STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175415	A. BUILDING _____ B. WING _____	07/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELMHAVEN EAST	1400 S 15TH STREET PARSONS, KS 67357

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 reported a census of 34 residents and identified two residents with unstageable pressure ulcers. The sample of three, included the two residents with pressure ulcers. Based on observation, interview, and record review, the facility failed to complete adequate skin assessments and failed to obtain new treatment orders when one sampled Resident (R) 1 developed an unstageable pressure ulcer to the coccyx and it declined to a tunneling 4 centimeters (cm) by 4.5 cm by 0.75 cm deep pressure ulcer. Findings included: - The electronic medical record evidenced the facility admitted resident (R1) on 02/14/19. The primary care physician documented on the Admission Record dated 02/14/19, included [DIAGNOSES REDACTED]. Resident (R) 1's Quarterly Minimum Data Set (MDS), dated [DATE], identified the resident with intact cognition with a Brief Mental Status (BIMS) score of 14. The resident had no pressure ulcers, was not at risk for pressure ulcers per risk assessment, and used pressure relieving devices in her chair and bed. The resident was independent with bed mobility, transfers, and walking. The Quarterly MDS, dated [DATE] revealed the resident scored 13/15 on the BIMS with cognition intact. The resident independently performed bed mobility and declined in transfer ability since the last MDS and required limited assistance of one staff for transfers. The resident did not walk. The resident had a pressure relieving device in her chair but failed to have any pressure relieving devices to the bed or a turn/reposition program with the decline in ability. The resident had no current pressure ulcer. Review of the 03/03/20 Nurses' Notes confirmed the resident declined in mental ability with confusion at times, fell , and experienced a left arm fracture (broken bone) and was to wear a sling until seen by the ortho (bone) physician. The resident required additional assistance to reposition herself in the bed and with transfers with the sling. The Annual MDS, dated [DATE], revealed the resident scored 13/15 on the BIMS, with cognition intact. The resident declined further in ability as the resident required limited assistance of one staff with bed mobility, transfers, and extensive assistance with walking. The assessment identified the resident had one unstageable pressure ulcer. (Unstageable, due to coverage of wound bed by slough, characterized as being yellow, tan, green or brown in color and may be moist, loose and stringy in appearance, and/or eschar, dry, thick, leathery tissue that is often tan, brown or black). The resident was at risk for pressure ulcer development. The Care Area Assessment (CAA) for pressure ulcers, dated 06/06/20, included a Braden (pressure ulcer risk scale) completed 05/25/20 with a score of 18 which placed the resident at risk to develop pressure ulcers. The resident had an unstageable pressure area on her coccyx (a small triangular bone forming the lower extremity of the spinal column), due to the wound bed being covered with slough. The resident was unable to get an appointment with the wound care due to the Covid-19 pandemic. Will contact attending physician for an order for [REDACTED]. Have encouraged her to lay down in the afternoon and the resident complied. It was very difficult to get the resident off her back. Have placed pillows and wedges to keep her on her side and she pulled those out and wiggled until she was back on her back again. The 04/14/20 Care Plan, directed staff to conduct a systematic skin inspection weekly and to report any further skin breakdown. An addition, dated 04/15/20, included instructions to use seat lifts or change position every 15 minutes. It directed the staff to place an alternating pressure air mattress on her bed and a gel cushion in her recliner. Staff were to return the resident to bed after lunch daily and turn the resident from side to side every two hours, as the resident's pressure ulcer was progressively worse. The resident also had an order as of today (04/14/2020), to see the wound care clinic related to the pressure ulcer. The resident's medical record contained a Braden pressure ulcer risk assessment, dated 06/01/20, which identified the resident at risk to develop pressure ulcers. On 07/13/20 at 03:45 PM, per request, LN D reviewed the resident's medical record further and reported the facility staff should complete a Braden pressure ulcer risk assessment on the residents quarterly. LN D reviewed the record from 02/14/20 through 06/01/20 and found no pressure ulcer risk assessment completed prior to the 06/01/20 assessment for R1. On 04/14/20 a Progress Note included, a certified nurse aide reported to the nurse that she noticed an open red area on the resident's buttock. The area was 2.0 cm by 2.0 cm with jagged edges and a bright pink center. The staff did not note any drainage at that time. The physician's orders [REDACTED]. The physician's orders [REDACTED]. Cover the area with border foam dressing, change it daily, and PRN (as necessary) until healed. The 04/17/20 Weekly Skin Assessment documented the resident had a pressure ulcer to the coccyx with treatment in place. It lacked any further description or measurement of the area. The 04/24/20 Weekly Skin Assessment documented no new altered skin. The assessment lacked any further description or measurement of the area. The 05/01/20 Weekly Skin Assessment documented area to the coccyx being treated. It lacked any further description or measurement of the area. The 05/08/20 Weekly Skin Assessment documented no new altered skin. It lacked any further description or measurement of the area. The 05/15/20 Weekly Skin Assessment documented the resident continued to have an open area on the coccyx with a dressing in place. The assessment lacked any further description or measurement of the area. The Progress Notes dated 05/23/20 documented the staff removed a soiled dressing from the resident's pressure ulcer area and noted approximately 80% of the dressing soiled. The foul odor was not noticeable until the staff removed the soiled dressing. The staff cleaned the area with NS, patted it dry, and applied a new bordered foam dressing. Staff measured the total area as 3.5 cm by 2.0 cm, with an inside open blackened area measuring 2.5 cm by 1.25 cm. The area between the wound edge and the blackened center area was a pale yellow. The resident made no complaint of pain or discomfort during the treatment and dressing change. The staff educated and encouraged the resident to change positions to off load the pressure. The facility staff sent a Fax to the wound clinic physician on 06/08/20, for a clinic consult for this resident, as the pressure area on her coccyx continued to become larger and the drainage increased and had a foul odor. Further review of the Care Plan, revealed additional interventions on 04/15/20, when staff placed a floatation type mattress on the resident's bed and placed a different pressure relieving cushion in the resident's recliner. Addition on 06/10/20, included a mattress overlay on the bed and a new wheelchair seat cushion. Addition, dated 06/12/20, included a new floatation mattress to the bed. A Progress Note on 06/09/20 included, the resident's coccyx area was circular shaped, being 4.5 cm long at the longest point, 4.0 cm wide at the widest point, and approximately 0.75 cm deep. The bed of the wound was green in color and soft with slough. At this time there was no drainage, but the dressing change was done earlier in the day. There was a horrific odor to the wound like dying tissue. The edges of the wound were [DIAGNOSES REDACTED]tous (exhibiting abnormal redness of the skin of the mucous membranes due to the accumulation of blood in dilated capillaries). There was undermining (going deeper/tunneling) and the resident had an appointment scheduled for 06/10/20. The Wounds Clinic Notes on 06/10/20 gave orders for scheduled outpatient surgery on 06/12/20 for debridement of the coccyx wound. The resident returned with a wound vac (vacuum-assisted closure of a wound is a type of therapy to help wounds heal. During the treatment, a device decreases air pressure on the wound) The new physician's orders [REDACTED]. If wound vac is off for more than 2 hours remove the dressing, apply wet to dry dressing, and notify the wound clinic. Progress Notes on 06/26/20 recorded the facility nurse called the wound clinic to report the wound vac had to be removed due to a dead battery and no means to charge the battery. However, the wound clinic closed at noon and so the nurse did not notify the clinic. The facility nurse returned to the prior treatment order of wet to dry dressing changes . (Due to this incident, the wound vac remained off of the pressure ulcer for three days.) On 06/29/20, the resident returned to the wound care clinic, after

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) having the wound vac off of the pressure ulcer for 3 days and saw the physician. The resident returned with Physician order [REDACTED]. The new treatment included apply [MEDICATION NAME] (antibiotic) ointment and Santyl Enzymatic [MEDICATION NAME] agent with stimulant powder to sprinkle in ointment, to the sacral wound. Right buttock wound wash with soap and water, cover with Polymem (foam type dressing), change every 3 days. On 07/20/20 at 02:45 PM, LN E reported the resident only had one pressure ulcer in the sacral coccyx area. She explained she felt the nurses completing the weekly skin wound assessments, documented different names for the pressure ulcer cite, but it was only one large wound. Observation on 07/06/20 at 09:00 AM revealed the resident just returned from the wound clinic with a wound vac in place. The resident lay in bed on her left side in a fetal position. She spoke softly when spoken to and reported she was not in any pain at that time. On 07/06/20 at 09:30 AM, Administrative Nurse B stated, It (pressure ulcer) developed and went fast. She had been ambulating and toileting herself. On 07/06/20 at 11:30 AM, Administrative Nurse B verified on 06/05/20, she requested a physician's orders [REDACTED]. This was almost 2 months after the pressure ulcer development, and the staff continued to use the same physician ordered treatment. The resident's wound was not healing well and continued to look worse and had increased in drainage and odor. On 07/06/20 at 01:10 PM, licensed nurse C verified at the time the pressure ulcer developed, the resident started laying more and more in the fetal position and was not wanting to move. Nurse C also verified several of the weekly wound assessments lacked completed accurate information. Interview on 07/06/20 at 03:40 PM with Administrative Nurse B revealed the wound care clinic refused to take patients due to the Covid - 19 epidemic for awhile. She also verified she did not have a wound nurse on staff for over a year and the charge nurses were to complete the weekly assessments and change the daily dressings . On 07/06/20 at 05:15 PM, Administrative Staff A reported he felt the Covid -19 distracted the staff from patient care some. The facility's Skin Assessment policy, dated 09/25/2019 included, once a week the treatment nurse will assess any wounds being treated. The treatment nurse will record the wound assessment on the computer, under observations-focused observations. The wound documentation will include the size, drainage, color, odor, redness and tunneling . The facility failed to complete weekly skin assessments with accurate and complete information to depict the status of the current coccyx pressure ulcer. The facility failed to notify the physician and obtain new treatment orders in a timely manner, when the resident's wound continued to worsen, from 04/14/20 with initial measurements of 2 cm by 2 cm to 06/9/20 with measurements of 4.5 cm by 4 cm by 0.75 cm deep. The wound progressed to unstageable due to the presence of slough and eschar tissue.