STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175187	A. BUILDING _____ B. WING _____	09/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OVERLAND PARK NURSING AND REHAB CENTER	6501 W 75TH STREET OVERLAND PARK, KS 66204

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 -** 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 identified a census of 64. The sample included three residents reviewed for pressure ulcers Based on record review and interviews the facility failed to prevent a pressure injury to Resident (R) 1's left elbow. R1 admitted to the facility on [DATE] with a left humerus (bone of the upper arm) fracture and required a sling immobilizer at all times, except during bathing and dressing. The facility failed to remove R1's LUE immobilizer in order to thoroughly assess his skin. This deficient practice resulted in a stage four (pressure injury which extends full thickness through tissue to exposed bone and/or tendon) pressure injury to R1's left elbow. Findings included: - R1's electronic medical record (EMR) documented [DIAGNOSES REDACTED]. The Admission Minimum Data Set ((MDS) dated [DATE] recorded R1 had a Brief Interview for Mental Status (BIMS) score of eight which indicated cognitive impairment. He required extensive assistance of one to two staff for all activities of daily living (ADLs) except eating, for which he required set up assistance. The MDS documented R1 was at risk for developing pressure injuries. It recorded R1 had no pressure injuries on admission to the facility. The MDS documented R1 had a pressure reducing device for his bed. The Pressure Ulcer/Injury Care Area assessment dated [DATE] recorded R1 was at risk for pressure injuries related to immobility and increased need for assistance with ADLs. The Care Plan dated 07/27/20 recorded R1 had a self-care deficit. It stated R1 required total dependence on one staff member for showering twice weekly and as needed. R1 also required extensive assistance of one staff member for bed mobility and dressing. The Care Plan recorded R1 had incontinence and was at risk for impaired skin integrity and instructed staff to observe his skin during weekly skin assessments. The Care Plan lacked interventions related to the use of the immobilizer for the left upper extremity. It did not state interventions which directed staff on how and when to remove the immobilizer, and lacked interventions related to pressure reductions and prevention of pressure injuries related to a medical device. The Care Plan did not specify interventions related to positioning of R1 in his wheelchair for offloading. It also did not state interventions which directed staff on how to care for the wound, assessment of potential complications with regards to the wound including pain and infection. The Discharge Paperwork sent from the hospital to the facility recorded R1 had a [MEDICAL CONDITION] proximal humerus. It recommended that R1 remain in a shoulder immobilizer at all times besides bathing and dressing. He was non-weightbearing on the left upper extremity. The immobilizer was in place for four to six weeks. The paperwork also listed another physician's orders [REDACTED]. The paperwork listed the following physician orders, dated 07/08/20: Non weight bearing on the left upper extremity. May get up to the chair. The head of the bed elevated to 30 degrees for comfort only. Wrist range of motion (ROM) as tolerated. Elbow range of motion with removal of immobilizer for bathing and dressing. The Skin Observation Evaluation in the EMR dated 07/09/20 recorded bruising to the left upper arm. There was no mention of a wound to the elbow in this assessment. The Skin Observation Evaluation in the EMR dated 07/17/20 recorded a left arm bruise secondary to fracture and right arm bruising. There was no mention of a left elbow wound in this assessment. A Progress Note dated 07/19/20 documented R1's skin was warm and dry and the color was within normal limits. A Progress Note by Consultant Physician HH dated 07/21/20 recorded R1 was seen on that day to follow up for swelling of the left wrist and increased temperature. The document recorded left hand [MEDICAL CONDITION] (swelling) and bruising. Consultant HH documented he did not feel an x-ray was necessary. The West Side Bath Assignment sheet dated 07/22/20 recorded R1 had no skin issues. An Orthopedic (related to bone) Physician Assessment by Consultant Physician GG completed on 07/23/20 documented a physical exam which revealed R1 had a sling immobilizer to the left upper extremity. The document recorded a diagnostic study of two view x-rays revealed routine healing of the left proximal humerus fracture. The plan directed R1 to continue the sling immobilizer and continue no weightbearing status. It directed R1 to anticipate immobilization for six to eight weeks. The review of systems did not mention skin issues and only recorded hypertension (elevated blood pressure), [MEDICAL CONDITION], and [MEDICAL CONDITION]. The Skin Observation Evaluation in the EMR dated 07/29/20 recorded a bruise secondary to a fracture on the left arm and bruising to the right arm. There was no mention of a left elbow wound in this assessment. A Care Plan Note dated 08/04/20 documented R1's therapy was limited by restrictions to his left arm which was in an immobilizer. R1 leaned on his elbow while sitting per the note. An Occupational Therapy (OT) Treatment Encounter Note dated 08/04/20 documented OT provided R1 a wider wheelchair with a reclining back and a two-inch foam seat cushion. The note recorded the wheelchair allowed extra ROM for the left upper extremity (LUE) in the immobilizer. R1 leaned on the LUE in the prior wheelchair, had increased LUE [MEDICAL CONDITION], and inability to extend the left wrist. The note further recorded R1 frequently sat in a wheelchair for several hours a day, slept, and leaned to the left side which resulted in poor positioning. The Skin Observation Evaluation in the EMR dated 08/05/20 recorded a bruise secondary to a fracture on the left arm and bruising to the right arm. There was no mention of a left elbow wound in this assessment. An Orthopedic Physician Assessment by Consultant GG completed on 08/06/20 included the therapist had concerns about R1 related to the swelling in R1's LUE and his leaning sideways on the wheelchair arm. The physical exam recorded notable swelling in the distal left arm and elbow region. At the hand, R1 was unable to extend his thumb, wrist, and fingers. The impression documented radial nerve palsy (condition which causes weakness, pain or decreased function of the hand and wrist) of the left upper extremity, probable positional. The plan recorded Consultant GG suspected palsy was due to the sling strap being excessively tight versus positional with R1's leaning sideways on the wheelchair arm. The plan directed to discontinue the immobilizer and eliminate him leaning on that side. The Physical Therapy (PT) Treatment Encounter Note dated 08/06/20 recorded Therapist II spoke with Consultant GG regarding R1. The resident had a drop wrist with radial nerve palsy most likely from positioning and not the fracture. The note recorded Consultant GG suggested to ensure padding was present when R1 sat in the wheelchair due to left sided leaning. Review of the 7/27/20 Care Plan lacked revision with placement of the padding in R1's wheelchair for positioning or discontinuation of the immobilizer. The PT Treatment Encounter Note dated 08/07/20 recorded Therapist II noted [MEDICAL CONDITION] and warmth to R1's upper extremity. Therapist II notified nursing staff. On 08/10/20 at 04:24 PM, a Skin and Wound Evaluation assessment documented a medical device related pressure injury. It further recorded the wound was full thickness with skin and tissue loss, stage four, on the left elbow. The wound measured 3.9 centimeters (cm) in length and 2.6 cm in width. The wound bed was 50 percent (%) slough (dead tissue, usually cream or yellow in color) and 50% eschar (dead tissue). It also recorded evidence of infection as redness and inflammation. The note documented the wound had a moderate amount of bloody drainage and faint odor. The note also recorded [MEDICAL CONDITION] extending greater than four cm around the wound. The Order Report Summary, under the Orders tab in the EMR documented an order dated 08/10/20 for the wound care consulting company to evaluate and treat. The Order Report Summary listed an order, dated 08/10/20 ordered [MEDICATION NAME] ointment (enzyme prescribed to break town dead tissue in order to promote wound healing) applied to the left elbow topically every day for wound healing. It further noted to cleanse the wound with wound cleanser, apply calcium alginate (specialized absorbent dressing), apply a nickel thick layer of [MEDICATION NAME] ointment, and cover with a dry dressing. Progress Note Details recorded the wound assessment performed by the wound consultant company on 08/11/20. R1 was seen for evaluation and management of an undiagnosed wound/[MEDICAL CONDITION]. The wound assessment, in the note, documented a stage four pressure injury with

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

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.

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) measurements of 4.1 cm in length, 3 cm width, and 0.3 cm depth. Joint and adipose (fat tissue) were exposed. There was a moderate amount of yellow drainage noted which had a mild odor. The wound bed was 25% slough, 75-100% granulation (new tissue growth). The note also recorded the wound had symptoms of infection at the time of the visit. It also documented R1 had an ulcer caused from pressure that was full thickness tissue loss with exposed bone, tendon, or muscle. It noted the affected body part was immobile and also indicated nursing staff noted it was directly from positioning. It noted the nursing staff determined the area of breakdown was consistent with applied external force. The note documented debridement (medical removal of dead, damaged, or infected tissue to improve the healing potential for the remaining healthy tissue) was performed to the left elbow wound at that time. The Order Report Summary , dated 08/11/20 ordered [MEDICATION NAME] (used to treat infection) ointment to the left elbow every day for the wound. It directed to cleanse with wound cleanser, put the ointment on the calcium alginate rope, stuff loosely into the wound edges on the left elbow, and then cover the center area with a bordered gauze. A PT Treatment Encounter Note dated 08/12/20 at 12:58 PM recorded Therapist II observed R1 with LUE [MEDICAL CONDITION], odor, and warm to touch when supine in bed. The note recorded R1 had increased confusion that day. A Skin Condition Note on 08/12/20 at 06:20 PM recorded R1 had a wound on his left elbow. The wound bed was pale with redness and bruising. Purulent (producing or containing pus) drainage was present with an odor. Staff performed wound treatment and R1 tolerated it well. A Progress Note recorded an assessment performed by Consultant HH on 08/13/20. The note recorded R1 had increased confusion and a urinalysis was pending. The note documented a wound to the left elbow and directed to continue wound care. A Nurse Note dated 08/15/20 at 01:31 PM recorded R1 had an elevated temperature. Staff notified Consultant HH and ordered R1 to go to the emergency room for evaluation and treatment. In an interview on 08/31/20 at 01:00 PM, Certified Nurse Aid (CNA) M stated R1 admitted on her hallway when he came to the building. She said staff removed R1's immobilizer to put his shirt on and the nurses looked at his skin at that time. CMA M provided care to R1 for the first 14 days and then he moved to a different hallway, out of isolation. CNA M stated when R1 was on her hallway his arm was good. She stated she heard he developed a wound. In an interview on 08/31/20 at 01:42 PM, Licensed Nurse (LN) G stated she was initially notified of the wound on 08/10/20. LN G said generally, the therapy department did everything regarding the immobilizer. The wound company came in the next day, did wound rounds, and debrided it at that time. When the wound consultant debrided it, it was to the bone. In an interview on 08/31/20 at 02:25 PM, LN H said she looked over the residents' skin weekly and made sure to document it. When someone had a splint, brace, or immobilizer, staff might elevate the area. LN H stated staff used the physician's orders [REDACTED]. Sometimes the orders say to remove the device at night, others say leave it on all the time. In that case, we just look at the skin and make sure that things are looking good. LN H stated she would periodically assess the skin of area affected by a splint or device. In an interview on 08/31/20 at 03:30 PM, Therapist JJ stated R1 had two different immobilizers and both were soft. She stated the area on R1's arm started out as a skin tear from his fall at home. Therapist JJ said therapy staff noted R1 developed [MEDICAL CONDITION] on the left arm and when they noted the [MEDICAL CONDITION], they immediately started to look for a bigger wheelchair. In an interview on 08/31/20 at 04:30 PM Administrative Nurse D stated staff should document everything noted on the skin and any new changes. She confirmed there should have been an order for [REDACTED]. Administrative Nurse D further revealed that she did not understand why the order for the immobilizer was not put into the chart and could not explain why it did not reflect on the MAR. She stated that she was not aware of a skin tear to R1s' elbow and the wound was not reported until 08/13/2020 to the wound care nurse. Administrative Nurse D further revealed that if an area is noted to be open by a nurse and therapist, she expected it to be documented in the chart. Administrative Nurse D verified, upon review of therapy documentation on 07/31/2020, R1 had [MEDICAL CONDITION] and an open are on his left elbow. Administrative Nurse D expected the doctor to be notified of the open area. Administrative Nurse D expected something to be noted in the chart for the device ordered. She stated the care plan did not represent an accurate picture of R1. She expected the care plan to reflect the immobilizer. The immobilizer would typically be placed on the care plan and then flow to the Kardex to alert staff. On 09/03/20 at 09:45 AM Consultant HH declined to comment on R1 or the situation, and stated he would need to check with the facility. The facility policy Preventative Skin Care Program revised 08/22/17 records the facility will implement preventative measures through ongoing monitoring of resident's at risk for skin breakdown. The resident's response to the preventative measures will be monitored and altered to meet resident's needs. The facility failed to ensure staff removed R1's LUE immobilizer in order to thoroughly assess his skin. This deficient practice resulted in a stage four pressure injury to R1, who was at risk for skin breakdown.