

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175291	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER Azria Health Great Bend		STREET ADDRESS, CITY, STATE, ZIP CODE 1560 K 96 Hwy Great Bend, KS 67530	

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)
<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204</p> <p>The facility identified a census of 62 residents, with three residents reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on record review, observation, and interview, the facility failed to provide necessary care, consistent with professional standards of practice, to prevent pressure ulcers including offloading for Resident (R) 1 who developed a facility-acquired 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 her left heel. This deficient practice also placed R1 at risk for infection and pain.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of a pubic fracture, pressure ulcers, weakness, abnormality of gait and mobility, and need for personal care. <p>R1's Admission Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R1 required substantial/maximum staff assistance with dressing, donning (putting on) footwear, and bed mobility. The MDS noted R1 was dependent on staff for all transfers. The MDS documented R1 was at risk for developing pressure ulcers; R1 was admitted with two Stage 2 (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) pressure ulcers and one Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) pressure ulcer. The MDS documented R1 had pressure ulcer treatments including nutrition and hydration management, pressure ulcer care, and application of ointments/medications.</p> <p>The Functional Abilities Care Area Assessment (CAA), dated 02/13/25, documented R1 had an alteration in self-care and mobility function with altered elimination, a risk for falls, and a risk for skin breakdown. The CAA identified R1 admitted with a Stage 3 pressure ulcer to her coccyx (tailbone area) and a Stage 2 pressure ulcer to her right and left buttocks. The CAA noted R1 received antibiotics for positive wound cultures and infection.</p> <p>The Pressure Ulcer/Injury CAA, dated 02/13/25, documented R1 entered the facility with pressure ulcers, and had contributing factors of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), weakness, and immobility.</p> <p>(continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>R1's Care Plan documented R1 required substantial to maximum assistance from one to two staff for bathing, bed mobility, and transfers; R1 was dependent on one to two staff for toileting. The care plan directed staff to follow facility policies and protocols for the prevention and treatment of skin breakdown, administer treatments as ordered, monitor for effectiveness, and provide pressure relieving/reducing devices on R1's bed and chair (02/10/25). The plan documented R1 was to wear heel protectors at all times (03/27/25). The plan directed staff to use caution during transfers and bed mobility to prevent R1 from striking her arms, legs, and hands against any sharp or hard surfaces (04/11/25). R1's Care Plan lacked interventions related to repositioning and lacked interventions related to offloading until 03/27/25.</p> <p>The Braden Scale for Predicting Pressure Sore Risk, dated 02/18/25, documented R1's score as 18, which indicated R1 was at low risk for pressure ulcer development.</p> <p>The Braden Scale for Predicting Pressure Sore Risk, dated 03/08/25, documented R1's score as 17, which indicated R1 was at low risk for pressure ulcer development.</p> <p>The Incident Note, dated 03/15/25 at 12:44 AM, documented the nurse was called into R1's room by the Certified Nurse Aides (CNA) who reported R1 had blood by her left heel. The note documented the nurse found R1 had five centimeters (cm) by three cm Stage 3 pressure ulcer on her left heel. The staff cleansed the wound with wound cleanser and applied Xerofoam (sterile non-adhering fine mesh gauze treated with a bacteriostatic agent) and a border dressing to R1's left heel.</p> <p>The Order Note, dated 03/20/25, documented a left heel dressing change. Staff were to cleanse the wound with wound cleanser, apply calcium alginate (highly absorbent dressing), cover with a bordered adhesive foam dressing and change daily and as needed.</p> <p>The Wound Assessment Note, dated 03/20/25, documented R1's left heel wound measured 5 cm by 6 cm by 0.2 cm deep.</p> <p>The IDT Note, dated 03/21/25, documented R1 had a new pressure ulcer on her left heel. Staff received orders to start calcium alginate to aid in the formation of granulation tissue (new tissue formed during wound healing) and to debride (medical removal of dead, damaged, or infected tissue to improve the healing potential for the remaining healthy tissue) areas of loose skin. The note documented the treated area had no signs or symptoms of infection.</p> <p>The Wound Assessment Note, dated 03/26/25 documented R1's left heel wound measured 5.5 cm by 7.4 cm and was mostly necrotic (pertaining to the death of tissue in response to disease or injury).</p> <p>The IDT Note, dated 03/26/25, documented R1's left heel treatment started the previous week. The peri-wound (tissue surrounding the wound) was opening up and increased in size. The wound had no signs or symptoms of infection noted to the area.</p> <p>The Wound Assessment Note, dated 04/03/25, documented R1's left heel wound measured 6 cm by 8.5 cm and had progressed to an unstageable ulcer.</p> <p>The IDT Note, dated 04/03/25 documented R1's left heel ulcer progressed in normal stages for pressure ulcers, the peri wound was sloughing (dead tissue, usually cream or yellow in color) off and the wound was expanding in size.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The Wound Assessment Note, dated 04/11/25, documented R1's left heel ulcer measured 5.7 cm by 8.5 cm and continued to be necrotic and unstageable.</p> <p>The Wound Assessment Note, dated 04/17/25, documented R1's left heel wound measured 5.6 cm by 8.3 cm. The wound was necrotic, unstageable, and had a foul odor.</p> <p>The IDT Note, documented all of R1's pressure sores showed signs of improvement except the left heel ulcer. Staff requested and received an order for a wound culture due to the wound's odor.</p> <p>The EMR lacked evidence of the culture results that were ordered.</p> <p>The Skin/Wound Note, dated 04/21/25, documented R1 had a large injury to her left leg. R1 obtained a laceration (cut) to her left inner calf during a transfer with a Hoyer lift (total body mechanical lift) caused by R1's leg rubbing on the back of the foot pedal. Staff called Emergency Medical Services (EMS) and sent R1 to the emergency room for suture (stitches) placement.</p> <p>The Hospital Progress Note, dated 04/22/25, documented the hospital placed nine sutures on R1's left anterior shin laceration to R1's leg that grazed the back of the foot pedals on her wheelchair. The note documented the hospital had concerns about R1's left heel wound due to the malodorous smell, and an X-ray was done that showed a large soft tissue wound posterior (back) to the calcaneus (heel bone) with adjacent soft tissue swelling, osseous (hard, mineralized tissue that provides the skeletal structure of the human body) destruction of the posterior calcaneal (heel bone) cortex (outer layer of any part) adjacent to the wound consistent with acute osteomyelitis (local or generalized infection of the bone and bone marrow). R1 received vancomycin (antibiotic) and Zosyn (antibiotic) at the transferring hospital. R1 was transferred to a higher-level hospital for surgical evaluation. R1's age, multiple comorbid conditions, and lack of mobility as well as dementia, resulted in a conservative treatment plan. R1's responsible party discussed the options to discharge back to long-term care on hospice versus continuation of intravenous (IV) antibiotics for six to eight weeks and see how R1 did.</p> <p>The General Progress Note, dated 04/28/25, documented R1 arrived from a higher level of care with diagnoses of failure to thrive, wounds, and frail elderly. R1 was admitted back to the facility on hospice.</p> <p>The Infection Note, dated 04/30/25, documented R1 continued an antibiotic for her left heel wound. There were no signs and symptoms of infection to left heel. The staff changed the dressing, and the area was without odor.</p> <p>On 05/07/25 at 11:30 AM, observation revealed R1 lay in bed sleeping. R1 had oxygen tubing pulled down below her chin. R1 had blue pressure-relieving boots on both feet. R1 lay on a low-air mattress.</p> <p>On 05/07/25 at 11:30 AM, R1 stated she did not know how she got the sore on her left heel, but it hurt. R1 apologized for being sleepy, saying she had just received a pain pill, which made her sleepy.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 05/07/25 at 01:00 PM, CNA O stated she could not remember if R1 had pressure-relieving boots prior to her obtaining the heel wound. CNA O stated she did not know if turning and repositioning was on R1's Care Plan but staff would turn and reposition anyway regardless of if it was on the care plan. CNA O stated R1 had been on an air mattress since R1's admission to the facility.</p> <p>On 05/07/25 at 01:10 PM, CNA P stated she did not think R1 had pressure-relieving boots on her feet before she developed the left heel pressure ulcer. CNA P stated there was nothing that alerted or informed staff which residents needed to be turned or repositioned, but the CNA just knew and did it anyway.</p> <p>On 05/07/25 at 01:20 PM, Licensed Nurse (LN) G stated she was sure R1 had been on an air mattress since admission, but she could not accurately say whether R1 had pressure-relieving boots to her feet prior to getting the pressure wound on the left heel.</p> <p>On 05/07/25 at 02:30 PM, Administrative Nurse D stated she did not know why R1's Care Plan did not include pressure-relieving boots as an intervention until 03/27/25 after R1 had sustained the left heel ulcer. Administrative Nurse D stated the facility was in between MDS nurses at that time, and training new MDS nurses about care plan interventions was complicated. Administrative Nurse D stated she thought R1 had pressure-relieving boots in place from admission. Administrative Nurse D stated she knew R1 had an air mattress since her admission to the facility. Administrative Nurse D stated she thought R1 had possibly been in the dying process since her admission, and that is why she obtained the pressure ulcer. Administrative Nurse D stated she expected that residents would develop facility-acquired pressure ulcers unless they were unavoidable.</p> <p>The facility did not provide a policy on pressure ulcer prevention.</p>		