STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheyenne County Village Inc	820 S Denison Street St Francis, KS 67756

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 43 residents with three residents reviewed for pressure ulcers. Based on record review and interview, the facility failed to identify, monitor, and provide appropriate treatments and interventions, to prevent pressure ulcers from worsening and prevent infection for Resident (R) 1. R1 admitted to the facility on [DATE] with a Stage 3 pressure ulcer (full thickness pressure injury extending through the skin into the tissue below) on his coccyx (area at the base of the spine). Nursing staff did not perform consistent wound assessments to include measurements and presence of infection. On [DATE], 81 days after admission, R1's wound had worsened and had foul-smelling yellow drainage. A wound culture recorded R1 had Methicillin-Resistant Staphylococcus Aureus (MRSA-a type of bacteria resistant to many antibiotics) and Escherichia coli (E. coli-bacteria commonly found in the lower intestine that had a potential for causing infections in the urinary tract with inadequate incontinence care) in the wound, and Consultant GG ordered a new treatment and started R1 on an antibiotic, Doxycycline. R1's Electronic Medical Record (EMR) alerted staff that the LiquaCel powder, used in R1's wound treatment, would interfere with the absorption of the antibiotic, but staff did not notify the providers, so no action was taken. On [DATE] a diagnostic scan of R1's abdomen and pelvis revealed sacral osteomyelitis (local or generalized infection of the bone and bone marrow). R1 had new order for intravenous (IV-administered directly into the bloodstream via a vein) and oral antibiotics. The wound consultant team saw R1 on Fridays and gave new orders for daily wound dressing changes. The facility nursing staff did not follow the orders regarding the wound dressing changes as Consultant GG issued multiple warning to staff to ensure the AG rope (used to absorb drainage and promote wound healing) was out of the wound. There were multiple occasions when the wound dressing was not performed as ordered due to unavailable wound supplies. The wound continued to worsen and on [DATE] was recorded as a Stage 4 pressure ulcer (a deep pressure wound that reaches the muscles, ligaments, or even bone) with exposed bone. On [DATE] R1's wound erupted with uncontrollable bleeding and R1 was sent to the local Emergency Department. R1 then transferred to a higher level of care and admitted to the hospital with sepsis (life threatening systemic reaction that develops due to infections which cause inflammation throughout the entire body) and dehydration. R1 died on [DATE]. The facility failure to provide appropriate pressure reducing interventions, failure to consistently monitor R1's wounds and assess and address signs of infection, failure to involve the physician when needed, and failure to provide appropriate wound care services and treatments including ensuring availability of treatment supplies, placed R1 in Immediate Jeopardy. Findings included: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of Stage 3 pressure ulcer, congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), metastatic lung cancer, hypertension (high blood pressure), and hyperlipidemia (condition of elevated blood lipid levels). The Admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) was not completed for R1. The MDS documented R1 did not have an altered level of consciousness, disorganized thinking, or inattention. The MDS documented R1 required substantial staff assistance with toileting, bathing, dressing, bed mobility, and transfer. The MDS documented R1 had not received scheduled pain medication, as needed pain medication, or any non-medication interventions for pain. During the pain interview, R1 stated he had the presence of pain, but the rest of the interview was not completed. The MDS documented R1 was at risk for developing pressure ulcers and had a Stage 3 pressure ulcer that was present on admission. The MDS documented R1 received a pressure reducing device for his bed, was not on a turning/repositioning program, did not have nutrition or hydration interventions to manage skin problems, was receiving pressure ulcer care and applications or nonsurgical dressing other than to his feet. The Quarterly MDS, dated [DATE], documented R1 had a Brief Interview for Mental Status score of five which indicated severely impaired cognition. The MDS documented R1 had impairment on both sides of his lower extremities. The MDS documented R1 was dependent on staff for oral hygiene, toileting hygiene, bathing, lower body dressing, putting on and taking off footwear, and personal hygiene. R1 required substantial staff assistance for rolling left to right, sitting to lying, lying to sitting, transfers, and ambulation. The MDS documented R1 had not received scheduled pain medication, as needed pain medication, or any non-medication interventions for pain. During the pain interview, R1 stated he had occasional pain during the look back period that was moderate in strength. The MDS documented R1 was at risk of developing pressure ulcers and currently had a Stage 4 pressure ulcer that was not present on admission. The MDS documented R1 had a pressure reducing device for his bed, a pressure reducing device for his bed, was not on a turning/repositioning program, had nutrition or hydration interventions to manage skin problems, received pressure ulcer care, and had application of ointments/medication other than to his feet. The Nutrition Care Area Assessment (CAA), dated [DATE], documented R1 admitted with a Stage 3 pressure injury to his coccyx and a deep tissue injury to his right heel. On admission R1 reported stabbing pain to his coccyx. The Pressure Ulcer/Injury CAA, dated [DATE], documented R1 had a Stage 3 pressure injury to his coccyx and deep tissue injury to his heel. The CAA documented R1 had bowel incontinence and required extensive assistance with bed mobility. R1 was on a Sizewise (a specialized mattress for pressure relief) mattress and was at risk for unidentified pain. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Care Plan directed staff R1 required extensive assistance of one to two staff for bed mobility and staff were to turn/reposition R1 every two hours in bed ([DATE]). R1 required an air mattress on his bed and cushions in his recliner and wheelchair ([DATE]). R1 required weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue, and exudate ([DATE]). R1 needed to be reminded to turn/reposition at least every two hours ([DATE]). R1 had acute pain related to pressure injury to the sacrum and R1 would verbalize adequate relief of pain. Staff were to monitor and document side effects of pain medication and report to the nurse any changes in usual activity attendance patterns related to signs or symptoms or complaints of pain or discomfort. ([DATE]). The Admitting Hospital Wound Care Note, dated [DATE], documented R1's pressure ulcer was present on admission to the hospital. R1's coccyx wound measured 2.2 centimeters (cm) by 3.7 cm by 0.2 cm, with 60% granulation tissue and 40% slough (dead tissue, usually cream or yellow in color). The Braden Scale for Predicting Pressure Sore Risk, dated [DATE], documented R1's risk score was 15, which indicated at risk. R1's was chairfast, skin was very moist, and noted friction and shear was a potential problem. The Admission Data Collection, dated [DATE], documented R1 had a Stage 3 pressure ulcer but no measurements were taken. A pressure reducing device for R1's bed would be used, R1's heels would be floated, and a turning and repositioning program would be implemented. The Admission Note, dated [DATE], documented R1 admitted on [DATE] at 02:00 PM with the admitting diagnosis of malignant tumor of the lung. R1 was weak but could walk twenty feet. R1's speech and vision were good but R1 was hard of hearing. R1 admitted with a Stage 3 pressure ulcer to his buttock, was a fall risk due to weakness, shown how to use the call light, and educated to wait for assistance to avoid a fall. The Advance Care Planning Note, dated [DATE], documented R1 was at the facility to gain strength after losing weight and strength from chemotherapy. R1 would participate in physical therapy and occupational therapy. R1's goal was to gain weight and strength so he could continue chemotherapy and return home. The Wound Daily Observation Note, dated [DATE], documented R1 had a foam dressing in place. The wound margin was pink and R1 denied pain. The wound did not have any drainage and the wound bed had pink epithelial tissue. The note documented the primary care provider was aware. The Wound Daily Observation Note, dated [DATE], documented R1's foam dressing was intact but had bowel movement in it, so it was removed. The wound was cleansed with normal saline and baby shampoo and rinsed. Skin prep (liquid skin protectant) was applied around the outer skin. Aquacel (a wound dressing) was placed into the wound and a foam dressing placed to cover the wound. The center of the wound was red with active bleeding. The old dressing had a moderate amount of yellow drainage and no odor. R1 denied pain. The wound bed was not assessed. R1's primary care provider was not notified. The Wound Daily Observation, dated [DATE], documented R1's dressing was removed, there was bowel movement in the wound, and the surrounding skin was red. R1 denied pain. The wound had fresh bleeding from the wound. Staff cleansed the wound with normal saline and baby shampoo, rinsed, applied skin prep to the surrounding skin, applied Aquacel, and covered with a foam dressing. (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 Daily Observation Note, dated [DATE], documented R1's dressing was changed and there was bowel movement in the dressing. The surrounding skin was red. There was no pain noted with the dressing change. A small amount of yellow/red drainage was noted. The wound bed was covered with s. The wound was cleaned with normal saline and baby shampoo, rinsed, skin prep applied to the surrounding skin, Aquacel applied, and covered with a foam dressing. R1's primary care provider was not notified of changes. The Consultant Note, dated [DATE], documented R1 was a new admission with a Stage 3 pressure ulcer to his sacrum (large triangular bone/area between the two hip bones). Consultant HH recommended four ounces of fortified juice at breakfast and an eight-ounce protein shake in the afternoon along with a multivitamin and Vitamin C 500 milligrams (mg) twice a day. R1's estimated calorie needs for healing were 2200 to 2500 calories. The Wound Daily Observation Note, dated [DATE], documented R1's wound treatment was completed per doctor's orders. The skin surrounding the wound was pink. R1 denied pain. No drainage was noted. The wound bed was not assessed. The note lacked notification of the changes to R1's primary care provider. The Wound Daily Observation Note, dated [DATE], documented the dressing was changed per R1's primary care provider's order. The skin around the wound was not assessed. No pain was noted during dressing change. Staff were unable to tell if there was drainage as R1 had bowel movement underneath the dressing. The wound bed had granulation (new tissue formed during wound healing). The note lacked notification of R1's primary care provider. The Wound Daily Observation Note, dated [DATE], documented R1's dressing was changed per his primary care provider's orders. Skin surrounding the wound was red. R1 had no complaints of pain. A moderate amount of yellow drainage was noted without odor. The wound bed had granulation tissue. The note lacked notification of R1's primary care provider. The Skin Observation Tool, dated [DATE], documented R1's coccyx wound measured 4 cm by 2 cm by 0.5 cm. The Wound Daily Observation Note, dated [DATE], documented R1's dressing was left in place because the dressing did not need changed. Staff documented R1's dressing was clean dry and intact and not changed because it was changed yesterday. (R1's dressing change order directed staff to change R1's dressing daily) The Wound Daily Observation Note, dated [DATE], documented R1's dressing was changed per doctor's orders. The skin surrounding the wound was pink. R1 denied pain. There was yellow drainage with active bleeding and the wound bed had granulation tissue. The note lacked notification of R1's primary care provider. The Wound Daily Observation Note, dated [DATE], documented R1's dressing was changed per his primary care providers orders. The skin surrounding the wound was red and staff noted a little old blood on the old dressing. The wound bed had granulation tissue. The note lacked notification of R1's primary care provider. (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 Daily Observation Note, dated [DATE] documented a new dressing was applied to R1's wound. The skin surrounding the wound was pink. R1 denied pain. The wound bed had granulation tissue. The note lacked notification of R1's primary care provider. The Skin Observation Tool dated [DATE] documented R1 had a Stage 3 decubitus ulcer (localized skin and tissue injuries that occur when the blood supply to the skin is cut off for more than two to three hours) to his coccyx which measured 3 cm by 1 cm by 0.7 cm. The Nutrition Note, dated [DATE], documented R1 would be receiving six-ounce house supplements with meals. The note included the mid-afternoon supplement shake was going untouched as R1 was always napping. The Wound Daily Observation Note, dated [DATE], documented R1 did not have a dressing to his coccyx. The treatment was done per doctor's orders. The skin surrounding the wound was red. R1 denied pain. No drainage or odor noted. The wound bed had granulation tissue. The note lacked notification of R1's primary care provider. The Skin Observation Tool, dated [DATE], documented R1's coccyx wound measured 2.5 cm by 0.5 cm by 0. 4 cm. The Wound Daily Observation Note, date [DATE], documented R1 did not have a dressing in place to his coccyx. A new dressing was applied per doctor's orders. The skin surrounding the wound was red. R1 denied pain. No drainage or odor noted. The wound bed had granulation tissue. The note lacked notification of R1's primary care provider. The Wound Daily Observation Note, dated [DATE], documented there was a band-aid on R1's wound. The skin surrounding the wound was red. R1 denied pain. The wound bed was red, with no drainage or odor noted. The note included R1's primary care provider did not need to be notified at that time. The Skin Observation Tool, dated [DATE], documented R1's coccyx wound measured 2.5 cm by 0.7 cm by 0. 5 cm. The Wound Daily Observation Note, dated [DATE], documented R1 did not have a dressing in place on his coccyx. Treatment to R1's Stage 3 decubitus ulcer done per doctor's orders. The skin surrounding the wound was red, with no drainage or odor noted, and R1 denied pain. The wound bed had some granulation tissue noted. R1's primary care provider was not notified. The Order Note, dated [DATE], documented R1 was to start LiquaCel (a liquid protein supplement) twice a day for wound healing assistance. The Wound Daily Observation Note, dated [DATE], documented R1's dressing to his coccyx was intact. A new dressing was applied per doctor's orders. The skin surrounding the wound was pink. A moderate amount of yellow drainage was noted. The wound bed had granulation tissue. The note lacked notification of R1's primary care provider. The Skin Observation Tool, dated [DATE], documented R1's coccyx wound measured 5 cm by 3 cm. (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 Daily Observation Note, dated [DATE], documented there was no dressing to R1's coccyx wound. Dressing change was performed per doctor's orders. The skin surrounding the wound was pink. R1 denied pain. There was no drainage or odor noted. The wound bed had granulation tissue. The note lacked notification of R1's primary care provider. The Skin Observation Tool, documented R1's coccyx wound measured 4 cm by 2 cm. The Wound Daily Observation Note, dated [DATE], documented R1 had no dressing to his coccyx. A new dressing was applied per doctor's orders. The skin surrounding the wound was pink. R1 denied pain. The wound bed had granulation tissue and no drainage or odor. The note lacked notification of R1's primary care provider. The Wound Daily Observation Note, dated [DATE], documented R1 had no dressing to his coccyx. Treatment was performed per doctor's orders. The skin surrounding the wound was pink. R1 denied pain. The wound bed had granulation tissue with no drainage or odor noted. The note lacked notification of R1's primary care provider. The Skin Observation Tool, dated [DATE], documented R1's coccyx wound was deep and measured 4 cm by 2 cm. The Wound Daily Observation Note, dated [DATE], documented R1 did not have a dressing to his coccyx. The treatment was done per doctor's orders. The skin surrounding the wound was pink. R1 denied pain. There was no drainage or odor noted. The wound bed had slough. The note lacked notification of R1's primary care provider. The Wound Daily Observation Note, dated [DATE], documented R1 had no dressing in place to his coccyx. The treatment was done per doctor's orders. The skin surrounding the wound was red. R1 denied pain. No drainage or odor was noted. The wound bed was not assessed. R1's primary care provider was not notified. The Skin Observation Tool, dated [DATE], documented R1 had an open sore on his coccyx and was healing slowly. The [DATE] Health Status Note documented R1 felt warm during rounds. R1's temperature was 100.5 degrees Fahrenheit (F) and staff administered 1000 milligrams (mg) of Tylenol (a fever reducing medication) to R1. The Daily Wound Observation Note, dated [DATE], documented R1's dressing was intact and changed. The skin surrounding the wound was pink. There was a moderate amount of thick yellow bloody drainage. The wound bed had slough. The note lacked notification of R1's primary care provider. The Skin Observation Tool, dated [DATE], documented R1's coccyx wound measured 2.5 cm by 0.5 cm with tunneling on the top side that measured 2.5 cm and tunneling on the right side which measured 0.5 cm. The note documented R1 sat in his recliner all day and refused to lay in bed during the day. The note stated the facility faxed R1's primary care provider requesting to send R1 to wound care as R1's wound was tunneling and had heavy drainage. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Daily Wound Observation Note, dated [DATE], documented R1 did not have a dressing in place but the dressing had been changed several times due to drainage. The skin surrounding the wound was red. R1 had pain rated at 8 out of 10, on a zero to ten scale. There was a huge amount of yellow drainage. The wound had 2.5 cm of tunneling at the top of the wound and 0.5 cm of tunneling to the right side of the wound. R1's primary care provider was notified of the change and a fax was sent requesting wound care. The Communication with Physician Note, dated [DATE], documented R1's Stage 3 pressure wound to his coccyx, which he was admitted with on [DATE], was becoming smaller in size. R1's wound had a huge amount of drainage without odor. Tunneling was noted 2.5 cm at the top of the wound and 0.5 cm noted to the right side of the wound. R1 denied pain since his admission but today his pain was rated 8 out of 10. The New Order Fax, dated [DATE], referred R1 to wound care at the hospital for evaluation and treatment for a Stage 3 decubitus ulcer and an order for oxycodone 5 mg by mouth every four hours as needed for coccyx pain. The Wound Daily Observation Note, dated [DATE] documented R1's dressing was saturated with drainage. The dressing was changed. R1's wound measurements to his coccyx measure 3.2 cm by 7 cm with tunneling to the right side of the wound which measured 0.7 cm. There was no pain with the dressing change. There was an excess amount of drainage, and an ABD pad was applied to accommodate the drainage. The drainage was yellow, pus-like drainage. The wound bed contained slough. R1's primary care physician ordered wound care at the hospital. The Wound Daily Observation Note, dated [DATE], documented R1 had gone to the hospital for wound care. The Wound Culture Result, dated [DATE], documented R1's coccyx wound had MRSA and E. coli. The Wound Daily Observation Note, dated [DATE], documented R1's dressing was intact and to be changed every other day and as needed. The dressing change orders included: Flush with 20 milliliters (ml) of quarter strength Dakin's solution (a topical antiseptic made of diluted sodium hypochlorite traditionally used to clean wounds to prevent infection), Flush with 20 ml normal saline, Aquacel AG rope (a wound dressing) into the wound bed, fluff 4 by 4's (gauze), apply XTRASORB (a super absorbent dressing), and secure with Mefix (skin friendly dressing retention tape). The Wound Daily Observation Note, dated [DATE], documented R1's dressing to his coccyx was intact. No dressing change needed as the dressing was change last night. The Wound Daily Observation Note, dated [DATE] at 08:45 PM, documented R1's dressing was changed to his coccyx. Erythema (redness) and drainage was noted. R1 stated the pain was terrible when the dressing was being changed. The wound had copious amounts of serosanguinous (semi-thick blood-tinged drainage) and purulent (producing or containing pus) drainage. The existing bandage was fully saturated. When flushed, a large amount of serosanguinous fluid was expelled from the wound. The wound bed had a slight amount of slough and tunneling was noted. Primary care physician had already been notified and R1 was being seen at the wound care. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Order Note, dated [DATE], documented doxycycline hyclate (an antibiotic) 100 mg by mouth twice a day for fourteen days for wound. The EMR system identified a possible drug interaction with LiquaCel Oral Liquid. LiquaCel Oral Liquid could impair the gastrointestinal absorption and decrease the antimicrobial effectiveness of doxycycline hyclate (an oral antibiotic) 100 mg. The facility staff failed to notify R1's primary care provider of the drug interaction. The Wound Daily Observation Note, dated [DATE], documented R1's dressing to his coccyx was changed. The skin surrounding the wound was pink. The wound measured 2.0 cm by 0.8 cm with 2.5 cm of tunneling to the right. R1 was given Percocet (a pain pill) at 11:45 AM. The drainage was greenish in color and there was a large amount of drainage. A small amount of odor noted. The wound bed had slough. R1's primary care provider was not notified as R1 would see wound care on Friday at 01:00 PM. The Skin Observation Tool, dated [DATE], documented R1's coccyx wound measured 2.5 cm by 0.5 cm with tunneling on the top side that measured 2.5 cm and tunneling on the right side which measured 0.5 cm. The note documented R1 would sit in his recliner all day and refused to lay in bed during the day. The Physician Note, dated [DATE], documented R1 saw wound cared for a pressure ulcer to his buttock that was infected with Methicillin-resistant Staphylococcus aureus (MRSA-a type of bacteria resistant to many antibiotics) and Escherichia coli (E. coli-bacteria commonly found in the lower intestine that had a potential for causing infections in the urinary tract with inadequate incontinence care) and was on doxycycline. R1 received dressing changes and there was concern about a fistula (abnormal passage from an internal organ to the body surface or between two internal organs) but the Computed Tomography (CT) scan was negative for this. There were findings of osteomyelitis (local or generalized infection of the bone and bone marrow). The wound care practitioner would speak to family about R1's goals. The Wound Daily Observation Note, dated [DATE], documented the dressing to R1's coccyx was saturated and had to be changed. The skin surrounding the wound was pink and R1 denied pain. Tunneling was noted to be deeper on top and both sides of the wound, with heavy yellow drainage noted. R1 primary care provider did not need to be notified as she saw R1 that day. The Wound Daily Observation Note, dated [DATE], documented R1 did not need a dressing change that day because R1 had been to the hospital for wound care. The Wound Daily Observation Note, dated [DATE], documented R1's coccyx dressing had to be changed because it was saturated. The margin around the wound was red and surrounding tissue was pink. R1 stated he was having some pain, but it was tolerable. The drainage was thick, yellow pus with a strong odor. The wound bed contained slough. R1's primary care physician did not need notified as R1 would go to wound care on Friday. The Wound Data Collection, dated [DATE], documented R1's coccyx wound measured 3.2 cm by 0.9 cm by 2.5 cm with 2.5 cm tunneling to the right side. The note documented R1's wound was worsening. The wound bed has 100% slough. The wound had heavy purulent (producing or containing pus) drainage. Preventative measures were air mattress, ROHO (pressure relief cushion that is made of soft, flexible air cells) cushion to the wheelchair, and LiquaCel with meals. (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 Daily Observation Note, dated [DATE], documented R1's dressing was intact to his coccyx and the dressing was not changed due to R1 would go to wound care that day. The Health Status Note, dated [DATE], documented new orders from wound care for IV antibiotics, weekly labs, and order for a magnetic resonance imaging (MRI-medical imaging used to view soft tissue). Orders would be faxed later that day. The New Order Fax, dated [DATE], documented new orders for R1's coccygeal osteomyelitis. New orders: Daptomycin (antibiotic) 6 mg/kg IV daily to start [DATE], Augmentin (an oral antibiotic) ,d+[DATE] mg one tab twice a day by mouth for six weeks, pharmacy to contact wound care provider on replacing Daptomycin with Dalvance (antibiotic), contact precautions MRSA/E.coli, and MRI of pelvis with and without IV contrast. The Wound Collection Tool, dated [DATE], documented R1's coccyx wound measured 3.0 cm by 1.2 cm by 2.5 cm with tunneling on the right and left of the wound. R1's wound was worsening. The wound bed was 100% slough. The wound had purulent drainage. The skin surrounding the wound was denuded (loss of epidermis caused by exposure to urine, feces, body fluids, wound drainage, or friction). Undermining was identified. The wound was suspected of infection. Preventative measures: air mattress, cushion to chair and wheelchair, LiquaCel with meals, stand to reposition every three hours. The Wound Daily Observation Note, dated [DATE], documented the dressing to R1's coccyx was changed because it was completely soiled with bowel movement and drainage. The wound's margin was red, and the surrounding skin was pink. R1 stated the dressing change was very painful. There was a large amount of purulent drainage with strong odor. The wound bed had slough. R1's primary care provider was not notified as she was already aware and R1 was seen at wound care. The Communication with Physician Note, dated [DATE], documented Consultant GG was called to clarify if he wanted the IV antibiotics started that day. The Augmentin (antibiotic) could be started on the following Monday. The Communication with Family Note, dated [DATE], documented R1's responsible party was called to gain permission to transport R1 to the hospital for IV antibiotics. R1's responsible party was notified Augmentin would be started by mouth on Monday and labs would be done weekly per Consultant GG. The Wound Daily Observation Note, dated [DATE], documented R1's dressing to his coccyx was saturated with drainage and bowel movement. The skin surrounding the wound was pink. R1 had pain present while doing the treatment to his coccyx but refused pain medication. The drainage was cloudy, thin, and yellow with no odor. The wound bed contained slough. Consultant GG was called for clarification of faxed order. IV antibiotics were started that day and oral antibiotic could be started the following Monday when the pharmacy was open. The Order Note, dated [DATE], documented Amoxicillin/Pot Clavulanate (Augmentin/antibiotic) ,d+[DATE] mg one tablet by mouth every twelve hours for coccygeal osteomyelitis for sixteen weeks. The Antibiotic Monitoring Note, dated [DATE], documented R1's appetite had decreased. The Antibiotic Monitoring Note, dated [DATE], documented R1 was on Daptomycin (antibiotic) IV 6 mg per kilogram (kg) that had been started that morning. R1 had decreased fluid and food intake. (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 Daily Observation Note, date [DATE], documented R1's coccyx dressing was saturated with yellow drainage and bowel movement. The skin surrounding the wound was pink. Some pain noted with dressing change but R1 did not require any pain medication. There was a large amount of thick yellow/bloody drainage without odor. R1's primary care provider was not notified due to R1 went to wound care of Fridays and had daily dressing changes at the facility. The Wound Daily Observation Note, dated [DATE], documented R1's dressing was saturated with drainage and bowel movement and was changed per doctor's orders. The skin surrounding the wound was pink. R1 had noted pain with the dressing change and was compliant with lying on his right side while the dressing was changed. The wound bed had slough. There was a large amount of thick yellow drainage without odor. R1's primary care provider did not need notified due to daily dressing changes at the facility and wound care on Fridays. The Antibiotic Monitoring Note, dated [DATE], documented R1's appetite had decreased, and the primary care provider had not been notified. The Communication with Physician Note, dated [DATE], documented Consultant GG was notified to clarify R1 would take doxycycline that morning then it would be discontinued and would start on amoxicillin , d+[DATE] mg twice a day thru [DATE] and would continue Daptomycin, 6mg/kg IV daily at the hospital, until the new antibiotic arrived; then Daptomycin would be discontinued and R1 would only have one IV antibiotic weekly. The New Fax Order, dated [DATE], documented R1 would receive Dalvance 1500 mg IV on [DATE] and then in eight days R1 would receive the second dose of Dalvance 1500 mg IV for diagnosis of osteomyelitis of the coccyx. Per the Dalvance website (www.dalvance.com) the medication is used to treat acute bacterial skin and skin structure infections (ABSSSI) caused by designated susceptible strains of Gram-positive microorganisms. The Important safety information header noted Clostridioides difficile-associated diarrhea (CDAD) has been reported with nearly all systemic antibacterial agents, including DALVANCE, with severity ranging from mild diarrhea to fatal colitis. Evaluate if diarrhea occurs. The Antibiotic Monitoring Note, dated [DATE], documented R1 had a decreased appetite and R1's primary care provider was not notified. The Wound Daily Observation Note, date [DATE], documented R1's dressing was intact and saturated with yellowish-greenish drainage and some bowel movement. Staff removed the old dressing, provided treatment, and applied a new dressing. The skin surrounding the wound was pinkish. R1 denied pain. There was a heavy amount of yellowish-green tinged drainage without odor. The wound bed was pinkish with a red center. The facility did not have the packing required for the dressing change. R1's primary care physician was not notified as R1 was seen yesterday at wound care. The At Risk Note, dated [DATE], documented R1 was on LiquaCel twice a day. The Certified Dietary Manager (CDM) requested Arginaid (a nonprescription nutritional drink that supplies the amino acid L-arginine al[TRUNCATED]

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 43 residents with three residents reviewed for pain. Based on record review and interview, the facility failed to provide Resident (R) 1 with pain relieving measures prior to or after pressure ulcer dressing changes though R1 had documented pain and demonstrated signs of discomfort during dressing change. This deficient practice resulted in untreated pain for R1 and placed him at risk for continued unnecessary pain and altered psychosocial well-being. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of Stage 3 pressure ulcer, congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), metastatic lung cancer, hypertension (high blood pressure), and hyperlipidemia (condition of elevated blood lipid levels). The Admission Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS), which was not completed. The MDS documented R1 did not have an altered level of consciousness, disorganized thinking, or inattention. The MDS documented R1 required substantial staff assistance with toileting, bathing, dressing, bed mobility, and transfer. The MDS documented R1 had not received scheduled pain medication, as needed pain medication, or any non-medication interventions for pain. During the pain interview, R1 stated he had the presence of pain, but the rest of the interview was not completed. The MDS documented R1 was at risk for developing pressure ulcers and had a Stage 3 pressure ulcer that was present on admission. The MDS documented R1 received a pressure reducing device for his bed, was not on a turning/repositioning program, did not have nutrition or hydration interventions to manage skin problems, was receiving pressure ulcer care and applications or nonsurgical dressing other than to his feet. The Quarterly MDS, dated [DATE], documented R1 had a Brief Interview for Mental Status score of five which indicated severely impaired cognition. The MDS documented R1 had impairment on both sides of his lower extremities. The MDS documented R1 was dependent on staff for oral hygiene, toileting hygiene, bathing, lower body dressing, putting on and taking off footwear, and personal hygiene. R1 required substantial staff assistance for rolling left to right, sitting to lying, lying to sitting, transfers, and ambulation. The MDS documented R1 had not received scheduled pain medication, as needed pain medication, or any non-medication interventions for pain. During the pain interview, R1 stated he had occasional pain during the look back period that was moderate in strength. The MDS documented R1 as at risk for developing pressure ulcers and currently had a Stage 4 pressure ulcer that was not present on admission. The MDS documented R1 had a pressure reducing device for his bed, a pressure reducing device for his bed, was not on a turning/repositioning program, had nutrition or hydration interventions to manage skin problems, received pressure ulcer care, and had application of ointments/medication other than to his feet. The Nutrition Care Area Assessment (CAA), dated 06/23/23, documented R1 was admitted with a Stage 3 pressure injury to his coccyx (area at the tailbone) and a deep tissue injury to his right heel. On admission R1 reported stabbing pain to this coccyx. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The Pressure Ulcer/Injury CAA, dated 06/23/23, documented R1 had a Stage 3 pressure injury to his coccyx and deep tissue injury to his heel. The CAA documented R1 had bowel incontinence and required extensive assistance with bed mobility. R1 was on a Sizewise (a specialty mattress that provides active pressure redistribution) mattress and was at risk for unidentified pain. R1's Care Plan directed staff to know R1 required extensive assistance of one to two staff for bed mobility and staff were to turn/reposition R1 every two hours in bed (06/19/23). R1 required an air mattress on his bed and cushions in his recliner and wheelchair (09/15/23). R1 required weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue, and exudate (09/15/23). R1 needed to be reminded to turn/reposition every at least every two hours (09/15/23). R1 had acute pain related to pressure injury to the sacrum and R1 would verbalize adequate relief of pain. Staff were to monitor and document side effects of pain medication and report to the nurse any changes in usual activity attendance patterns related to signs or symptoms or complaints of pain or discomfort. (06/19/23). The New Order Fax, dated 09/05/23, ordered for a referral for R1 to wound care at the hospital for evaluation and treatment for Stage 3 pressure ulcer and an order for oxycodone (narcotic opioid pain medication) 5 mg by mouth every four hours as needed for coccyx pain. The Daily Wound Observation Note, dated 09/05/23, documented R1 did not have a dressing in place but the dressing was changed several times due to drainage. The skin surrounding the wound was red. R1 rated his pain an eight on a 0-10 scale (zero being no pain and 10 the worst pain imaginable). There was a huge amount of yellow drainage from the wound. The wound had tunneling present, which measured 2.5 cm at the top of the wound and 0.5 cm of tunneling to the right side of the wound. R1's primary care provider was notified of the change and the facility sent a fax requesting wound care. The Wound Daily Observation Note, dated 09/10/23 at 08:45 PM, documented staff changed R1's dressing to his coccyx and noted erythema (redness) and drainage. R1 stated the pain was terrible when staff changed the dressing. There were copious amounts of serosanguinous (semi-thick blood-tinged drainage) and purulent (producing or containing pus) drainage. The existing bandage was fully saturated. When flushed, a large amount of serosanguinous fluid expelled from the wound. The wound bed had a slight amount of slough and tunneling was noted. The resident's primary care physician was already notified and R1 was being seen at the hospital for wound care. R1's MAR, dated September 2023, documented staff did not administer pain medication to R1 until after the dressing change on 09/14/23. The Wound Daily Observation Note, dated 09/16/23, documented staff changed the dressing to R1's coccyx because it was completely soiled with bowel movement and drainage noted to the area. The wound's margins were red, and the surrounding skin was pink. R1 stated the dressing change was very painful. There was a large amount of purulent drainage noted with strong odor from the wound. The wound bed had slough present. R1's primary care provider was not notified as she was already aware and R1 was seen at the hospital for wound care. R1's MAR, dated September 2023, documented R1 was not given any pain medication on 09/16/23. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The Wound Daily Observation Note, date 09/17/23, documented R1's coccyx dressing was saturated with yellow drainage and bowel movement. The skin surrounding the wound was pink. R1 had some pain noted with the dressing change, but R1 did not require any pain medication. There was a large amount of thick yellow/bloody drainage without odor from the wound. R1's primary care provider was not notified due to R1 went to wound care of Fridays at the hospital and had daily dressing changes at the facility. R1's MAR, dated September 2023, documented R1 was not given any pain medication on 09/17/23. The Wound Daily Observation Note, dated 09/18/23, documented R1's dressing was saturated with drainage and bowel movement and was changed per doctor's orders. The skin surrounding the wound was pink. R1 had pain with the dressing change and was compliant with lying on his right side while staff changed the dressing. The wound bed had slough present and there was a large amount of thick yellow drainage without odor noted from the wound. R1's primary care provider did not need notified due to daily dressing changes at the facility and wound care at the hospital on Fridays. R1's MAR, dated September 2023, documented R1 was not given any pain medication on 09/18/23. The Wound Daily Observation Note, dated 09/20/23, documented R1's coccyx dressing was intact but was saturated through the dressing. Staff completed a dressing treatment per doctor's orders. The skin surrounding the wound was a normal pink color. R1 denied pain but jumped a few times while staff completed the treatment. There was a copious amount of light brown, thick, slimy drainage without odor from the wound. The wound bed center was red and had slough present. Tunneling was noted upward and on both sides of the wound. R1's primary care provider was not notified. T R1's MAR, dated September 2023, documented R1 was not given any pain medication on 09/20/23. The Wound Daily Observation Note, dated 09/20/23, documented R1's coccyx dressing was changed due to being saturated with bowel and urine. The skin surrounding the wound was pink. R1 verbalized pain during the dressing change but then stated it was ok once staff completed the dressing change. There were copious amounts of yellow and brown tinged discharge with a foul smell from the wound. The wound bed was red with slough and tunneling present. R1's primary care physician was not notified. R1's MAR, dated September 2023, documented R1 was not given any pain medication on 09/20/23. The Wound Daily Observation Note, dated 09/23/23, documented R1's coccyx dressing was saturated with a large amount of drainage and was changed per doctor's orders. The skin surrounding the wound had undermining present. R1 voiced some pain with the dressing change. There was a large thick amount of slimy brown drainage from the wound. The wound bed had slough present with a bright red center. R1's primary care provider was not notified. Wound care gave new dressing orders on 09/22/23. R1's MAR, dated September 2023, documented R1 was not given any pain medication on 09/23/23. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The Wound Daily Observation Note, dated 09/23/23, documented R1's coccyx dressing was completely saturated and soiled with bowel. The dressing change was completed. The skin around the wound had undermining. R1 had pain with the dressing change. There was thick yellow and brown slimy drainage with a foul odor. The wound bed had slough present with a red center. Staff removed e 45 cm of the existing AG rope (a packing to help absorb moderate to heavy amounts of wound drainage) was and packed 45 cm of new AG rope into the wound. R1's primary care provider was not notified. R1's MAR, dated September 2023, documented R1 was not given any pain medication on 09/23/23. The Wound Daily Observation Note, dated 09/24/23, documented R1's coccyx dressing was soiled with bowel movement present. Staff changed R1's dressing. Undermining was noted to the wound. R1 had pain with the dressing change. There was thick brown slimy discharge from the wound, which was foul smelling. The wound bed had slough with a bright red center present. R1's primary care provider was not notified as she was already aware. R1's MAR, dated September 2023, documented R1 was not given any pain medication on 09/24/23. The Wound Daily Observation Note, dated 09/25/23, documented R1's coccyx dressing was intact, old dressing removed, and treatment done with a new dressing in place. The skin surrounding the wound was pink. R1 had pain while the treatment was performed. There was a heavy amount of thick brownish drainage with some odor present. The wound bed had undermining and slough. R1's primary care provider was not notified as she was already aware. R1's MAR, dated September 2023, documented R1 was not given any pain medication on 09/25/23. The Wound Daily Observation Note, dated 09/26/23, documented R1's coccyx dressing was intact but soiled. The old dressing was removed, and treatment done per order. The skin surrounding the wound was pink. R1 had pain with the treatment. There was a copious amount of thick brown drainage with a foul odor. The would bed had undermining, slough, and was red. During the dressing change 45 cm of AG rope was removed from the wound. No AG rope was inserted into the wound as there was no AG rope available. An AG pad was placed on the wounds entrance. R1's primary care provider was not notified as she was already aware. R1's MAR, dated September 2023, documented R1 was not given any pain medication on 09/26/23. The Wound Daily Observation Note, dated 09/26/23, documented R1's coccyx dressing was intact. The old dressing was removed, and a new dressing was applied without the AG rope as the facility was out. The skin surrounding the wound was pink. R1 had pain in his coccyx with the dressing change. There was a large amount of dark brown fluid that was very odorous. The wound bed had slough. R1's primary care provider was not notified due to R1 receiving daily dressing changes at the facility and weekly wound care at the hospital. R1's MAR, dated September 2023, documented R1 was not given any pain medication on 09/26/23. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The Wound Daily Observation Note, dated 09/27/23, documented R1's coccyx dressing was intact but saturated with drainage. Staff completed a treatment and applied a new dressing. The skin surrounding the wound was undermining. R1 had intermittent pain during the dressing change. There was a large amount of serosanguineous drainage that was thick and slimy and without odor from the wound. The wound bed had approximately fifty percent granulation tissue. R1's primary care provider was not notified because she was already aware. R1's MAR, dated September 2023, documented R1 was not given any pain medication on 09/27/23. The Wound Daily Observation, dated 10/04/23, documented R1's coccyx dressing was intact but saturated with drainage. Staff completed the treatment per doctor's orders with a new dressing in place. The skin surrounding the wound was pink. R1 denied pain but flinched during the treatment. The wound bed had slough and tunneling present. There was a moderate amount of thick brownish slimy discharge from the wound. R1's wound culture results noted R1 was negative and no longer needed to be in isolation. R1's MAR, dated October 2023, documented R1 was not given pain medication before or after the dressing change on 10/04/23. The Wound Daily Observation, dated 10/05/23, documented R1's coccyx dressing was intact and was changed. The skin surrounding the wound was beefy red. R1 had pain with the dressing change. There was a large amount of thick brown fluid with some odor. The wound bed had slough. R1's primary care provider was not notified. R1's MAR, dated October 2023, documented R1 was not given any pain medication on 10/05/23. The Wound Daily Observation Note, dated 10/07/23, documented R1's dressing was intact and was changed. The skin surrounding the wound was beefy red. R1 had pain with the dressing change. There was a copious amount of thick dark brown fluid with odor from the wound. The wound bed had slough. R1's primary care provider was not notified. R1's MAR, dated October 2023, documented R1 was not given any pain medication on 10/07/23. The Wound Daily Observation Note, dated 10/08/23, documented R1's coccyx dressing was intact but saturated and removed and a new dressing was applied. The skin surrounding the wound had exposed subcutaneous tissue that was beefy red and erythematous with fifty percent granulation tissue present. R1 had pain with the dressing change. The wound bed had slough. R1's primary care provider was not notified because R1 went to weekly wound care at the hospital on Fridays. R1's MAR, dated October 2023, documented R1 was not given any pain medication on 10/08/23. The Wound Daily Observation Note, dated 10/10/23, documented R1's dressing was intact, saturated, and changed. The skin surrounding the wound had exposed subcutaneous tissue with erythema and fifty percent granulation tissue present. R1 had increased pain with the placement of the Aquacel rope. There was a copious amount of thick brown drainage. The wound bed had slough. R1's primary care provider was not notified. R1's MAR, dated October 2023, documented R1 was not given any pain medication on 10/10/23. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The Wound Daily Observation Note, dated 10/12/23, documented R1's coccyx dressing was changed per orders. The skin surrounding the wound was light pink. R1 cussed and moaned when his wound was packed. There was a large amount of brownish liquid drainage. The wound bed was not assessed. R1's primary care provider already aware. R1's MAR, dated October 2023, documented R1 was not given pain medication before or after the dressing change on 10/12/23. The Wound Daily Observation Note, dated 10/13/23, documented R1 had a shower that day and R1's dressing was changed. The ulcer border had undermining and was beefy red. R1 had increased pain with the dressing change to his sacral region. There was an excessive amount of thick, brownish bloody drainage with odor noted from the wound. The wound bed had slough present. R1's primary care provider was not notified because R1 went to wound care that day at the hospital. The Wound Daily Observation Note, dated 10/15/23, documented R1's coccyx dressing was intact but soiled and changed per doctor's orders. The skin surrounding the wound was beefy red. R1 voiced pain with the dressing change. There was a large amount of thick brownish bloody drainage with some odor noted from the wound. The wound bed had slough present. R1's primary care provider was not notified. R1's MAR, dated October 2023, documented R1 was not given any pain medication on 10/13/23. The Wound Daily Observation Note, dated 10/17/23, documented R1's coccyx dressing was intact but soiled and was changed per doctor's orders. The skin surrounding the wound was red. R1 had pain with the dressing change. There was thick drainage with odor present. The wound bed had slough. An AG rope was used with the dressing change. R1's primary care provider was not notified. R1's MAR, dated October 2023, documented R1 was not given any pain medication on 10/17/23. The Wound Daily Observation Note, dated 10/19/23, documented R1's coccyx dressing was changed, and staff was unable to find the AG rope inside R1's wound. R1 was very agitated with the dressing change. R1 moaned a lot during the dressing change and fought with cares and tried hitting at the nurse. There was brownish colored drainage present from the wound. The wound bed was not assessed. R1's primary care provider was already aware. R1's MAR, dated October 2023, documented R1 was not given any pain medication before or after the dressing change on 10/19/23. The Wound Daily Observation Note, dated 10/22/23, documented R1's coccyx dressing was intact but soiled. The dressing was changed per orders. The wound margin showed the ulcers border was undermining and red. R1 had pain with the dressing change and did not tolerate the dressing change well. There was slimy brown malodorous drainage from the wound. The wound bed had slough present. R1's primary care provider was not notified. R1's MAR, dated October 2023, documented R1 was not given any pain medication on 10/22/23. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The Wound Daily Observation Note, dated 10/23/23, documented R1's coccyx dressing was intact but saturated from drainage. The treatment was done per orders. The wound margin was undermining. R1 had sharp pain rated an eight while Aquacel (a wound dressing) was being placed inside the tunnel. There was a heavy amount of slimy brownish drainage with odor noted from the wound. The wound bed had slough. R1's primary care provider was not notified as R1 was seen by provider every Friday in wound care. R1's MAR, dated October 2023, documented R1 was not given any pain medication on 10/23/23. The Wound Daily Observation Note, dated 10/24/23, documented R1's coccyx dressing was soiled and changed. The wound margin was red with undermining. R1 had pain with the dressing change. There was a large amount of thick brown drainage. The wound bed had slough. R1's primary care provider was not notified. R1's MAR, dated October 2023, documented R1 was not given any pain medication on 10/24/23. The Wound Daily Observation Note, dated 10/25/23, documented R1's coccyx dressing was soiled and changed. The wound margin was red and tunneling. R1 complained of pain to the sacral area with the dressing change. There was thick brown drainage present from the wound. The wound bed had slough present. Two AG ropes were used in dressing R1's wound. R1's primary care provider was not notified. R1's MAR, dated October 2023, documented R1 was not given any pain medication on 10/25/23. The Wound Daily Observation Note, dated 10/26/23, documented R1's coccyx dressing was intact but saturated and leaking drainage from the wound site. Staff completed the wound treatment per doctor's orders. The wound margin had undermining. R1 had pain during the dressing change. There was a large amount of brown drainage with some odor noted from the wound. The wound bed had slough present. R1's primary care provider was not notified as provider would observe the next day. R1's MAR, dated October 2023, documented R1 was not given any pain medication on 10/26/23. The Wound Daily Observation Note, dated 11/14/23, documented R1's coccyx dressing was soiled and removed. Staff completed the treatment per doctor's order. The wound margin was pink and undermining. R1 had pain with the dressing change and did not tolerate the dressing change well. R1 continued to try to roll onto his back. There was a moderate amount of brown slimy drainage from the wound. The wound bed had slough and undermining present. R1's MAR, dated November 2023, documented R1 was not given any pain medication on 11/14/23. On 04/02/24 at 12:30 PM, Licensed Nurse (LN) G stated R1 would refuse to lay down in bed and would sit in his recliner all day. LN G stated R1 always denied pain during dressing changes. LN G stated she could not recall if R1 was on a turning/repositioning program. On 04/02/24 at 02:30 PM, Administrative Nurse D agreed that all interventions to prevent R1's pressure ulcer from worsening were not in place on R1's admission to the facility. Administrative D was unaware R1 was not administered pain medication before or after dressing changes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheyenne County Village Inc	820 S Denison Street St Francis, KS 67756

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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 0697 Level of Harm - Actual harm Residents Affected - Few	The facility's Pain Policy, revised October 2022, documented the purposes of this procedure are to help the staff identify pain in the resident, develop interventions that are consistent with the residents' goals and needs and that address the underlying causes of pain. The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan and the resident's choices related to pain management. Pain Management is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. Pain management is a multidisciplinary care process that includes the following: Assessing the potential for pain, recognizing the presence of pain, identifying characteristics of pain, developing, and implementing approaches to pain management, Identifying, and using specific strategies for different levels and sources of pain, monitoring for the effectiveness of interventions, and modifying approaches as necessary. The facility failed to provide R1 with pain relieving measures prior to or after pressure ulcer dressing changes though R1 had documented pain and demonstrated signs of discomfort during dressing change. This deficient practice resulted in untreated pain for R1 and placed him at risk for continued unnecessary pain and altered psychosocial well-being.