STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175366	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Atwood	650 Lake Road #216 Atwood, KS 67730

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 27. The sample included three residents reviewed for pressure injuries/ulcers. Based on record review and interview, the facility failed to ensure adequate treatment to prevent the worsening of a facility acquired pressure ulcer and failed to promote healing. On 12/15/23, Resident (R) 1, who required assistance from two staff for bed mobility, developed a facility acquired unstageable (depth of the wound is unknown due to the wound bed is covered by a thick layer of other tissue and pus) pressure ulcer to her left heel. The facility applied heel protectors but did not involve the provider until seven days later. The provider ordered a dressing to the wound, changed every seven days. The wound became stagnant and lacked any signs of healing from 12/22/23 through 03/23/24 when a new treatment was started. The facility also did not measure the wound for two weeks from 03/09/24 through 03/22/24. On 03/29/24, the facility spoke with the dietician and the telehealth wound nurse and received new orders for R1's deteriorating wound but did not involve the physician despite increased wound dimensions and the presence of signs of possible infection including increased drainage and pain, until 04/02/24 when the facility received a new order from the wound nurse and the facility's medical director. On 04/03/24, the facility identified drainage from the wound and a new open area on the inside of the left foot but did not notify the physician. On Saturday, 04/06/24, the facility documented R1 would go for a podiatry referral the following Tuesday. On 04/07/24, R1 was assessed by her provider and sent to the hospital for respiratory issues and wound care. Upon admission to the hospital, R1's left heel wound was necrotic (pertaining to the death of tissue in response to disease or injury) with purulent (producing or containing pus), foul-smelling drainage and had advanced to a Stage 4 pressure ulcer (a deep pressure wound that reaches the muscles, ligaments, or even bone) with exposed bone. Further testing revealed R1 had osteomyelitis (local or generalized infection of the bone and bone marrow) of her left heel bone. R1 was sent to a higher level of acute care for wound care and vascular evaluation. The surgeon recommended amputation (surgical removal) of the left lower extremity, above the knee. R1 and her family did not want the procedure. R1 was placed on palliative care and passed away on 04/27/24 at the local hospital. The facility's failure to notify and involve the physician and ensure physician assessment of an evolving, and progressively worsening, facility acquired pressure ulcer placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of multiple sclerosis (MS-progressive disease of the nerve fibers of the brain and spinal cord), moderate protein calorie malnutrition, weakness, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). (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	The Admission Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R1 required moderate staff assistance for bed mobility, maximum staff assistance with sit to stand, chair to bed transfer, toileting, and bathing. The MDS documented R1 did not ambulate. The MDS documented R1 was admitted to the facility with intact skin and was at risk for pressure ulcer development. The MDS documented R1 had a pressure reducing device for her chair, a pressure reducing device for her bed, and was on a turning/repositioning program. R1 was not on a nutrition or hydration program to manage skin problems. The Admission Function Abilities Care Area Assessment (CAA), dated 11/27/23, documented R1 presented to the facility with weakness, poor coordination, impaired balance, and pain related to her MS. The CAA documented R1 had occasional urinary incontinence which was likely due to her immobility. The CAA documented R1 was no longer able to ambulate and due to the progressive neurological nature of her disease process, R1 was not expected to improve. The Admission Pressure Ulcer/Injury CAA, dated 11/27/23, documented R1 was at risk for skin breakdown due to her need for staff assistance for bed mobility, having an at risk Braden (assessment tool used to predict risk for pressure injuries) score, and being on psychotropic (alters mood or thought) medications. The CAA documented R1 had no skin issues oat the time of her admission on 11/21/23. The CAA documented all residents of the facility had mattresses that helped with weight distribution to help prevent skin breakdown from occurring. The CAA documented R1 was on a turning/repositioning program and had a pressure reducing cushion in her wheelchair to help reduce her risk and help maintain her skin integrity. The CAA documented the goal was for R1 to remain free from skin breakdown. The Significant Change MDS, dated [DATE], documented R1's BIMS score was 12, which indicated moderately impaired cognition. The MDS documented R1 had one or more unhealed pressure ulcers. The MDS documented R1 had one unstageable pressure ulcer due to slough (dead tissue, usually cream or yellow in color) and/or eschar (dead tissue), and this pressure ulcer was not present on R1's admission. The CAA documented R1 had a pressure reducing device for her chair, a pressure reducing device for her bed, was on a turning/repositioning program, and was receiving pressure ulcer care. The CAA documented R1 was not receiving an application of any dressing to her feet with or without topical medications. The Significant Change Functional Abilities CAA, dated 02/27/24, documented R1 required assistance with her activities of daily living (ADL's), had an unstageable pressure ulcer to her left heel, and R1's decline was felt to be due to the progression of her MS; she was not expected to improve. The Significant Change Pressure Ulcer/Injury CAA, dated 02/27/24, documented R1 had an unstageable pressure ulcer to her left heel. She was incontinent, dependent on staff for mobility, and had an at risk Braden score. The CAA documented R1 had an air mattress, was on a turning/repositioning program, and had a cushion to her wheelchair. The CAA documented R1 had MS which was the biggest contributing factor that restricted her mobility. (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 assistance from two staff for all bed mobility (11/23/23). The care plan directed staff to provide R1 a pressure reducing mattress and cushion and to float her heels (11/23/23). The care plan directed staff to notify the nurse immediately of any new areas of skin breakdown redness, blisters, bruises, or discoloration noted during baths or daily care (12/15/23). The care plan directed staff to provide R1 an air mattress due to R1 refused to get out of bed sometimes and was at risk for further skin breakdown (01/11/24). R1 was non-ambulatory and used a wheelchair with bilateral foot pedals propelled by staff (01/12/24). The care plan directed staff to place an Allevyn (foam dressing) heel dressing and change on bath days; the dressing could be left on for seven days and change as needed (01/24/24). The care plan directed staff R1 required two staff assistance with check and changes with position change (03/27/24). The care plan lacked direction regarding how often R1 was to be repositioned. The care plan directed staff to ensure heel protectors were on R1's feet (03/27/24). The care plan directed staff to perform a Wound Data Collection daily and to inform R1 and her family about any new area of skin breakdown (03/27/24). The care plan directed staff to apply a Xeroform (non-adherent dressing) foam dressing to the left heel and secure with Kerlix (cotton gauze) and paper tape and change daily (03/27/24). The care plan directed staff to avoid positioning R1 on her right side. R1 could be placed on her left side or on her back with heel protectors on and feet elevated as much as possible (04/06/24). The care plan directed staff to apply calcium alginate (a highly absorbent dressing for cavity wounds with moderate to heavy drainage), cover with bordered foam dressing, secure with Kerlix and paper tape and change every day (04/11/24). (This intervention was never performed in the facility as R1 never returned). The Kardex [nursing tool that gives a brief overview of the care needs of each resident] did not address any turning or repositioning program or directives for R1. The Admission Braden Scale, dated 11/21/23, documented R1 a score of 16, which indicated mild risk. The Braden Scale intervention guide recommended frequent turning (e.g., every two hours), maximal remobilization, pressure reduction support surfaces if bed or chair bound, protect heels, manage moisture, manage nutrition, manage friction and shear (the separation of skin layers caused by friction or trauma). If other major risk factors were present advance to next level of risk. On admission, on 11/21/23, R1 had an order for thrombo-embolic deterrent hose (TED-compression stockings) to her bilateral legs, on in the morning and off at night. This order was discontinued on 12/19/23. Review of R1's clinical record lacked evidence the staff who signed off on the application and removal of the TED hose noted any skin changed to R1's left heel. R1's medication Review Report documented an order dated 11/29/23 for house shake nutritional supplements, 120 milliliters with meals. R1's EMR recorded a Physician's Order dated 12/01/23 to start on 12/08/23, for a weekly skin check every Friday. The Skin Observation Tool, dated 12/08/23, documented R1's skin check was completed and had no skin conditions observed. The Skin Observation Tool, dated 12/15/23, documented R1 had an unstageable pressure ulcer to the left medial (inner) heel. The Skin Observation Tool lacked evidence staff notified R1's primary care physician or family of the unstageable pressure ulcer. (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 Data Collection Tool, dated 12/15/23, documented R1 had an unstageable pressure ulcer with eschar to her left heel that measure 2 centimeters (cm) by 3.5 cm with no depth. The wound bed was covered with 100 percent eschar. The surrounding skin was intact and pink. This was the initial data collection on the pressure ulcer and the pressure ulcer was not present on admission. There was no dressing on R1's left heel wound. The Wound Data Collection Tool, lacked evidence staff notified R1's primary care physician or family of the pressure ulcer. The Wound Data Collection Tool, dated 12/16/23, documented R1 had an unstageable pressure ulcer to her left heel. The wound was 100% covered with eschar. No dressing had been placed to the left heel wound. A pressure relieving gel heel protector was placed to R1's left heel. The Wound Data Collection Tool, lacked evidence staff notified R1's primary care physician or family. The Wound Data Collection Tool, dated 12/17/23, documented R1 had a pressure ulcer to her left heel with pink blanchable surrounding skin. No dressing was present to the left heel wound. Blue heel protectors were placed to R1's heels. The Wound Data Collection Tool, lacked evidence staff notified R1's primary care physician or family. The Wound Data Collection Tool, dated 12/19/23, documented R1 had a pressure ulcer to her left heel which measured 1.5 cm by 2 cm. Eschar covered 100 % of the wound bed. The surrounding skin was pink, intact, and macerated (softening and breaking down of skin as a result from prolonged exposure to moisture, such as sweat, urine, feces, or wound drainage for extended periods). There was no dressing to R1's left heel. The Wound Data Collection Tool, lacked evidence staff notified R1's primary care physician or family. The Communication/Visit with Physician Note, dated 12/22/23, documented a new order for Allevyn heel dressing to R1's left heel. Change every seven days or as needed. This Communication/Visit with Physician Note was the first documented evidence of notification to the physician of R1's unstageable pressure ulcer to her left heel, dated 12/22/23, seven days after staff discovered the pressure injury. The Wound RN Assessment, dated 12/22/23, documented R1 had an unstageable pressure ulcer to her left heel. The wound was covered with eschar and had minimal drainage. R1's physician was notified regarding the wound status and a new order for Allevyn heel dressing was ordered. Modifications to R1's interventions were repositioning/turning, support surfaces, nutrition, friction/shear management, and wound treatment. R1's Treatment Administration Record (TAR), dated December 2023, documented an order for Allevyn dressing to the left heel; may be on up to seven days, change as needed, and check twice daily, with a start date of 12/22/23. The Wound Data Collection Tool, dated 12/29/23, documented R1 had an unstageable pressure ulcer to her left heel which measured 3.5 cm by 3.2 cm. The wound bed was covered with 95% eschar and 5% granulation (new tissue formed during wound healing). The record lacked evidence staff notified R1's primary care physician of the increased size of R1's wound. The January 2024 TAR, documented an order for an Allevyn dressing to the left heel. The dressing could stay on up to seven days. Change as needed. Check twice daily with a start date of 12/22/23. (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 Data Collection Tool, dated 01/03/24, documented R1 had an unstageable pressure ulcer which measured 2.5 cm by 2.5 cm. The wound bed was covered with 95% of eschar and 5% of granulation. The wound had a moderate amount of purulent drainage. The record lacked evidence staff notified R1's primary care physician of the purulent drainage. The Wound RN Assessment, dated 01/03/24, documented R1 had an unstageable pressure ulcer to her left heel. The top layer of the wound was peeling back with pink tissue noted underneath. The note documented to continue the current plan of treatment. The Health Status Note, dated 01/03/24, documented R1 was not safe to transfer with the sit-to-stand lift and would be transferred with a full body lift from then on. The Wound Data Collection Tool, dated 01/09/24, documented R1 had an unstageable pressure ulcer to her left heel which measured 3 cm by 3 cm. There was no dressing present. The wound bed was covered with 100% eschar. The record lacked evidence staff notified R1's primary care physician. The Care Plan Change Note, dated 01/11/24, documented an air mattress was added due to R1 refused to get out of bed some of the time and risk for further skin break down. The Care Plan Change Note, dated 01/12/24, documented the mobility bars were removed from R1's bed. The Wound RN Assessment, dated 01/12/24, documented R1 had an unstageable pressure ulcer to her left heel. The left heel wound was documented as 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) and the area was hard, with skin flaking off. The underneath skin was healed. The record lacked evidence staff notified R1's primary care physician. The 1-16-24 Clinic Visit documented R1 was seen by her physician with a chief complaint of none recorded. The visit recorded a reviewed problem of a left heel wound with an onset date of 10/27/22 [sic]. The HPI [history of present illness] section recorded the resident was calmy sitting in a chair. She initially voiced no concerns. She did then remark that she had some swelling in her legs and feet. Nursing reported she had recurrent urinary tract infections. The resident denied shortness of breath. The Musculosketal section documented R1 had normal muscle strength and poor tone; she had two plus edema (swelling) to her lower extremities. The document noted R1 had heel protector boots on and a dressing to the right [sic] heel. The note followed this with not removed. The Assessment/Plan section did not address or mention the wound. The Wound RN Assessment, dated 01/19/24, documented R1 had a non-pressure wound with partial thickness tissue loss. The note documented to continue with the current treatment. The record lacked evidence staff notified R1's primary care physician. The Wound Data Collection Tool, dated 01/19/24, documented R1 had an unstageable pressure wound to her left heel that measured 4 cm by 3.5 cm with dry flaky skin. The wound bed was covered with 100 % eschar. The record lacked evidence staff notified R1's primary care physician. The Wound RN Assessment, dated 01/22/24, documented R1 had a non-pressure wound with partial thickness tissue loss. The noted documented to continue with the current treatment plan. The record lacked evidence staff notified R1's primary care physician. (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 RN Assessment, dated 01/29/24, documented R1's left heel wound was a non-pressure wound with partial thickness tissue loss. The nurse documented to continue the current plan of treatment. The record lacked evidence staff notified R1's primary care physician. The Wound Data Collection Tool, dated 01/30/24, documented R1 had a pressure ulcer to her left heel which measured 3.75 cm by 3.25 cm and was a deep tissue injury. The wound bed was 100% covered with eschar. The record lacked evidence staff notified R1's primary care physician. R1's February 2024 TAR, documented an order for an Allevyn dressing to the left heel. May be on up to seven days. Change as needed. Check twice daily with a start date of 12/22/23. The Wound Data Collection Tool, dated 02/13/24, documented R1 had a deep tissue unstageable pressure ulcer to her left heel that measured 4.5 cm by 3 cm. The wound bed was 100% covered with eschar and had minimal sanguineous (bloody drainage) drainage. The description of the dressing was a Medihoney (medical-grade honey used to aid wound healing) patch to the wound bed, covered with an Allevyn heel dressing, and secured with paper tape. The record lacked evidence staff notified R1's primary care physician. R1's EMR lacked orders regarding the use of Medi-honey to the wound. The Wound Data Collection Tool, dated 02/19/24 documented R1 had a deep tissue unstageable pressure ulcer to her left heel that measured 3.5 cm by 4.0 cm. Drainage was present on the dressing and leaking around the dressing. The wound bed was 100% covered with eschar. The surrounding skin was pink and macerated. The dressing description described Medihoney pad with an Allevyn dressing secured with tape. The record lacked evidence staff notified R1's primary care physician. The Wound RN Assessment, dated 02/19/24, documented R1 had an unstageable pressure ulcer to her left heel. The note documented the wound had smaller measurements with new tissue growth after the eschar sloughed off. The note documented to continue the current plan of treatment. The record lacked evidence staff notified R1's primary care physician. The Late Entry Communication with Dietitian Note, dated 02/19/24 but created on 04/06/24, documented the dietitian was notified via email of R1's deep tissue injury and recommended to continue current protein supplement with no other recommendations given. The Health Status Note, dated 02/20/24, documented the dressing was changed to R1's left heel due to the dressing being soiled. The 2-20-24 Clinic Visit documented R1 was seen by her physician with a chief complaint of NH [nursing home] 2nd 30 day visit The visit recorded a reviewed problem of a left heel wound with an onset date of 10/27/22. The HPI section recorded the resident was doing better feeding herself and asked how long she will be there. She denied pain. She was wearing heel protectors and denied pain or other concern. Her husband continued to help her. She had gotten over recent pneumonia (inflammatory condition of the lungs). The Musculosketal section documented R1 had normal muscle strength and poor tone; her joints, bones, and muscles showed no contractures (abnormal fixation of joints or muscles), malalignment, tenderness, or bony abnormalities. She had normal movement of all extremities. Extremities: edema (tr to LE but feet in heel protectors.). The document noted R1 had edema and wore heel protectors. The Assessment/Plan section did not address or mention the wound. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Other Progress Note, dated 02/23/24, documented a fax was sent to the clinic to request an order for Vitamin C 500 milligrams (mg) daily for wound healing. The medication was received from the pharmacy. The Wound RN Assessment, dated 02/26/24, documented R1 had an unstageable pressure ulcer. The note documented to continue the current treatment. The record lacked evidence staff notified R1's primary care physician. The Wound Data Collection Tool, dated 02/27/24, documented R1 had a deep tissue injury unstageable pressure ulcer to her left heel that measured 4 cm by 4 cm with 0.1 cm in depth. The wound bed was covered with 95% of eschar and 5% epithelial (denoting the tissue forming the outer layer of the of the body's surface) tissue. The wound had a moderate amount of serosanguineous (semi-thick blood-tinged drainage) drainage. The dressing description was Medihoney with an Allevyn dressing. The record lacked evidence staff notified R1's primary care physician. The MDS Note, dated 02/27/24, documented the facility had changed R1's Quarterly MDS to a Significant Change MDS due to recent behaviors noted, a decline in the BIMS score, and a 5% weight loss over 30 days. R1 had a long-standing history of MS with complaints of frequent pain. R1 had a pressure ulcer to her left heel and slept on an air mattress. The March 2024 TAR, documented an order for an Allevyn dressing to the left heel. May be on up to seven days. Change as needed. Check twice daily with a start date of 12/22/23. This order was discontinued on 03/22/24. The Wound RN Assessment, dated 03/05/24, documented R1 had an unstageable pressure ulcer to her left heel. The note documented to continue with the current plan of care. The record lacked evidence staff notified R1's primary care physician. The Wound Data Collection Tool, dated 03/08/24, documented R1 had a full thickness pressure ulcer to her left heel that measured 4.4 cm by 4 cm by 0.1 cm. The wound bed was 75% covered with eschar and 25% covered with granulation. There was a moderate amount of serosanguineous drainage present. The noted documented the wound was very tender to the touch. The record lacked evidence staff notified R1's primary care physician. The Wound RN Assessment, dated 03/13/24, documented R1 had an unstageable pressure ulcer to her left heel. The note documented to continue the current plan of treatment. The record lacked evidence staff notified R1's primary care physician. R1's clinical record lacked evidence of staff measuring the unstageable left heel ulcer from 03/09/24 through 03/22/24. The 3-19-24 Clinic Visit documented the physician saw R1 with a chief complaint of NH 30 day visit. The visit recorded a reviewed problem of a left heel wound with an onset date of 10/27/22. The HPI section recorded she had a visit with another doctor and had severe dementia based on the results of the Mini-Mental State examination (MMSE). The Physical Examination section lacked assessment the musculosketal or skin. The Assessment/Plan section did not address or mention the wound. (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 Data Collection Tool, dated 03/22/24, documented R1 had a deep tissue injury that was a full thickness wound to her left heel which measured 5 cm by 4 cm by 0.2 cm. The wound had a moderate amount of serosanguineous drainage that was foul smelling and had leaked out of the dressing. The wound bed was covered with 95% eschar and 5% epithelial tissue. The skin around the wound was denuded (skin that has had the first protective layer removed). The dressing was described as Xeroform with an Allevyn heel dressing. The tool lacked evidence staff notified R1's primary care physician. The Wound RN Assessment, dated 03/22/24, documented R1 had an unstageable pressure ulcer to her left heel. The note documented R1's wound was deteriorating evidenced by the wound continued to have a layer of eschar over the top of the wound. The note documented to continue the current plan of treatment. The record lacked evidence staff notified R1's primary care physician. Review of the Order Audit report for R1 revealed on 03/22/24 Licensed Nurse (LN) I entered an order for Xeroform, foam border dressing, secured with Kerlix and paper tape for pressure ulcer to left heel. Change every dayshift. The order was entered as a prescriber written order by Consultant HH. R1 clinical record lacked documentation when Consultant HH was contacted and lacked a provider visit note regarding the wound or a written order. The March 2024 TAR documented a new dressing order started on 03/23/24 for Xeroform, foam border dressing, secured with Kerlix and paper tape for pressure ulcer to left heel. Change every dayshift. A Late Entry Health Status Note, dated 03/23/24 but created on 04/12/24, documented Xeroform was started to help with wound management. A Clinic Referral (used for Visits to Doctor or Hospital Outpatient) dated 03/26/24 recorded a follow up for R1's upper respiratory infection; imaging of R1's chest and laboratory values were reviewed. The documentation lacked any mention of R1's wound and lacked evidence the wound was visualized or assessed by the provider. The Wound Data Collection Tool, dated 03/29/24 documented R1 had an unstageable pressure ulcer to her left heel that was a full thickness wound and in the middle of the wound was an area of hard eschar tissue. The wound measured 4.5 cm by 4 cm by 0.5 cm. There was heavy purulent foul-smelling drainage which had leaked out of the dressing. The collection tool noted there was the presence of possible complication to the wound as evidenced by a deep tissue injury surrounded the upper part of the left heel wound. R1 grimaced during the dressing change. The wound bed was 100% covered with eschar. The skin surrounding the wound was macerated and erythematous (red). The dressing description was Xeroform foam dressing secured with kerlix and paper tape. The record lacked evidence staff notified R1's primary care physician. The Wound RN Assessment, dated 03/29/24, documented R1 had an unstageable pressure ulcer to her left heel that was deteriorating due to non-healing eschar. The note documented staff notified the wound nurse and the dietitian of the non-healing wound. The note lacked documentation staff notified R1's primary care physician. The Late Entry Health Status Note, dated 03/29/24 but created on 04/12/24, documented the facility staff spoke with the wound nurse and she recommended to continue with the Xeroform with an Allevyn heel protector and secure with tape. The note lacked documentation staff notified R1's primary care physician. (continued on next page)

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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	R1's April 2024 TAR, documented an order for Xeroform foam border dressing, secured with Kerlix and paper tape for pressure ulcer to left heel, started on 03/23/24 and discontinued on 04/02/24. The Communication with Dietitian Note, dated 04/01/24, documented an email was sent to the dietitian regarding R1's non-healing wound. R1 continued house shakes three times a day with meals. The Communication/Visit with Physician Note, dated 04/02/24, documented new orders were received to add Santyl (an ointment to removed damaged tissue from chronic skin ulcers) to the wound bed, cover with Xeroform and foam bordered dressing, per the wound nurse and the facility's medical director. The Nutrition Status Note, dated 04/02/24, documented the dietitian was consulted regarding a non-healing wound on R1's left heel. R1 was receiving soft and bite sized diet with mildly thickened liquids and health shakes three times a day. Intake was good and R1 was eating greater than 50% of her meals 73% of the time over the past two weeks. R1's current weight was 100 pounds and weight had trended up since her admission in November 2023. R1's previous diagnosis was resolved: inadequate oral intake related to decreased appetite and adjustment to living situation. The dietitian documented R1's current diet and supplements should have been adequate to meet her estimated needs. R1 received a daily multivitamin supplement to optimize micronutrient intake for wound healing. The dietitian recommended to continue the current plan of care. R1's April 2024 TAR documented a new dressing order started on 04/03/24 to cleanse the wound to the left heel with wound cleanser, pat dry, place Santyl ointment on the wound bed; cover with Xeroform and wrap in gauze. Change daily. This order was discontinued on 04/05/24. The Nursing Services Note, dated 04/03/24, documented R1's dressing to her left heel had to be changed due to the dressing being saturated with drainage and the drainage going all the way through all the dressing and Kerlix. The dressing order was followed, left heel protectors were applied, and R1's left heel was floated on two pillows. A new sore was noted on the inside of R1's left foot. The nurse documented she would pass along the information to the day shift. The record lacked evidence staff notified R1's primary care physician. The Wound RN Assessment, dated 04/04/24, documented R1 had an unstageable wound to her left heel and deterioration of the wound was evidenced by eschar tissue covering the top of the wound. The note documented R1's primary care physician was notified of the wounds status and the care plan was updated. Santyl was started to debride the dead tissue. The Wound Data Collection Tool, dated 04/05/24, documented R1 had an unstageable pressure ulcer to her left heel which measured 5.5 cm by 6 cm by 0.4 cm. The wound bed was covered with 75% eschar, 10% slough, and 5% epithelial tissue. There was a moderate amount of serosanguineous drainage. The surrounding skin was macerated and erythematous. The note documented a new treatment of calcium alginate to the wound bed covered with foam border, secured with kerlix and paper tape. R1's April 2024 TAR documented a new dressing change order dated 04/06/24 to cleanse the wound to the left heel with wound cleanser, pat dry, place calcium alginate on wound bed, cover with an Allevyn heel dressing, and secure with tape. (This order was placed on hold after R1 was admitted to the hospital.) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175366	A. Building B. Wing	05/09/2024

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Communication Note, dated 04/06/24, documented due to R1's non-healing wound on her left heel and R1 was being referred to podiatry (foot doctor). An appointment was scheduled for Tuesday, 04/09/24, at the local hospital. The Health Status Note, dated 04/07/24, documented R1 was running a fever and her oxygen saturations were dropping into the low 80 percentiles (normal saturation are 93 percent or above). R1's oxygen was increased to 3.5 liters (L) and R1's oxygen saturation was still low. A mask was placed on R1, and her oxygen saturation came up to 90%. The staff contacted R1's family and they wanted the provider, a physician's assistant, to come down to see R1. The staff contacted R1's provider and he stated he would come to the facility and check on R1. The Health Status Note, dated 04/07/23, documented Consultant GG saw R1 and wanted R1 to be admitted to the hospital for an upper respiratory infection and for wound care. R1 was transferred to the local hospital. The Hospital Health and Physical (H&P), dated 04/07/24, documented R1 admitted with a Stage 4 pressure ulcer to her left heel. The H&P documented R1's left heel ulcer was necrotic and mushy with purulent foul-smelling drainage. The wound measured 6 cm by 6 cm by 0.5 cm. A wound culture obtained, showed R1's wound had Escherichia coli (E. coli-bacteria commonly found in the lower intestine that had a potential for causing infections in the urinary tract with inade[TRUNCATED]