STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Healthcare Resort of Kansas City	8900 Parallel Parkway Kansas City, KS 66112

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 55 residents. The sample included three residents reviewed for foot care. Based on record review and interviews, the facility failed to ensure Resident (R) 1, who had a history of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin) and amputations of his right leg and his left fifth toe related to DM, received appropriate wound care and services to prevent complications from his medical conditions. As a result, R1's toe wound became progressively worse and infected and ultimately required surgical removal. This also placed R1 at risk for increased pain and decreased mobility. Findings included: - R1 admitted to the facility on [DATE] and transferred to the hospital on 03/14/24. The Diagnoses tab of R1's Electronic Medical Record (EMR) documented diagnoses of DM, unsteadiness on feet, peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), acquired absence of right leg below the knee, dementia (a progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, and amputation of the right leg below the knee. R1's Admission Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. The MDS recorded R1 had no behaviors and no rejection of care. R1 had impairment on one side for upper and lower extremities and required substantial/maximal assistance with bathing. R1 required supervision with upper body dressing and partial/moderate staff assistance with lower body dressing and with his footwear. R1 required partial/moderate assistance from staff to walk 10 feet. The MDS recorded R1 had medically complex conditions that included DM but did not have a terminal (a life expectancy of less than six months) diagnosis. R1 had skin tears and moisture-associated skin damage (MASD- inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva, or mucous) but no vascular wounds. R1 did not receive treatments or ointments for his feet during the assessment period. (continued on next page)

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

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Pressure Ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction)/Injury Care Area Assessment (CAA) dated 02/17/24, documented R1 had an alteration in functional abilities and required assistance from staff. R1 had a risk of an alteration in his skin integrity. The CAA documented R1 had redness and MASD to his groin and skin tears to bilateral knees and left forearm. The CAA indicated staff would assess R1's skin as ordered and report to the physician as needed. R1's Care Plan dated 02/05/24 and revised on 02/22/23 documented R1 had an alteration in functional abilities due to DM, PVD and R1 had a right below knee amputation with a prosthesis (artificial body part). The plan directed staff R1 required partial/moderate assistance from staff for walking short distances, transfers, lower body dressing, and putting on/taking off footwear. The plan recorded an intervention dated 02/23/24 that directed R1 to wear a left foot ankle-foot orthosis (AFO- a hard brace worn on the lower leg that improves overall walking safety and efficiency). R1's Care Plan dated 02/05/24 and revised 02/22/24, documented R1 was at risk for alteration in skin integrity related to DM and PVD. The Care Plan documented interventions, with a start date of 02/05/24, that directed R1 needed monitoring, reminding, and assistance to turn and position; staff notified the nurse of any new areas of skin breakdown. The plan directed staff to perform a skin assessment as ordered and reported to the physician as needed (initiated on 02/05/24 and revised on 02/23/24). The plan recorded an intervention dated 02/22/24 that directed staff to administer antibiotics to a left toe infection as ordered and monitor and report adverse effects. An intervention dated 02/22/24 documented treatment to the left foot as ordered and report to the physician for increased signs and symptoms of infection. An intervention dated 02/29/24 documented R1 was followed by a wound specialist. R1's Care Plan dated 02/23/24 documented R1 had DM with neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet) and listed a goal that R1 would have no complications related to his DM. The plan directed staff to administer his DM medication as ordered and monitor his blood glucose levels as ordered. The plan directed staff to monitor the insulin (a hormone that lowers the level of glucose in the blood) injection sites and monitor and report signs of hypoglycemia (low blood glucose level) or hyperglycemia (high blood glucose level). The plan lacked direction to staff regarding care for R1's foot. R1's EMR recorded a Physician Order dated 02/05/24 that directed the wound specialist may evaluate and treat for wound care. R1's Physical Therapy Treatment Encounter Notes documented a summary of services dated 02/07/24 which noted the therapist instructed R1 in skilled intervention to address gait training focused on facilitation of toe clearance at swing limb advancement and directional changes to improve R1's safety with independent ambulation. R1's Physical Therapy Treatment Encounter Notes dated 02/15/24 lacked mention of any issues identified or brought to nursing. R1's EMR recorded a Nursing note on 02/15/24 at 03:28 PM that documented Pt came to nurse and asked her to look at his toe. R1's second toe on his left foot had moist, loose skin. Staff cleaned the toe and wrapped it with gauze. The note documented that the toe needed followed up with by the doctor. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A Nurse Practitioner (NP)/Physician Assistant (PA) Progress Note on 02/15/24 at 04:29 PM by Consultant GG documented R1 had a foot ulcer as a current medical problem. R1's skin color was appropriate for race, warm, and visible skin intact. The note documented a plan, but the plan did not address R1's foot. A review of R1's EMR lacked evidence staff monitored R1's left foot after placing gauze on the second toe on 02/15/24, lacked evidence of treatment orders obtained, physician notification, and lacked a formal assessment of the area until 02/21/24. A Daily Skilled Note on 02/21/24 at 02:53 AM documented R1 had a skin tear located on his left middle toe, R1 was compliant with treatment, and the skin condition was not a new onset. The note did not indicate which toe was referred to as the middle toe (R1 only had four toes due to a fifth toe amputation). A Physician Progress Note on 02/21/24 at 12:55 PM documented R1 was seen at the nurse's station for a new open area to the third left toe with a possible infection. The note directed to start Bactrim (antibiotic medication used to treat infections) 800 milligrams (mg)- 160 mg twice daily for 14 days and lactobacillus (probiotic supplement used to replace good bacteria in the gut) daily for 14 days with directions to see wound care orders for treatment plan of care. A Nursing note on 02/21/24 at 03:32 PM documented R1 was seen by the NP related to a new diabetic ulcer to the third toe of the left foot. The wound bed was discolored with some drainage and some moisture was noted to the bottom of the toe. There was dry skin to the top of the toe. The NP ordered Bactrim twice daily for 14 days, lactobacillus daily, and R1 should be on the wound care list for the next scheduled day. There was an order to cleanse the wound, apply triple-antibiotic ointment (TAO), and wrap it with gauze and tape. R1's EMR recorded a Physician Order dated 02/21/24 that directed to cleanse R1's third toe of the left foot with wound cleanser, apply TAO, and cover with gauze, and tape in place two times a day. The Silhouette Wound + Skin Assessment note signed on 02/27/24 documented an encounter to evaluate the chief complaint of an open wound/skin lesion. The note documented R1 was new to the wound specialty service. The note listed on 01/23/24 R1 was seen by podiatry prior to his admission at the facility on 02/05/24 and a toenail was removed completely. On 02/15/24 the patient asked staff to look at his toe and there was moist, loose skin that was cleaned and monitored. On 02/21/24 the area started to look necrotic (pertaining to the death of tissue in response to disease or injury). The note documented no X-ray was completed. The note recorded R1 had a history of a right below-knee amputation and a left fifth toe amputation. The note recorded an X-ray was ordered to evaluate for osteo (osteomyelitis - a local or generalized infection of the bone and bone marrow). R1's EMR recorded a Physician Order dated 02/29/24 that directed to cleanse the wound with wound cleanser, apply Santyl (a prescription enzyme used to help break up and remove dead skin and tissue from a wound), mupirocin (antibiotic ointment), and cover with bordered gauze every dayshift. R1's EMR recorded a Physician Order dated 02/29/24 that ordered a 3-view X-ray of the left foot. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A Nursing note dated 02/27/24 at 11:53 PM and marked Late Entry documented R1 was seen by the wound care specialist due to a wound on the left third toe. The note indicated the wound was unable to be staged (a rating system used to rate wound severity for pressure injuries) and an X-ray was called to the X-ray vendor. The note indicated see wound report for dimensions. A Nursing note dated 02/29/24 at 01:43 PM documented staff spoke with a representative from the X-ray vendor regarding R1's profile to ensure R1's X-ray of his left foot was obtained. The note documented R1 was added at that time and the X-ray was scheduled with an estimated time of that day. A Nursing note dated 03/01/24 at 10:03 AM documented the X-ray obtained on 02/29/24 showed no evidence of osteomyelitis; staff informed the wound nurse. A LN-SKIN Ulcer Non-Pressure Weekly assessment in R1's EMR under the Assessment tab revealed an assessment dated [DATE] which documented an initial assessment of the left third toe. The assessment indicated the onset date was 02/15/24. The wound had 25 percent (%) slough (dead tissue, usually cream-colored or yellow), 50 % granulation tissue (new tissue formed during wound healing), and 25% epithelial tissue (new skin growing in a superficial wound). The wound measured 1.4 centimeters (cm) by 2 cm by 0.2 cm. The Silhouette Wound + Skin Assessment note with a service date of 03/13/24 documented the wound care specialist observed R1 in the company of the facility wound nurse. The wound care noted R1's left leg was visibly soiled and his Tubi-grips (elasticated tubular bandage designed to provide tissue support in treating strains, sprains, soft tissue injuries, general edema, and tissue protection) and dressing were saturated from weeping (slow leaking of fluid from the tissue). The note recorded there was a concern for the possibility of auto-amputation of the toe. The note recorded R1 was at higher risk due to a previous amputation of the fifth toe and a right leg amputation as well. The hospital Progress Notes, dated 03/14/24, documented R1 was from a facility with a history of 10 to 14 days of left foot redness, swelling, and a wound to his left third toe. R1's left lower extremity showed marked redness, warmth, and swelling of the foot and ankle; there was a wound on the tip of the third toe; and the fifth toe had been amputated. The hospital Master Treatment Plan (MTP), dated 03/15/24, documented R1's MTP was updated to reflect the toe amputation surgery. R1's had the third toe of his left foot amputated. Observation of three digital pictures dated 02/21/24, revealed R1's third toe on his left foot had a visible wound. The wound was located on the tip and pad of his third toe and had moist, yellow/white tissue with what appeared to be fibers or hair hanging off the wound. The anterior surface of R1's third toe had what appeared to be a brown, crusted residue. R1's second toe did not appear to have any moist or loose skin. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 03/28/24 at 11:38 AM, R1's representative stated R1 fell in January and ripped his toenail off. She stated she soaked R1's foot in hot water and did wound care on the toenail bed before he was admitted to the hospital in January. R1's representative stated when R1 admitted to the facility, the toenail bed had no signs of infection and was almost healed. R1's representative stated she told the admitting nurse about the toe. She stated the admitting nurse did a head-to-toe assessment when R1 admitted and looked at his toe. R1's representative stated when she came in on 02/21/24 and saw R1's third toe, it had a wound and it appeared as though some of the bandage was left behind on the toe. R1's representative stated when R1 transferred to the hospital on 03/14/24, his third toe was black. On 03/28/24 at 01:57 PM, Licensed Nurse (LN) G stated the first time she saw an issue with R1's left foot was when therapy told her he had bumped his toe. She stated she had put a bandage on it on 02/15/24 and then went in later that day because the toe felt boggy (abnormal texture of tissues characterized by sponginess, usually because of high fluid content) so she cleaned it and wrapped it with gauze. LN G stated she called the doctor but did not document it and she knew the doctor saw the toe before 02/21/24 because she was with them. She stated R1 was started on Bactrim on 02/21/24. LN G stated when a new skin issue was found, she made a note and put a wound care order in, then notified the doctor and Administrative Nurse D. She stated she was not good at documenting all of the notifications. She was unable to find an order in place to monitor R1's toe on 02/15/24 until he was seen by the provider on 02/21/24. On 03/28/24 at 03:05 PM, Administrative Nurse D stated when the open wound was noticed, the facility immediately got treatment for it. She stated 02/21/24 was the day it was documented as found and 02/15/24 was when the nurse documented there was something wrong with his toe. Administrative Nurse D stated she did not remember being notified of the skin condition on 02/15/24. She stated if there were new skin issues, a treatment was initiated, documentation was completed, and notification was made to the provider and her. She stated the note on 02/15/24 did not specifically say the provider was notified but the provider came in Monday, Wednesday, and Friday so they would have followed up the next day. Administrative Nurse D stated the provider saw him on 02/15/24 and documented he had a foot ulcer, but she did not know why the NP would put ulcer when there was no treatment on 02/15/24 for it. She stated the nurse described the toe as moist and loose and sometimes if there was no bleeding or drainage, the nurse put gauze on it to pad the area, but it was not necessarily a treatment. Administrative Nurse D stated if a nurse adhered something to the skin, she expected nursing to follow up on the area and she expected the nurse to report it to the physician. On 03/29/24 at 11:34 AM, Administrative Nurse E stated R1 originally had moist skin on his third toe with gauze used to keep it dry and the nurse completed that daily. She stated on 02/21/24, R1 hit the third toe in therapy and had a skin tear that was cleaned and wrapped. Administrative Nurse E stated on 02/15/24 R1 had moist skin on the same toe that was kept dry with gauze. She stated she saw that R1 had a bandage on his toe on 02/21/24 and he had new orders from the NP that day. Administrative Nurse E stated she was told about the moist toe and the nurse showed her then the gauze was put on the toe to absorb the moisture. She stated since it was not an open wound, she did not think there was an order, but it should have been followed up on. She stated up until 02/21/24, R1 only had moisture on his toe. She stated moisture could break down the skin. On 04/09/24 at 10:54 AM Consultant GG stated R1 usually had his shoes on when she saw him and stated the facility had not informed her of the toe issue on 02/15/24 so she did not look at R1's foot on that date. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The facility's Skin and Wound Monitoring and Management policy revised 12/2023 documented a licensed nurse will assess/evaluate each pressure injury and/or non-pressure injury that exists on the resident. This assessment/evaluation should align with the scope of practice and include but not be limited to: 1. Measuring the skin injury. 2. Staging the skin injury (when the cause is pressure). 3. Describing the nature of the injury (e.g., pressure, stasis, surgical incision). 4. Describing the location of the skin alteration. 5. Describing the characteristics of the skin alteration. Areas of breakdown, excoriation, discoloration, or other unusual findings (either initially identified at the time of admission or as new findings) must be documented in the nursing notes or on the appropriate weekly assessment form. A licensed nurse will assess/evaluate at least weekly each area of alteration/injury, whether present on admission or developed after admission, which exists on the resident. This assessment/evaluation should include but not be limited to items 1 through 5 above, and the following: 6. Describing the progress with healing, and any barriers to healing that may exist. 7. Identifying any possible complications or signs/symptoms consistent with the possibility of Infection. Once an area of alteration in skin integrity has been identified, assessed, and documented nursing. shall administer treatment to each affected area as per the Physician's Order. Treatments per physician order, should be documented in the resident's clinical record at the time. they are administered. The facility failed to ensure R1, who had a history of DM and amputations was closely monitored and assessed for complications after a concern was noted on 02/15/24 on a toe on his left foot. R1's foot and toe later became infected and required surgical removal. This also placed R1 at risk for increased pain and decreased mobility.