STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175202	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colby Operator, LLC	105 East College Drive Colby, KS 67701

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 34 residents with three residents reviewed for pressure ulcers. The facility failed to identify and provide appropriate interventions consistent with the standards of care to prevent pressure ulcers from developing and worsening for Resident (R) 1. On 03/11/24, R1 developed two facility-acquired Stage 2 (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) 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) to her bilateral buttocks. On 05/16/24 the wound specialists identified diffuse pressure and redness to the entire intergluteal cleft (a deep groove that separates the buttocks and runs from the third or fourth sacral spine to the anus) area. The facility did not implement further preventative measures to address offloading or positioning until 07/11/2024. The facility further failed to assess R1's pressure wounds weekly to determine the effectiveness of treatments. On 08/07/24, R1 was transferred to an acute care hospital where they identified she arrived with an unstageable pressure ulcer (depth of the wound is unknown due to the wound bed being covered by a thick layer of other tissue and pus) to her coccyx (area at the base of the spine) with necrosis (localized tissue death that occurred in a group of cells in response to disease or injury) and slough (dead tissue, usually cream or yellow) in the wound bed, a Stage 3 pressure ulcer (full thickness pressure injury extending through the skin into the tissue below) to her left buttock, a Stage 3 pressure ulcer to her right buttock, a 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) to the right heel a DTI to the left trochanter (bony prominence on the upper part of the thigh bone) that serves as a site for muscle attachment. The facility's failure to identify and implement interventions consistent with standards of care to prevent the development of further pressure injuries and to promote healing of existing facility-acquired pressure ulcers placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of pressure ulcer of unspecified stage to unspecified buttock, fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue, and severe sleep disturbance), morbid obesity, diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status score of 15, which indicated intact cognition. The MDS documented R1 had no impairment of her upper or lower extremities. The MDS documented R1 was completely dependent on staff for assistance with toileting, dressing, personal hygiene, bed mobility, and transfer. The MDS documented R1 had no pressure ulcers, was at risk for pressure ulcer development, had a pressure-reducing device for her chair, had a pressure-reducing device for her bed, and was on a turning/repositioning program. The MDS documented R1 received nutrition interventions to manage skin problems, received pressure ulcer care, and application of dressings and ointments/medications. The Quarterly MDS, dated [DATE], documented R1 had a BIMS score of 15 which indicated intact cognition. The MDS documented R1 had impairment of her bilateral lower extremities. The MDS documented R1 was completely dependent on staff for assistance with toileting, dressing, personal hygiene, bed mobility, and transfer. The MDS documented R1 had two Stage 2 pressure ulcers that were not healed. The MDS recorded R1 was at risk for pressure ulcer development, had a pressure-reducing device for her chair, and was on a turning/repositioning program. R1 received nutrition interventions to manage skin problems and had application of ointments/medications. The Functional Abilities Care Area Assessment (CAA), dated 12/21/23, documented R1 was at risk for potential alterations in her activity of daily living (ADL) function, had several medical conditions that affected her ADL functions, and required supervision to dependent assistance from staff with her ADLs. The Pressure Ulcer Injury CAA, dated 12/21/23, documented R1 was at risk for pressure-related injuries/ulcers. R1's skin was intact and was being treated for moisture-associated skin damage (MASD). The CAA documented weekly skin assessments were performed and R1 had interventions in place to prevent skin breakdown. R1's Care Plan documented R1 was unable to ambulate and required a sit-to-stand lift for all transfers by two staff members. R1 required total assistance of two staff members for toileting, was dependent on two staff members to turn and reposition in bed and was totally dependent on two staff members for bathing, personal hygiene, and dressing. The care plan documented R1 had the potential for altered skin integrity related to DM, pain, anxiety, and immobility. The care plan directed staff to follow the facility policies and protocols for preventative/treatment of skin breakdown. The care plan documented R1 was to lay down in bed for sixty minutes every day, but R1 refused to comply and would sit in her recliner most of the time. The care plan documented R1 required a pressure relieving/reducing cushion to her wheelchair (03/22/24). The care plan documented R1 was being seen by the wound care clinic and staff were to follow their treatment plan. The Braden Scale for Predicting Pressure Injury Scale, dated 05/08/24, documented a score of 16, low risk for pressure ulcer development. The Braden Scale for Predicting Pressure Injury Scale, dated 08/06/24, documented a score of 10, high risk for pressure ulcer development. The Progress Note, dated 03/11/24, documented R1 had a bleeding wound on her buttocks bilaterally that was cleaned and had to be bandaged twice during the shift. A large amount of blood was noted during bathroom use and the first bandage was soaked through and replaced. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Weekly Skin Condition Report, dated 03/11/24, documented R1 had MASD on her right and left buttock. No measurements of the wounds were documented. The note documented a large amount of exudate (drainage). The surrounding skin had discoloration. The area pained R1. The comments documented R1 agreed to lie in bed for one hour daily as R1 typically stayed in her recliner and slept in her recliner. No specialty interventions were documented. The Progress Note, dated 03/13/24, documented R1 with a wound to her buttocks. R1 stated it hurt. Staff encouraged R1 to lie in bed and get off of her buttocks to aid in healing and decrease the pain. R1 stated she was not lying in bed and wanted the doctor called to get a stronger pain pill. The Progress Note, dated 03/14/24, documented R1 had multiple wounds on her buttocks, but it was likely due to the amount of time R1 spent up in her recliner. The note recorded staff attempted to ask R1 to lay in bed to relieve pressure off her sores and R1 denied this. Staff applied honey barrier cream liberally to R1's buttocks while she was up on the commode. R1 stated she could not tell if it was helping. The Progress Note, dated 03/15/24, documented staff encouraged R1 to lie in bed and get off of her bottom. R1 stated she could not lay in the bed as it kills her to lay in that bed. The Progress Note, dated 03/17/24, documented that the dressing on R1's buttocks was saturated that morning. The areas to the left and right buttocks remained open. Staff cleansed the wound, patted the area dry, and applied a new sacral foam dressing. R1 reported discomfort to the area. The Progress Note, dated 03/18/24, documented that a Certified Nurse's Aide (CNA) requested the nurse come to R1's room. R1 had a bowel movement, and the CNA was unsure if the dressing should be changed due to mild soiling. The old dressing was removed. The area to R1's buttocks remained open and small amounts of bloody drainage were noted. Staff cleansed the area with wound cleanser, patted the area dry, and applied a new dressing. R1 reported discomfort on her buttocks. R1 was repositioned in the recliner. The Secure Conversations Note, dated 03/18/24, documented the nurse asked R1's provider if R1 could have a wound consult with wound care so the facility could apply the right dressing. Administrative Nurse D responded the facility now had a wound care consultant in-house and the doctor could see R1 through telehealth and asked for orders for R1 to be seen. R1's provider responded he agreed with a wound consult and directed to keep him posted. The Weekly Skin Condition Report, dated 03/18/24, documented R1 had pressure wounds on her right and left buttocks. No measurements of the wounds were documented. The report indicated there was no exudate noted, and the surrounding skin was reddened. No specialty interventions were documented. The Progress Note, dated 03/19/24, documented R1 refused to see wound care via telehealth and wanted to be seen in person. An appointment was made at the wound clinic for 03/21/24 at 09:00 AM. The Secure Conversation Note, dated 03/20/24, documented the nurse requested and order from R1's provider to start R1 on Arginaid (protein drink to aid in healing) twice a day and a multivitamin and vitamin C daily. R1's provider responded yes to start them. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Weekly Skin Condition Report, dated 03/26/24, documented R1 had pressure wounds on her right and left buttocks. No measurements of the wounds were documented. The report indicated there was no exudate noted, and the surrounding skin was reddened. No specialty interventions were documented. The Weekly Skin Condition Report, dated 04/02/24, documented R1 had pressure wounds on her right and left buttocks. No measurements of the wounds were documented. No exudate was noted. The surrounding skin was normal. No specialty interventions were documented. Nutritional interventions were documented as vitamin therapy. The Wound Care Progress Note, dated 04/04/24, documented R1 presented to the wound care clinic for initial evaluation of pressure wounds to bilateral buttocks. R1 stated the wounds were painful. The wounds have been ongoing for at least one month. R1 stated they bled a lot. R1 stated she sat in a recliner most of the time as she felt her bed was not comfortable at all. R1 did not have a cushion for her recliner or her wheelchair. R1 stated she laid on her back in her bed only to sleep at night. The left buttock wound measured 6 cm by 8 cm by 0.1 cm and had copious amounts (a lot) of sanguineous (bloody drainage) drainage. The right buttock wound measured 6 cm by 8 cm by 0.1 cm and had copious amounts of sanguineous drainage also. There was a treatment ordered for staff to apply Triad paste (zinc-oxide based hydrophilic paste for light to moderate levels of wound exudates and helps to maintain an optimal wound healing environment to facilitate autolytic debridement), Maxsorb sheet (an alginate dressing that locks fluid away as a gel providing beneficial, moist wound environment), and bordered foam dressing. Change every two to three days and as needed if saturated. R1 needed a good cushion (preferably Roho [pressure relief cushion that is made of soft, flexible air cells]) in her recliner and wheelchair. The resident was to change position every two hours. Follow up with wound care in two weeks or sooner if needed. The Progress Note, dated 04/05/24, documented R1 had a wound care appointment the previous day on 04/04/24 and the facility received the following new orders: 1. Apply Triad paste, then Maxsorb sheet, then bordered foam dressing. Change every 2-3 days and as needed if saturated, soiled, or falling off. 2. Get a good cushion for R1's recliner and wheelchair preferably a Roho cushion. 3. Please be sure R1 is changing positions and shifting weight often as these wounds are due to constant pressure in this area. 4. Follow up in wound care in two weeks, sooner if needed. The Nutrition Note, dated 04/08/24, documented R1 had open wounds to her left and right buttocks. R1 refused her Juven/Argenaid for wound healing. The registered dietitian recommended discontinuing the Juven/Arginaid and giving R1 1 to 2 ounces of extra protein with all meals. R1 agreed with the recommendation. The Weekly Skin Condition Report, dated 04/09/24, documented R1 had pressure wounds on her right and left buttocks. No measurements of the wounds were documented. A moderate amount of serosanguinous (semi-thick blood-tinged drainage) exudate was noted. The wound bed had dark pink/red tissue. The surrounding skin was reddened. No specialty interventions were documented. The nutritional intervention was vitamin therapy. The Weekly Skin Condition Report, dated 04/16/24, documented R1 had pressure wounds on her right and left buttocks. No measurements of the wounds were documented. No exudate was noted. The surrounding skin was normal for skin. No specialty interventions were documented. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Wound Care Progress Note, dated 04/18/24, documented wound care follow-up with R1 due to pressure wounds to the buttocks. R1 stated the pain was much improved. R1 stated she had a cushion in her recliner and her wheelchair. R1 stated the staff at the facility changed the dressing every other day. The left buttock wound measured 7.4 cm by 4 cm by 0.1 cm with a moderate amount of drainage. The right buttock wound measured 7.4 cm by 4 cm by 0.1 cm with a moderate amount of drainage. The resident received a treatment of Adaptic (a non-adhering wound contact layer made of knitted cellulose) folded in fourths on the right buttock and covered with bordered foam dressing and bordered foam dressing to the left buttock. No debridement. Wounds were much improved, with a small open area to the right buttock noted with bleeding upon initial evaluation. Follow up in one month or sooner if needed. The Nutrition Note, dated 04/18/24, documented R1 remained on treatment for pressure areas to her left and right buttocks. The wounds were reported to be improving. R1 was eating well, on 1-2 ounces of protein powder with meals for wound healing. The Progress Note, dated 04/19/24, documented new orders received from wound care on the dressing to R1's bottom. The note documented to continue with Triad paste and cover with a foam dressing and documented staff needed to try and get R1 off her bottom as much as possible. The dressing was to be changed every three days and as needed if soiled or falling off. The Weekly Skin Condition Report, dated 04/25/24, documented no skin issues. No measurements of the wounds were documented. No exudate was noted. The surrounding skin was normal for skin. A wheelchair/chair cushion was documented as a specialty intervention. The Weekly Skin Condition Report, dated 05/09/24, documented R1 had pressure wounds on her right and left buttocks. No measurements of the wounds were documented. No exudate was noted. The surrounding skin was normal for skin. No specialty interventions were documented. The Wound Care Clinic Progress Note, dated 05/16/24, documented wound care follow-up. R1 presented with pressure wounds to the bilateral buttocks. R1 stated her right buttock was painful when she was sitting. R1 stated she never laid in her bed as it was very uncomfortable. R1 had one bordered foam dressing to each buttock. The right buttock wound measured 4.5 cm by 3 cm by 0.1 cm and the left buttock wound measured 1.4 cm by 0.7 cm by 0.1 cm. No active bleeding was noted on the exam. R1 did have open wounds bilaterally and her entire buttocks/intergluteal cleft area was ecchymotic (bruised), evidence of pressure injury diffusely. R1 stated she refused to lay in bed as it was uncomfortable, and she had arthritis. The wound care provider would talk to R1's primary care provider to see if it was an option for the nursing home to get a Sizewise (specialty bariatric hospital-type bed with a larger surface area) bed. Discussed with R1 that unless she attempted to offload this area her wounds would not heal and would worsen. The Nutrition Note, dated 05/16/24, documented R1 continued to have open areas to her left and right buttocks with treatment in place. Continue current interventions for wound healing. Weight fluctuations were noted. The registered dietitian would continue to monitor monthly until R1's wounds were healed. The Weekly Skin Condition Report, dated 05/17/24, documented R1 had MASD on her right and left buttock. No measurements of the wounds were documented. No exudate was noted. The area pained R1. The wound bed was documented as pale pink tissue. The surrounding skin was reddened. No specialty interventions were documented. The nutritional intervention was vitamin therapy. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Weekly Skin Condition Report, dated 05/25/24, documented R1 had no type of wound documented to her right and left buttocks. No measurements of the wounds were documented. No exudate was noted. The wound bed had pink, pale tissue. The surrounding skin was normal for skin. No specialty interventions were documented. The Weekly Skin Evaluation Note, dated 05/29/24, documented R1's skin was intact. The Weekly Skin Condition Report, dated 06/01/24, documented R1 had no type of wound documented to her right and left buttocks. No measurements of the wounds were documented. No exudate was noted. The wound bed was normal for skin. The surrounding skin was normal for skin. No specialty interventions were documented. The Weekly Skin Evaluation Note, dated 06/08/24, documented R1's skin was intact. The Nutrition Note, dated 06/12/24, documented R1 had been eating well. R1 had an open area to her coccyx (tail bone) and redness to her right and left iliac crest (the curved, bony ridge that forms the upper border of the ilium the largest of the three bones that make up the hip bone). Recommended to continue current interventions for wound healing. The Wound Care Clinic Progress Note, dated 06/13/24, documented wound care follow-up for pressure wounds to the bilateral buttocks. R1 complained of increased bleeding to wounds. R1 stated she slept in her recliner every night and refused her bed as it was very uncomfortable. R1 also refused to shift her weight from side to side and stated she sat right in the center of her buttocks. No measurements were noted. Triad paste to bilateral buttocks. No active bleeding was noted. R1 had superficial open areas to her right buttock but nothing of depth. The note recorded the wound would not heal if R1 continued to sit directly on her buttocks all day and all night. The note recorded someone would see about ordering a Roho cushion for R1, however R1 stated it would not work in her recliner. The Weekly Skin Condition Report, dated 06/20/24, documented R1 had no type of wound documented to her right and left buttocks. No measurements of the wounds were documented. No exudate was noted. The wound bed was normal for skin. The surrounding skin was normal for skin. No specialty interventions were documented. The Progress Note, dated 06/21/24, documented a message was sent to R1's provider requesting an as-needed administration for Triad paste due to R1 not having any on that morning after toileting and the wound was bleeding. The Progress Note, dated 06/21/24, documented starting Triad past every other day. R1 tolerated well. The Progress Note, dated 06/23/24, documented a new order to receive Triad hydrophilic wound dress external paste to bilateral buttocks every other day remained in place. The Weekly Skin Evaluation Note, dated 06/25/24, documented a Stage 2 ulcer to R1's coccyx. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Secure Conversation Note, dated 06/26/24, documented the facility was having difficulty maintaining the Triad paste barrier with every other day application. Request for as-needed order to reapply when needed especially when the order date did not line up with R1's bath day. R1's provider said yes to the request. The Weekly Skin Condition Report, dated 06/27/24, documented R1 had pressure wounds on her right and left buttocks. No measurements of the wounds were documented. No other description of the wounds was documented. The area pained R1. No specialty interventions were documented. The nutritional intervention was documented as vitamin therapy. The report documented R1 was being seen at the wound care clinic and to see notes. The Weekly Skin Evaluation Note, 07/01/24, documented R1's skin was intact. The Weekly Skin Condition Report, dated 07/04/24, documented R1 had a Stage 2 pressure wound on her right buttock. No measurements of the wounds were documented; serous (thin, clear) exudate was noted. The wound bed had pink/pale tissue. The surrounding skin was reddened and macerated. The area pained R1. A wheelchair/chair cushion was noted as the specialty intervention. The nutritional intervention was vitamin therapy. The report documented R1 was being seen at the wound care clinic, see notes. The note documented the area had deteriorated. The Secure Conversation Note, dated 07/09/24, documented the facility thought it would be beneficial for R1 to have an order for a catheter (a tube inserted into the bladder to drain urine). The wound to R1's bottom was not improving. Triad past was being used on R1's wound. R1's provider asked if R1 was willing to consider the placement of a Foley catheter and if so, he would be willing to order it. The facility responded R1 was willing to try it. R1's provider responded to place a Foley catheter to dependent drainage and once the wound was healed, remove the catheter. The Wound Care Clinic Progress Note, dated 07/11/24, documented a wound care follow-up for pressure wounds to the bilateral buttocks. R1 had no concerns during the visit. The nursing home continued to use Triad paste to the buttocks. No measurements were noted for the right buttock wound. The left buttock wound measured 3 cm by 0.5 cm by 0.1 cm. The Rental Review Receipt, dated 07/11/24, documented the facility acquired a bariatric frame and a bariatric therapeutic support mattress for R1. The Weekly Skin Condition Report, dated 07/12/24, documented R1 had a Stage 2 pressure wound on her right and left buttock. No measurements of the wounds were documented. Serosanguinous exudate was noted. The wound bed had pink/pale tissue. The surrounding skin was normal for skin. The area pained R1. The nutritional intervention was vitamin therapy. No specialty interventions were documented. The Weekly Skin Condition Report, dated 07/18/24, documented R1 had a coccyx pressure wound. No measurements of the wound were documented. Serous exudate was noted. The wound bed had pink/pale tissue. The surrounding skin was reddened. A specialty bed was noted as the specialty intervention. The nutritional intervention was vitamin therapy. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Secure Conversation Note, dated 07/30/24, documented that Administrative Nurse D requested advice regarding R1. The note stated R1 utilized the bed but now R1 would not get up from the bed. R1 refused weights even though the full body lift with scale would be used. R1 refused to let staff reposition and refused staff to change incontinent products. R1 stated it hurt too much to move and complained of increased pain. The facility wanted to do what was best for R1. R1's wound to her buttocks showed no improvement. R1's provider responded he would see R1 the next day. The Physician Progress Note, dated 07/31/24, documented R1 complained of sacral (the region at the bottom of the spine between the fifth segment of the lumbar spine and the coccyx) pain secondary to a wound. R1 was started on an antibiotic for a urinary tract infection. R1 continued to see wound care for a sacral ulcer. The Infection Note, dated 08/01/24, documented R1 was alert and able to make needs known. Antibiotic therapy was in progress for a urinary tract infection. R1 had Bactrim-DS (antibiotic) for ten days. R1 had no complaints of discomfort post-void and was afebrile. Fluids were encouraged and accepted. Respirations were even and unlabored. No signs and symptoms of acute distress. The Weekly Skin Condition Report, dated 08/01/24, documented R1 had a coccyx pressure wound. No measurements of the wound were documented. No exudate was noted. The wound bed had pink/pale tissue. The surrounding skin was normal for skin. A specialty bed was noted as the specialty intervention. The nutritional intervention was identified as vitamin therapy. The Progress Note, dated 08/01/24, documented the facility received a phone call from R1's provider and he ordered a repeat urine sample and sensitivity as R1 had two bacteria in her urine. R1's provider at first ordered ceftriaxone one gram intramuscularly (IM-administered directly into the muscle) but then realized R1 was allergic to it, so ordered R1 to continue with the Bactrim-DS. The Infection Note, dated 08/03/24, documented R1 was in bed with her eyes opened, respirations even and unlabored, skin warm and dry to the touch; R1 was able to make her needs known, and confusion was noted. R1 continued antibiotic therapy. Fluids were encouraged and incontinent care was provided. Treatment of R1's coccyx was ongoing. The Progress Note, dated 08/04/24, documented R1 was alert and awake, respirations were even and unlabored, no acute distress was noted, and skin warm and dry to the touch. R1 transferred to the recliner per full lift. The Progress Note, dated 08/06/24, documented the nurse went to assess R1 after a phone call from R1's daughter. R1 was alert and oriented, lung sounds were clear, and R1 had times of confusion. The note documented R1's hands shook a lot more than they used to. The Communication with Physician Note, dated 08/06/24, documented the nurse called R1's provider to discuss R1's change of status. The nurse talked to R1's provider about R1's confusion, shaking hands, elevated blood pressure, and coccyx wound. R1's provider ordered lab work, vitals twice a day, and one-time blood sugar. R1's provider would round on R1 tomorrow. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Skin and Wound Evaluation, dated 08/06/24, documented a pressure wound to R1's coccyx which measured 4.64 cm by 1.42 cm, a pressure wound to R1's left buttock which measured 2.01cm by 1.66 cm, and a pressure wound to R1's right buttock which measured 9.3 cm by 2.09 cm. The evaluation documented that on 08/12/24 Administrative Nurse D changed the coccyx wound and the left buttock wound description to Kennedy terminal ulcers (KTU- a pressure-based injury that can develop quickly and is often a sign of terminal illness or impending death) in the wound description tab. The Progress Note, dated 08/07/24, documented the facility received a call from the lab reporting R1 had a critical value for a potassium level of 6.2 milliequivalents per liter. R1's provider was notified of the critical lab value, and he ordered R1 to be transferred to the hospital via ambulance. R1's responsible party was notified. R1 was diagnosed with acute kidney failure (a condition in which the kidneys suddenly cannot filter waste from the blood). R1 would be transferred to a higher level of care but it was unknown where R1 would be sent. The ER Progress Notes, dated 08/07/24, documented R1 had a right heel pressure ulcer that was erythematous (redness) and eccymotic with an intact blister and seemed to be painful for R1. It also noted a pressure area to R1's coccyx. The notes did not include measurements or descriptions. The hospital's Wound Service Consult Note, dated 08/08/24, documented R1 presented to the higher level of care hospital with an unstageable pressure injury to her coccyx, a Stage 3 pressure injury with evolving DTI to her left buttock, a Stage 3 pressure injury with evolving DTI to her right buttock, a DTI to her right heel, and a DTI to her left trochanter (hip bone). The exam noted an unstageable pressure injury to R1's coccyx that was active with necrotic (pertaining to the death of tissue in response to disease or injury) tissue with the ability to probe through the fascia (band of thin, fibrous connective tissue)to the bone to the center point of injury which measured 4 cm by 2 cm by 2 cm. Adhered slough with necrosis to the wound edges with malodor. Bilateral buttocks pressure injuries were full-thickness tissue injuries at Stage 3 with superimposed DTI features. The wound edges were irregular indicative of continual friction and shearing forces adversely impacting condition epidermal stripping forces more prominent to the left buttock. The left buttock wound measured 4 cm by 2 cm by 0.2 cm and the right buttock injury measured 8 cm by 6 cm by 0.3 cm. The left trochanter DTI had an intact bulla with darkened purple discoloration to the wound bed and measured 7 cm by 3 cm. Generalized DTI formations were noted to the gluteal cleft and gluteal tissue. The right heel DTI with intact bulla with darkened purple discoloration to the wound bed and measured 4 cm by 4 cm. Evidence of neglect. Consider magnetic resonance imaging (MRI-medical imaging used to view soft tissue) for coccygeal pressure injury. The coccyx and bilateral buttock pressure injuries were cleansed with saline-moistened gauze, Medihoney (medical grade honey used to aid wound healing) gel applied to the wound beds, covered with Allevyn (brand of dressing) pink bordered heel dressing, ensure all three injuries are covered. Change every two days or as needed. To the right heel DTI and left trochanter DTI, maintain heel Allevyn to the right heel and a 6 X 6 Allevyn to the left trochanter. Change every 48 hours or when soiled, saturated, or dislodged. If the blisters pop, take a picture and send it to wound care. On 08/12/24 at 10:30 AM, observation revealed a wheelchair in the corner of R1's room that had a pressure relieving cushion (not a Roho cushion) in it. R1's recliner was in the center of the room covered with chucks. Observation of the bed revealed a regular mattress on a twin bed frame. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175202	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colby Operator, LLC	105 East College Drive Colby, KS 67701

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/12/24 at 11:00 AM, Certified Nurse Aide (CNA) M stated she did not ever remember R1 having a pressure-relieving cushion in her recliner. CNA M stated R1 sat in her recliner twenty-four hours a day, seven days a week because it was too painful for R1 to get into bed. On 08/12/24 at 11:15 AM, CNA N stated she took care of R1 all the time and there was never a pressure relieving cushion in R1's recliner. CNA M stated there were always chucks and maybe a turn sheet in R1's recliner but never a pressure relieving cushion. CNA N stated R1 would refuse to reposition at times because she was comfortable where she was and did not want the pain to start. CNA N stated aides were able to reposition R1 in her recliner using three aides, but it was difficult. CNA N stated aides would also change R1's briefs in the recliner. CNA N stated once R1 had an air mattress she was able to get into bed and not have pain. On 08/12/24 at 11:30 AM, Licensed Nurse (LN) G stated she never saw a pressure relieving cushion in R1's recliner. LN G stated when R1 got an air mattress, she finally got into bed. LN G said that prior to getting the air mattress, R1 constantly sat up in her recliner. On 08/12/24 at 12:15 PM, Administrative Nurse D stated the facility did not order a specialized mattress because R1 kept saying she would not use it and R1 had not paid her bill at the facility so the facility would then be out that much more money for the bed. Administrative Nurse D stated R1 was very non-compliant but unfortunately, that was not in the care plan until after she came down with the pressure ulcers to begin with. Administrative Nurse D stated she knew there was a cushion in R1's recliner. Administrative Nurse D stated she talked with the doctor, an [TRUNCATED]