurse D stated R5 had just returned to the facility and R2 would sometimes empty his own urine collection bag and would measure and show the CNA's how much his urine output was. Administrative D stated she thought the care plan outlined about a dignity bag and he had tried to handmake his own cover bags. The facility policy Handwashing/Hand Hygiene dated August 2019, revealed staff should use an alcohol-based hand rub or soap and water before handling clean or soiled dressings, before moving from a contaminated body site to a clean body site during resident care, after contact with resident's intact skin, after contact with blood or body fluids, after handling used dressings, after contact with objects in the immediate vicinity of the resident, and after removing gloves. The facility policy Catheter Care, Urinary dated August 2022, revealed the purpose of the procedure was to prevent urinary catheter-associated complications, including urinary tract infections. The staff were to position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder. The facility failed to maintain an effective prevention and control program with failure to perform appropriate glove removal and hand hygiene during after a disposable brief removal and during a dressing change for Resident (R)3 on 07/29/24, lacked hand hygiene during peri-care for R2, stored R2's pressure reducing boot directly on the floor, and failed to ensure R5's catheter drainage bag positioned appropriately to ensure proper urine flow.