STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175522	A. BUILDING _____ B. WING _____	**08/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDICALODGES GREAT BEND	**1401 CHERRY LANE GREAT BEND, KS 67530**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 53 residents. The sample included four residents, with three reviewed for pressure ulcers. Based on observation, record review, and interview, the facility failed to revise Resident (R) 3's care plan for pressure ulcers after the resident obtained three pressure ulcers to her heels. Findings included: - R3's Physician order [REDACTED]. The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had severely impaired cognition, totally dependent on two staff for transfers, and required extensive assistance of two staff for bed mobility, dressing, toileting and bathing. The MDS documented the resident at risk for pressure ulcers and used a pressure relieving device for her bed and chair. The Pressure Ulcer Care Assessment (CAA), dated 06/26/20, documented the resident a moderate risk for skin breakdown and had no pressure ulcers. The assessment directed staff to assess the resident's skin each week, use proper interventions to prevent skin breakdown, and reposition the resident at least every two hours and as needed for comfort. The CAA further directed staff to notify the resident's physician of any abnormal findings and obtain treatment orders. The dietician monitored the resident's food and fluid intake and implemented dietary interventions as necessary. The Pressure Ulcer Care Plan, dated 06/11/20, documented the resident at risk for skin breakdown and directed staff to use a pressure relieving mattress on the resident's bed, assess her skin, report any changes, and encourage her to shift or alter weight and body position. The care plan update, dated 08/04/20, directed staff to not place socks on the residents' feet until her heels were completely healed. The care plan update, dated 08/24/20, directed staff to apply pixie dust (antibiotic powder for wounds) and a dressing to both of the resident's heels daily. (34 days after treatment began) The Braden Scale Assessment, dated 06/11/20, recorded a score of 14, indicating moderate risk to develop pressure ulcers, and directed staff to reposition the resident and float her heels. The Nutritional Assessment, dated 06/29/20, documented the resident's skin intact. The Nurse's Note, dated 07/17/20 at 10:00 AM, documented the resident had three sores on her heels. The residents left heel wound measured 3 centimeters (cm) x 2 cm and red in color, a second left heel wound measured 4 cm x 2.7 cm and black in color. The right heel measured 4.7 cm x 4 cm with a pink base and black around the wound. The note further documented staff contacted the physician for treatment orders and offloaded (keep pressure off of the heels) the resident's heels. R3's Physician Orders, dated 07/18/20, directed staff to offload the resident's heels and start wound care. The order lacked specific treatment orders for the resident. The Nurse's Note, dated 07/20/20 at 11:25 AM, documented staff contacted the resident's family regarding the pressure ulcers. (three days after wounds identified) The Nurse's Note, dated 07/23/20 at 09:04 AM, documented the resident's left heel wound measured 3 cm x 2 cm and red in color and right heel wound measured 4.7 cm x 4 cm. The note documented the facility notified the physician for wound care orders. (seven days after the wounds were found) R3's Physician Orders, dated 07/23/20, directed staff to elevate the resident's heels and apply pixie dust. The Treatment Administration Record, dated 07/25/20, documented staff applied pixie dust to the resident's heels. The Fax to the Physician, dated 07/30/20, requested clarification of the compound mix of the pixie dust for the resident's wounds. (seven days after the physician ordered the pixie dust) R3's Physician Orders, dated 07/30/20, directed staff to apply polyoxyl/[MEDICATION NAME] (antibiotic powder), cover the wounds with a 3 x 3 [MEDICATION NAME] (an absorbent dressing), and change every other day for the [DIAGNOSES REDACTED]. The assessment further documented the heels were dark purple, extremely dry, and the skin was beginning to peel off with pink skin underneath. Staff off loaded the resident's heels and placed regular socks on her feet. The Nurse's Note,' dated 08/08/20 at 02:33 PM, documented the bottom of the resident's right heel bright red and tender to touch, soft, and with clear drainage. The note further documented the resident was not compliant with keeping her heels on the pillows to offload pressure. The Nurse's Note, dated 08/09/20 at 01:34 PM, documented the bottom of the resident's right heel dark red, tender to the touch, had a small crack in the middle of the heel, and was bleeding. R3's Physician Orders, dated 08/10/20, directed staff to off load the resident's heels and administer Bactrim DS (an antibiotic) one tablet by mouth for 10 days for [MEDICAL CONDITION] (a bacterial skin infection). The Registered Dietician Note, dated 08/10/20 at 11:09 AM, recommended liquid protein 30 millimeters (ml) and a multivitamin daily. (23 days after the wounds were found) The Nurse's Note, dated 08/25/20, documented staff cleansed both of the resident's heels with normal saline and applied pixie dust, obtained measurements, and applied [MEDICATION NAME] with gauze roll to bilateral heels. The note further documented the left heel measured 2.2 cm x 1.2 cm with minimal serosanguinous (composed of clotted or diluted red blood cells mixed with serum) drainage and yellow eschar (scab), and the right heel measured 2.5 cm x 1.25 cm with no eschar or drainage. On 08/25/20 at 08:15 AM, observation revealed the resident in her recliner, footrest up, pillow under the resident's right calf, left leg off the pillow with her heel resting directly on the footrest. Further observation revealed a pair of heel protectors on her bed. On 08/25/20 at 09:10 AM, observation revealed Licensed Nurse (LN) G washed her hands, applied clean gloves, and cut the gauze off of the resident's feet. Observation revealed the [MEDICATION NAME] was stuck to the resident's right heel so the nurse applied normal saline to remove the [MEDICATION NAME], cleansed the heel with normal saline, and dried with a gauze 4 x 4. Further observation revealed LN G removed her soiled gloves, applied a new pair of gloves, and measured the wound at 2.5 cm x 1.25 cm. Continued observation revealed LN G applied a layer of pixie dust on the resident's heel, applied [MEDICATION NAME], and wrapped the resident's foot with gauze. Observation revealed LN G removed her soiled gloves, applied clean gloves, and used normal saline to remove the [MEDICATION NAME] on the resident's left heel. Observation revealed the [MEDICATION NAME] had a small amount of serosanguinous drainage on it and LN G cleansed the heel with normal saline. LN G removed her soiled gloves, applied clean gloves, and measured the wound at 2.2 cm x 1.5 cm. LN G then applied a layer of pixie dust, placed an [MEDICATION NAME] dressing on the heel, and covered it with gauze. LN G removed her gloves and washed her hands. On 08/25/20 at 10:10 AM, LN G stated the resident used to wear the heel protectors, but the doctor did not want anything touching the resident's heels. LN G stated she had removed the heel protectors from the resident's room several times but staff kept bringing them back. LN G further stated the protocol after finding a wound on a resident was to contact the physician and cover the wound until the doctor gave treatment orders. LN G stated the dressing changes for the resident were completed daily and staff floated the resident's heels with two pillows. On 08/25/2020 at 01:30 PM, Certified Nurse Aide (CNA) M stated the resident used to wear heel protectors but now the physician did not want them on her because they rubbed her heels. Staff floated the resident's heels by placing pillows under the resident's calves. On 08/25/20 at 02:24 PM, Administrative Nurse D stated all staff were able to update care plans and verified the wound care should be on the care plan. The facility's Wound Prevention and Management Policy, dated December 2018, documented the plan of care would address problems, goals, and interventions directed towards prevention or pressure ulcers and/or skin integrity concerns identified. The Director of Nursing or designee would review the resident care plan and revise as indicated with each weekly review. The facility failed to revise R3's care plan with the treatment of [REDACTED].

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

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F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1)
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 53 residents. The sample included four residents with three reviewed for pressure ulcers. Based on observation, record review, and interview, the facility failed to provide interventions to prevent pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure in combination with shear and/or friction) for one of three sampled residents, Resident (R) 3, who developed pressure ulcers on both heels. Findings included: - R3's Physician order [REDACTED]. The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had severely impaired cognition, totally dependent on two staff for transfers, and required extensive assistance of two staff for bed mobility, dressing, toileting and bathing. The MDS documented the resident at risk for pressure ulcers and used a pressure relieving device for her bed and chair. The Pressure Ulcer Care Assessment (CAA), dated 06/26/20, documented the resident a moderate risk for skin breakdown and had no pressure ulcers. The assessment directed staff to assess the resident's skin each week, use proper interventions to prevent skin breakdown, and reposition the resident at least every two hours and as needed for comfort. The CAA further directed staff to notify the resident's physician of any abnormal findings and obtain treatment orders. The dietician monitored the resident's food and fluid intake and implemented dietary interventions as necessary. The Pressure Ulcer Care Plan, dated 06/11/20, documented the resident at risk for skin breakdown and directed staff to use a pressure relieving mattress on the resident's bed, assess her skin, report any changes, and encourage her to shift or alter weight and body position. The care plan update, dated 08/04/20, directed staff to not place socks on the resident's feet until her heels were completely healed. The Braden Scale Assessment, dated 06/11/20, recorded a score of 14, indicating moderate risk to develop pressure ulcers, and directed staff to reposition the resident and float her heels. The Nutritional Assessment, dated 06/29/20, documented the resident's skin intact. The Nurse's Note, dated 07/17/20 at 10:00 AM, documented the resident had three sores on her heels. The residents left heel wound measured 3 centimeters (cm) x 2 cm and red in color, a second left heel wound measured 4 cm x 2.7 cm and black in color. The right heel measured 4.7 cm x 4 cm with a pink base and black around the wound. The note further documented staff contacted the physician for treatment orders and offloaded (keep pressure off of the heels) the resident's heels. R3's Physician Orders, dated 07/18/20, directed staff to offload the resident's heels and start wound care. The order lacked specific treatment orders for the resident. The Nurse's Note, dated 07/20/20 at 11:25 AM, documented staff contacted the resident's family regarding the pressure ulcers. (three days after wounds identified) The Nurse's Note, dated 07/23/20 at 09:04 AM, documented the resident's left heel wound measured 3 cm x 2 cm and red in color, and right heel wound measured 4.7 cm x 4 cm. The note documented the facility notified the physician for wound care orders. (seven days after the wounds were found) R3's Physician Orders, dated 07/23/20, directed staff to elevate the resident's heels and apply pixie dust (antibiotic powder for wounds). The Treatment Administration Record, dated 07/25/20, documented staff applied pixie dust to the resident's heels. The Fax to the Physician, dated 07/30/20, requested clarification of the compound mix of the pixie dust for the resident's wounds. (seven days after the physician ordered the pixie dust) R3's Physician Orders, dated 07/30/20, directed staff to apply polyoxyl/[MEDICATION NAME] (antibiotic powder), cover the wounds with a 3 x 3 [MEDICATION NAME] (an absorbent dressing) dressing, and change every other day for the [DIAGNOSES REDACTED]. The heels were off loaded and regular socks were placed on her feet. The Nurse's Note,' dated 08/08/20 at 02:33 PM, documented the bottom of the resident's right heel bright red and tender to touch, soft, and with clear drainage. The note further documented the resident was not compliant with keeping her heels on the pillows to offload pressure. The Nurse's Note, dated 08/09/20 at 01:34 PM, documented the bottom of the resident's right heel dark red, tender to the touch, had a small crack in the middle of the heel, and was bleeding. R3's Physician Orders, dated 08/10/20, directed staff to off load the resident's heels and administer Bactrim DS (an antibiotic) 1 tablet by mouth for 10 days for [MEDICAL CONDITION] (a bacterial skin infection). The Registered Dietician Note, dated 08/10/20 at 11:09 AM, recommended liquid protein 30 millimeters (ml) and a multivitamin daily. (23 days after the wounds were found) The Nurse's Note, dated 08/25/20, documented staff cleansed both of the resident's heels with normal saline and applied pixie dust, obtained measurements, and applied [MEDICATION NAME] with gauze roll to bilateral heels. The note further documented the left heel measured 2.2 cm x 1.2 cm with minimal serosanguinous (composed of clotted or diluted red blood cells mixed with serum) drainage and yellow eschar (scab), and the right heel measured 2.5 cm x 1.25 cm with no eschar or drainage. On 08/25/20 at 08:15 AM, observation revealed the resident in her recliner, footrest up, pillow under the resident's right calf, and left leg off the pillow with her heel resting directly on the footrest. Further observation revealed a pair of heel protectors on her bed. On 08/25/20 at 09:10 AM, observation revealed Licensed Nurse (LN) G washed her hands, applied clean gloves, and cut the gauze off of the resident's feet. Observation revealed the [MEDICATION NAME] was stuck to the resident's right heel so the nurse applied normal saline to remove the [MEDICATION NAME], cleansed the heel with normal saline, and dried with a gauze 4 x 4. 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The facility's Wound Prevention and Management Policy, dated December 2018, documented the purpose of the policy was to provide a systemic approach for identifying residents at risk for skin breakdown and develop interventions to decrease the incidence of residents who develop pressure ulcers while providing guidelines for optimal care to promote healing for residents with all identified skin alterations. The policy further documented the facility would review all residents with wounds weekly during a risk meeting and the Director of Nursing or designee would be responsible to implement and monitor the skin integrity program. The responsible party and physician would be notified of any changes in status. The Director of Nursing or designee are to notify the Registered Dietician of wounds. The registered dietician would complete a nutritional assessment to determine appropriate nutritional interventions to meet individualized resident needs. The physician would be notified when wounds show no signs of healing to show decline in order to evaluate current treatment and need for changes in treatment. The facility failed to provide treatment and interventions to prevent two facility acquired pressure ulcers for cognitively impaired dependent R3, identified at risk for pressure ulcers, placing the resident at risk for delayed wound healing.