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	175221	A. BUILDING _____ B. WING _____	C 09/15/2022

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ADVENA LIVING AT FOUNTAINVIEW	601 N ROSE HILL ROAD ROSE HILL, KS 67133

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #171069, #171154, #173291, #174141, #174472, and #174594. This 2567 was electronically sent to the facility on 09/19/2022. A revision was electronically sent to the facility on 09/26/2022.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/19/2022

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§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 42 residents. Based on observation, record review, and interview, the facility failed to provide housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior in the resident rooms, as evidenced by concerns of 14 of the 27 bed mattresses and three residents' chairs.

Findings included:

- On 08/31/2 at 08:44 AM, a tour of the resident rooms with Maintenance Staff U revealed seven of 14 resident mattresses observed on hallway 100 with peeling of the mattress surface. Five of the 14 mattresses were observed with debris and/or staining and/or a dried substance directly on the surface of the mattress under the linens. Observation of the 200 hallway, revealed seven of 13 mattresses with peeling of the mattress surface, two of the 13 with debris under the linens, and one of the 13 with dark staining directly to the mattress surface. Both halls

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included one recliner with a dried yellow substance on the seat of the chair and some spots on the arms of the chair. One straight back chair had splits covering the vinyl seat of the chair, and one straight back chair with several spots/stains on the fabric seat surface.

On 08/31/22 at 09:11 AM, Administrative Nurse D stated he would tell the staff again to be sure to clean the bed mattresses, as he was having the night shift do it.

On 08/31/22 at 09:14 AM, Maintenance Staff U stated the Certified Nurse Aides (CNA's) or housekeeping staff should tell him when a mattress was bad-whoever was changing linens or cleaning the mattress should report. He had one or two extra mattresses on hand.

On 08/31/22 at 09:19 AM, Maintenance Staff U stated the straight chair with the splits in the vinyl covering should have been thrown away, as it was an old dining room chair, and he was not sure where the staff found it.

On 08/31/22 at 11:07 AM, Certified Medication Aide (CMA) R stated the residents' mattresses should be sanitized by nursing or the housekeeping staff if crumbs or stains were present before applying a sheet. If the mattress were to have rips, or the surface material was peeling, the staff would let Maintenance Staff U know. CMA R stated they tell Maintenance Staff U verbally or put in a work order to alert him of the items in need of repair.

On 09/01/22 at 08:24 AM, Administrative Staff A stated he would expect the staff to take a picture of the mattress and report it so it could be

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F 584	Continued From page 3 replaced. He would expect the staff to sanitize mattresses before applying washed and cleaned linens and he would expect chair upholstery to be cleaned when soiled. The facility policy "Environment - General Clean and Maintenance of Resident" dated 10/2021 revealed areas used by residents will be kept clean and free of offensive odors. Staff will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, functional and comfortable interior. The facility policy "Bed Making" dated 02/2018, revealed prior to applying clean sheets the mattress if soiled or wet should be washed and then dried with a paper towel. The staff should notify the supervisor if there was flaking of plastic from mattress, rips in mattress, or tears in the mattress were observed. The facility failed to provide necessary housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior in these resident rooms.	F 584		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility reported a census of 42 residents with ten selected for review including six reviewed for hygiene/bathing services. Based on observation, record review, and interview, the	F 677		

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facility failed to offer and provide required assistance for bathing to the six reviewed residents, Resident (R)102, R211, R2, R201, R101, and R3.

Findings included:

- The "Medical Diagnosis" tab located in the electronic medical record (EMR) for Resident (R)102 included diagnoses of muscle weakness, need for assistance with personal care, and dementia (progressive mental disorder characterized by failing memory, confusion).

The "Admission Minimum Data Set" dated 08/17/22 assessed R102 with "Brief Interview of Mental Status" (BIMS) score of 13 indicating intact cognition. He had four to six days of verbal behavior symptoms of the seven-day assessment period, other behavior symptoms one to three days, and rejected care one to three days. He required physical help in part of bathing activity by one staff. R102 admitted to the facility on 08/11/22.

The "ADL [activities of daily living] Care Area Assessment" dated 08/24/22 revealed R102 required extensive assist with his ADL functioning and could make his needs known.

The "Care Plan" dated 08/30/22, revealed R102 had a self-care performance deficit related to his dementia and for the staff to provide a sponge bath when a full bath or shower could not be tolerated.

The "Shower Schedule" undated, revealed the staff were to offer R102 bathing during the day shift on Wednesdays and Sundays.

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The "Bathing" task, located in the EMR, for the past 30 days from 08/31/22 revealed "no data found" indicating the staff did not provide any bathing to the resident from 08/11/22 to 08/31/22 (a period of 20 days).

The "Shower Sheet" located in the miscellaneous tab of the EMR revealed he received a shower on 08/15/22.

The "Shower Sheet" located on paper, dated 08/26/22, documented R102 refused a shower.

The facility failed to offer bathing on five scheduled days: 08/14/22, 08/17/22, 08/21/22, 08/24/22, and 08/28/22, however did offer bathing on 08/15/22 and R102 did not refuse.

On 08/31/22 at 11:07 AM, Certified Medication Aide (CMA) R stated the facility had a bathing schedule that documented the list of residents with scheduled showers for the day, the staff fill out a shower sheet when a bath was given, and the staff documented each shower in the electronic record system. R102 refused a lot of cares, the staff would document when he refused and let the nurse know.

On 09/06/22 at 03:18 PM Administrative Staff A stated the admitting nurse assessed resident bathing preferences. The charge nurse, Director of Nursing, and the MDS nurse add the residents to the "Shower Schedule". The facility should provide showers to the residents per the resident's preference. If a resident refuses bathing, the CNA should notify the charge nurse and the charge nurse will confirm the refusal and try to help the resident desire a shower. The

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refusal should be documented in the EMR and written on a shower sheet. The charge nurse was responsible to assure bathing tasks were completed with oversight from clinical leadership.

The facility policy "Quality of Life - Dignity" dated 10/2021, revealed each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. The facility culture is one that supports and encourages humanization and individuation of residents, and honors resident choices, preferences, values, and beliefs. Some examples of ways in which respect for choices and values are exercised include personal grooming.

The facility failed to offer bathing per the planned schedule five of five days, resulting in the16 days following without hygiene/bathing provided.

- The "Medical Diagnosis" tab, located in the electronic medical record (EMR) for Resident (R)211 included diagnoses of need for assistance with personal care, muscle weakness, major depressive disorder (major mood disorder), schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The "Significant Change Minimum Data Set" (MDS) dated 02/11/22, assessed R211 with a "Brief Interview of Mental Status" (BIMS) score of 11, indicating moderate cognitive impairment, did not reject care, and required supervision and

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setup assistance for bathing.

The "ADL [activities of daily living] Functional/Rehabilitation Potential Care Area Assessment" dated 02/21/22, revealed R211 required supervision to limited assistance of staff with her ADL's.

The "Quarterly MDS" dated 07/25/22, assessed R21 with a "BIMS" score of seven, indicating severe cognitive impairment, she did not reject care, and required one person to physically assist her with transfers for bathing.

The "Care Plan" dated 06/27/22 revealed R211 liked to shower twice weekly and preferred them on Tuesdays and Fridays in the morning. She required supervision to limited assist of one staff member for bathing.

On 04/22/22 at 11:12 AM, a confidential caller reported R211 had dirty hair when she was in the facility on 04/03/22.

The "Bathing Report" dated 03/01 through 03/31/22 for R211, revealed an answer of "Not applicable" on 03/10/22 and lacked any bathing activity occurrence during the rest of the month.

The facility did not have any "Shower Sheet" forms for 03/2022 for R211.

The "Bathing Report" dated 04/01 through 04/30/22 revealed R211 received bathing on 04/07/22. She missed bathing on her preferred days of 04/01 and 04/05/22.

The "Plan of Care Response History" for bathing, located in the EMR, revealed the staff failed to

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offer R211 a shower/bath on her preferred days 08/02/22, 08/05/22, 08/09/22, 08/12/22, 08/16/22, 08/19/22, 08/26/22, however the staff offered and the resident received a bath/shower on 08/11/22, 08/20/22, and 08/27/22, and she refused on 08/06/22. R211 missed seven of nine opportunities for bathing per the schedule for 08/2022, with two given the next day.

On 08/30/22 at 10:37 AM, R211 moved from laying to sitting on the side of the bed, with the hair disheveled but it appeared clean.

On 08/31/22 at 11:07 AM, Certified Medication Aide (CMA) R stated the facility had a bathing schedule that documented the list of residents with scheduled showers for the day, the staff fill out a shower sheet when a bath was given, and the staff documented each shower in the electronic record system. CMA R stated R211 would refuse some days to take a shower and she did not like her hair washed. R211's hair would get a greasy appearance and the staff washed her hair when she takes a shower.

On 08/31/22 at 02:05 PM, Administrative Staff D stated the documentation in the EMR revealed R211 did not receive a shower for the month of 03/2022 and the facility lacked any "Shower Sheet" forms to show any showers provided for the month of 03/2022.

On 09/06/22 at 03:18 PM, Administrative Staff A stated the admitting nurse assessed resident bathing preferences. The charge nurse, Director of Nursing, and the MDS nurse add the residents to the "Shower Schedule". The facility should provide showers to the residents per the resident's preference. If a resident refuses

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bathing, the CNA should notify the charge nurse and the charge nurse will confirm the refusal and try to help the resident desire a shower. The refusal should be documented in the EMR and written on a shower sheet. The charge nurse was responsible to assure bathing tasks were completed with oversight from clinical leadership.

The facility policy "Quality of Life - Dignity" dated 10/2021 revealed each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. The facility culture is one that supports and encourages humanization and individuation of residents, and honors resident choices, preferences, values, and beliefs. Some examples of ways in which respect for choices and values are exercised include personal grooming.

The facility failed to offer bathing to R211 on her preferred days for the months reviewed of March 2022, two days reviewed in April 2022 and seven days in August 2022.

- The "Medical Diagnosis" tab located in the electronic medical record (EMR) for Resident (R)2 included diagnoses of need for assistance with personal care, muscle weakness, and cerebral infarction (stroke - damage to tissues in the brain due to a loss of oxygen to the area).

The "Admission Minimum Data Set" (MDS) dated 12/30/21, assessed R2 with a "Brief Interview of Mental Status" (BIMS) score of 15, indicating intact cognition. She did not reject care and required one person to physically help with bathing task.

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The "ADL (activities of daily living) Functional/Rehabilitation Potential Care Area Assessment" dated 01/04/22 revealed R2 required limited to extensive assistance from staff with her ADL's.

The "Quarterly MDS" dated 07/24/22, assessed R2 with a "BIMS" score of 13, indicating intact cognition. She did not reject care and had no changes to her bathing performance and support provided.

The "Care Plan" dated 08/23/22, revealed R2 required limited assistance with bathing, and she preferred the bathing task to be done in the morning on Mondays and Fridays.

The "Shower Schedule" undated, revealed R2's shower days were on Mondays and Thursdays on the day shift. The facility failed to have her shower days on her preferred days per her "Care Plan."

The "ADL - Bathing POC (point of care) Response History" report, dated 08/02/22 through 08/31/22, for R2 revealed the staff failed to offer her a bath/shower on 08/11/22, 08/18/22, 08/22/22, and 08/29/22, however they did offer on 08/19/22 and 08/23/22 and R2 accepted.

On 08/30/22 at 03:42 PM, R2 stated the staff help her with bathing and they have a terrible time getting it done because there are so many residents. R2 stated she was to get bathed twice weekly but has never received two in one week, one time she missed getting bathed for two weeks, and the staff did not offer her one during that time.

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On 08/31/22 at 11:07 AM, Certified Medication Aide (CMA) R stated the facility had a bathing schedule that documented the list of residents with scheduled showers for the day, the staff fill out a shower sheet when a bath was given, and the staff documented each shower in the electronic record system.

On 09/06/22 at 03:18 PM, Administrative Staff A stated the admitting nurse assessed resident bathing preferences. The charge nurse, Director of Nursing, and the MDS nurse add the residents to the "Shower Schedule". The facility should provide showers to the residents per the resident's preference. If a resident refuses bathing, the CNA should notify the charge nurse and the charge nurse will confirm the refusal and try to help the resident desire a shower. The refusal should be documented in the EMR and written on a shower sheet. The charge nurse was responsible to assure bathing tasks were completed with oversight from clinical leadership.

The facility policy "Quality of Life - Dignity" dated 10/2021 revealed each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. The facility culture is one that supports and encourages humanization and individuation of residents, and honors resident choices, preferences, values, and beliefs. Some examples of ways in which respect for choices and values are exercised include personal grooming.

The facility failed to offer bathing four scheduled days of 08/2022 to R2, who preferred to be bathed twice weekly on Monday and Friday and

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failed to have her scheduled days on the "Shower Schedule" on her preferred days.

- The "Medical Diagnosis" tab located in the electronic medical record (EMR) included diagnoses for Resident (R)201 of cerebral infarction, (stroke - damage to tissues in the brain due to a loss of oxygen to the area) dementia (progressive mental disorder characterized by failing memory, confusion), anxiety disorder (feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought).

The "Admission Minimum Data Set" dated 08/16/22 assessed R201 with a "Brief Interview of Mental Status" (BIMS) score of two, indicating severe cognitive impairment and did not reject care. R201 required one person to provide physical assistance with part of bathing activity. R201 admitted to the facility on 08/10/22.

The "Cognitive Loss Care Area Assessment" dated 08/23/22, revealed R201 required extensive to total assistance from the staff for her ADL's (activities of daily living).

The "Care Plan" dated 08/31/22, revealed R2 required total assist with her showering needs and preferred a shower two times a week.

The "Shower Schedule" undated revealed R201 was to receive a shower during the day shift on Wednesdays and Sundays.

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The "ADL - Bathing" task, located in the EMR, from admission on 08/10/22 through 08/31/22, for R201, revealed "No data found" indicating the staff did not offer her a shower during those days.

The "Shower Sheet" form, dated 08/28/22, revealed R201 received a shower on 08/28/22.

The facility did not provide documentation upon request to show that R201 received any type of bathing by a hospice provider from 08/10/22 through 08/31/22.

On 08/31/22 at 11:07 AM, Certified Medication Aide (CMA) R stated the facility had a bathing schedule that documented the list of residents with scheduled showers for the day, the staff fill out a shower sheet when a bath was given, and the staff documented each shower in the electronic record system.

On 09/06/22 at 03:18 PM, Administrative Staff A stated the admitting nurse assessed resident bathing preferences. The charge nurse, Director of Nursing, and the MDS nurse add the residents to the "Shower Schedule". The facility should provide showers to the residents per the resident's preference. If a resident refuses bathing, the CNA should notify the charge nurse and the charge nurse will confirm the refusal and try to help the resident desire a shower. The refusal should be documented in the EMR and written on a shower sheet. The charge nurse was responsible to assure bathing tasks were completed with oversight from clinical leadership.

The facility policy "Quality of Life - Dignity" dated 10/2021 revealed each resident shall be cared for in a manner that promotes and enhances his or

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her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. The facility culture is one that supports and encourages humanization and individuation of residents, and honors resident choices, preferences, values, and beliefs. Some examples of ways in which respect for choices and values are exercised include personal grooming.

The facility failed to assist R201 with showers on five of six opportunities from 08/10/22 through 08/31/22.

- The "Medical Diagnosis" tab located in the electronic medical record (EMR) for Resident (R)101, included diagnoses of muscle weakness, need for assistance with personal care, and dementia (progressive mental disorder characterized by failing memory, confusion).

The "Annual Minimum Data Set" (MDS) dated 12/27/21 assessed R101 with a "Brief Interview of Mental Status" (BIMS) score of 15, indicating intact cognition. He did not reject care and required one staff to provide physical assistance with part of bathing activity.

The "ADL (activities of daily living) Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 12/28/21, revealed R101 required supervision to limited assistance with his ADL's.

The "Quarterly MDS" dated 06/20/22, assessed R101 with the same BIMS score, did not reject care, and required one staff to assist him with the transfer only for the bathing activity.

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The "Care Plan" dated 06/07/22 for R101, revealed he required limited to extensive assistance with showering and preferred a shower in the morning on Thursdays and Sundays.

The "Shower Schedule" undated, revealed R101's shower days were on the day shift on Mondays and Thursdays. The facility failed to put him on the schedule for his preferred days per the care plan.

Per the "Shower Schedule" of Mondays and Thursdays for shower days and the "ADL-Bathing POC (point of care) Response History" for 08/02-08/31/22, revealed the facility failed to offer bathing on 08/04/22, 08/08/22, 08/11/22, 08/15/22, 08/18/22, 08/22/22, and 08/29/22, however he did receive a shower on 08/16/22 and 08/30/22 and refused a shower on 08/12/22. R2 went 11 days without a shower before staff offered and he refused on 08/12/22.

On 08/30/22 at 02:48 PM, R101 stated the staff wash his back when he takes a shower, and the showers need to "Come more often." He did not know how often they were to give him a shower. R101 stated "sometimes it is a week, sometimes a week-and-a-half, sometimes every two weeks" before the staff would assist him with a shower. He said that previously he was used to having a shower every morning when he got up for the day.

On 08/31/22 at 11:07 AM, Certified Medication Aide (CMA) R stated the facility had a bathing schedule that documented the list of residents with scheduled showers for the day, the staff fill out a shower sheet when a bath was given, and

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the staff documented each shower in the electronic record system.

On 09/06/22 at 03:18 PM, Administrative Staff A stated the admitting nurse assessed resident bathing preferences. The charge nurse, Director of Nursing, and the MDS nurse add the residents to the "Shower Schedule". The facility should provide showers to the residents per the resident's preference. If a resident refuses bathing, the CNA should notify the charge nurse and the charge nurse will confirm the refusal and try to help the resident desire a shower. The refusal should be documented in the EMR and written on a shower sheet. The charge nurse was responsible to assure bathing tasks were completed with oversight from clinical leadership.

The facility policy "Quality of Life - Dignity" dated 10/2021 revealed each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. The facility culture is one that supports and encourages humanization and individuation of residents, and honors resident choices, preferences, values, and beliefs. Some examples of ways in which respect for choices and values are exercised include personal grooming.

The facility failed to offer showers on seven of eight opportunities for R101 and failed to offer them his preferred days per his care plan.

- The "Medical Diagnosis" tab located in the electronic medical record (EMR) for Resident (R)3 included diagnoses of muscle weakness, need for assistance with personal care, anxiety

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(feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and schizoaffective disorder (mental disorder characterized by abnormal thought processes and an unstable mood).

The "Annual Minimum Data Set" (MDS) dated 11/24/21, assessed R3 with a "Brief Interview of Mental Status' (BIMS) score of 15, indicating intact cognition. She did not reject care and required one staff to provide physical assistance with part of bathing activity.

The "ADL (activities of daily living) Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 12/02/21 revealed R3 required extensive assistance to total assistance with her ADL's.

The "Quarterly MDS" dated 06/07/22 for R3, did not reveal any changes from the prior "Annual MDS."

The "Care Plan" dated 06/23/22 for R3 revealed she required one staff to assist her with bathing/showering twice a week and as necessary. R3 preferred bathing to be done in the "PM" on Mondays and Fridays.

The "Shower Schedule" undated, revealed the staff were to assist R3 with bathing on the day shift on Mondays and Thursdays. The facility failed to have her on the schedule for her preferred days per her "Care Plan."

The "ADL-Bathing POC Response History" report, dated for the past 30 days from 08/02/22 through 08/31/22, revealed no occurrences where she refused to bathe. The staff failed to assist

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with bathing on 08/04/22, 08/08/22, 08/11/22, 08/18/22, 08/22/22, and 08/29/22 per the "Shower Schedule" however, she did receive bathing on 08/03/22, 08/19/22, 08/25/22, 08/26/22, and 08/30/22.
The "Shower Sheet" revealed the staff provided bathing on 08/07/22 and 08/15/22.

On 08/30/22 at 04:01 PM, R3 stated she gets a shower once a week and prefers them twice a week on Mondays and Fridays. R3 stated she had to keep asking and the staff will give her one, and her shower was in the evening, but she asked for it to be changed to daytime. R3 stated she was to get a shower yesterday (08/29/22) and it did not get done so she talked to the Director of Nursing, and he talked to the staff, and then they assisted her with a shower this morning before her appointment.
On 08/31/22 at 11:07 AM, Certified Medication Aide (CMA) R stated the facility had a bathing schedule that documented the list of residents with scheduled showers for the day, the staff fill out a shower sheet when a bath was given, and the staff documented each shower in the electronic record system.

On 09/06/22 at 03:18 PM, Administrative Staff A stated the admitting nurse assessed resident bathing preferences. The charge nurse, Director of Nursing, and the MDS nurse add the residents to the "Shower Schedule". The facility should provide showers to the residents per the resident's preference. If a resident refuses bathing, the CNA should notify the charge nurse and the charge nurse will confirm the refusal and try to help the resident desire a shower. The refusal should be documented in the EMR and written on a shower sheet. The charge nurse was

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F 677	Continued From page 19 responsible to assure bathing tasks were completed with oversight from clinical leadership. The facility policy "Quality of Life - Dignity" dated 10/2021 revealed each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. The facility culture is one that supports and encourages humanization and individuation of residents, and honors resident choices, preferences, values, and beliefs. Some examples of ways in which respect for choices and values are exercised include personal grooming. The facility failed to offer bathing on six of eight scheduled shower days and failed to have her showers scheduled per her preference on her care plan.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		

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The facility reported a census of 42 residents with ten selected for review including three residents reviewed for wounds. Based on observation, record review, and interview, the facility failed to perform an ongoing assessment of a 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) and implement interventions to prevent further development of pressure areas for one of the three Residents (R)102.

Findings included:

- The "Medical Diagnosis" tab located in the electronic medical record (EMR), for Resident (R)102 included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), acute (disease characterized by a relatively sudden onset of symptoms that are usually severe) kidney failure, metabolic encephalopathy (a chemical imbalance in the blood that affects the brain and can lead to personality changes), cellulitis (skin infection caused by bacteria characterized by heat, redness and swelling), muscle weakness, and need for assistance with personal care.

The "Admission Minimum Data Set" (MDS) dated 08/17/22 revealed R102 admitted to the facility on 08/11/22. He had a "Brief Interview of Mental Status" (BIMS) score of 13 indicating intact cognition. R102 rejected care one to three days of the seven-day assessment period. He required extensive assistance of one staff for bed mobility and transfers and did not ambulate. He used a wheelchair for mobility. He was at risk for developing pressure ulcers/injuries and had a

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Stage two (partial thickness loss of the dermis presenting as a shallow open ulcer with a red-pink wound bed or present as an intact or open/ruptured blister) pressure area which was present upon admission. R102 had a pressure reducing device for the chair and bed, was on a turning/repositioning program, received nutrition or hydration intervention to manage skin problems, received pressure ulcer/injury care, received application of non-surgical dressing other than to his feet, and applications of ointments/medications other than to his feet.

The "Pressure Ulcer Care Area Assessment" dated 08/24/22 revealed he required limited to extensive assistance with his ADL's (activities of daily living) and he admitted with a Stage two area and cellulitis. R102 could make needs known at times, would use his call light, and would yell out, throw things, and be aggressive towards the staff.

The "Baseline Care Plan" dated 08/11/22, revealed R102 had current skin integrity issues-possible cellulitis and a history of skin integrity issues. He required one person to assist him with bed mobility, two or more to assist with transfers, and used a wheelchair for mobility. Handwritten on the care plan, undated, revealed he admitted with cellulitis to the lower extremities, a stage one blister to his left lower extremity and a stage two to his coccyx. On 08/15/22 a handwritten note revealed R102 was refusing dressing changes, care, and changing to ace wraps to lower bilateral extremities. On 08/16/22 a handwritten note included refusing cares and dressing changes and on 08/26/22 seen by doctor for refusing cares and ADL's. On 08/31/22 handwritten included R102 was still refusing

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cares and wound changing. The care plan lacked interventions to prevent worsening/prevention of further development of pressure ulcers.

The "Care Plan" dated 08/31/22 for R102 revealed he had a Stage two pressure ulcer on his coccyx (the area below the sacrum commonly known as the tailbone) present upon admission related to his immobility. The staff were to assess/record/monitor wound healing weekly/as needed measuring length, width and depth where possible, assess/document status of wound perimeter, wound bed, exudate, and healing progress. The staff were to report improvements and declines to the medical doctor. The resident/family/caregivers were to be informed of any new areas of skin breakdown. The staff were to monitor the dressing daily and as needed to ensure it was intact and adhering. R102 required assistance from staff for bed mobility, toilet use, and transfers.

The "Braden Scale for Predicting Pressure Sore Risk" dated 08/11/22 scored R102 at a "15" indicating at risk for pressure ulcer development.

The "Progress Note" located in the EMR, dated 08/11/22 at 12:09 PM, revealed R102 admitted to the facility at this time with ace wraps (elastic bandage) in place to his bilateral feet.

The "Admit/Readmit Screener" dated 08/11/22, in the "Skin Integrity" section, revealed R102 had normal skin color, warm skin temperature, and listed a site of left and right heel. The assessment lacked a description of his heels, lacked an assessment of his lower extremities, and lacked assessment of the pressure area to his coccyx.

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The "Skin Observation Tool" dated 08/12/22, revealed R102 had a stage one (intact skin with non-blanchable [discoloration of the skin that does not turn white when pressed] erythema) to his sacrum and the assessment lacked measurements for the area.

The "Shower Sheet" dated 08/15/22 for R102 lacked indication of any skin abnormalities to the sacrum.

The "Orders" tab, located in the EMR, included an order dated 08/18/22, for Wound Care Plus (wound consultant company) to evaluate and treat R102 for his blister on his left lower extremity and his lower extremity edema. The order lacked evaluation and treatment of the coccyx.

The "Pressure Injury Review" weekly report dated 08/19/22 lacked documentation of the pressure area to R102's coccyx.

The "Weekly Wound Note" located under the progress notes tab in the EMR dated 08/22/22 lacked assessment information for R102's coccyx.

The "Skin Observation" located in the EMR under the task tab dated 08/23/22 at 01:47 AM, revealed the resident had a red area, discoloration, and an open area and the skin condition was new. (The task does not require the staff to document location of the skin condition).

The "Orders" tab, located in the EMR, included an order dated on 08/25/22 for the staff to clean the wound to the coccyx every other day with wound cleanser, apply a protective dressing -

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ABD pad (abdominal pad-used for large wounds or wound requiring high absorbency) over the wound every other day.

The "TAR" (treatment administration record) located in the EMR for 08/11-08/31/22 lacked a treatment order to the coccyx until 08/25/22. The TAR revealed the staff performed a dressing change on 08/25/22, 08/27/22, 08/29/22, and 08/31/22. There were no other treatment orders for his skin listed except to his bilateral lower extremities.

The "Pressure Injury Review" weekly report dated 08/26/22 included R102 had a stage two pressure area to his coccyx which was present on admission and measured three cm by one cm by 0.5 cm deep. The staff were cleansing the area with wound cleanser and applying a bulky dressing and notified Wound Care Plus on 08/19/22.

The "Skin Observation Tool" located under the assessment tab in the EMR, dated 08/29/22 at 07:02 AM, with a status of "In progress" for R102 revealed a stage two pressure area to the coccyx which measure 1.5 cm by one cm and lacked a measurement of the depth of the wound. The assessment included an additional stage two pressure ulcer to the left "butt cheek" which measured 2.5 cm by 1.5 cm and lacked a measurement for the depth of the wound.

The physician "Telephone Order" dated 09/01/22 for R102 instructed the staff to send him to the emergency department for evaluation and treatment for a decline.

The hospital "Final Report" for 09/01/22 revealed

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R102 had significant new excoriation/wounds to his peri area and buttocks since his dismissal on 08/11/22.

The hospital "Narrative Note" dated 09/01/22, for R102 revealed an unstageable pressure ulcer covered with black eschar (dead tissue) under his left buttocks and a stage two pressure ulcer to his coccyx measuring 1.0 cm by 0.5 cm by 0.0 cm. The pressure area on his coccyx was present on his previous admission.

On 08/30/22 at 10:12 AM, R102 was resting flat on his bed and verbalized he wanted repositioned.

On 08/30/22 at 10:16 AM, Certified Nurse Aide (CNA) M stated R102 had been repositioned "not too long ago" and maybe he had "moved around."

On 08/30/22 at 10:22 AM, CNA O stated R102 gets agitated if woke up in the morning, so the staff let him sleep.

On 08/30/22 at 10:24 AM, CNA O and CNA N went to assist the resident and he decided he did not want to get up then changed his mind. His brief was dry, and his coccyx and buttocks were not observed at this time. CNA O and CNA N transferred him to his recliner in his room from the bed.

On 08/30/22 at 12:20 PM, R102 was sitting in his recliner in his room, with visitors present in the room.

On 08/30/22 at 02:56 PM, R102 was sitting in his recliner in his room with his legs in the down position.

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ADVENA LIVING AT FOUNTAINVIEW	601 N ROSE HILL ROAD ROSE HILL, KS 67133

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On 08/30/22 at 04:17 PM, R102 was sitting in his recliner in his room with his legs in the down position.

On 08/30/22 at 09:05 AM, a confidential reporter stated the unstageable pressure ulcer to the left buttocks measured two by two centimeters.

On 09/07/22 at 09:56 AM, CNA N stated that on 08/23/22, herself and Licensed Nurse (LN) I were taking R102 to the bathroom and when CNA N pulled the incontinent product down CNA N noticed a red/purplish area, then the resident turned and CNA N explained that time LN I said, "Oh my there's a big open area on his tailbone." LN I did not think the area had been documented in his paperwork. CNA N stated she did not personally see the open area.

On 09/07/22 at 10:07 AM, 01:51 PM, and 04:04 PM, attempts to reach LN I by phone for further interview were not successful.

On 09/07/22 at 02:03 PM, Administrative Nurse D stated when a resident is newly admitted to the facility the staff have 24 hours to complete a head to toe skin assessment to assess for ulcerations, injuries, etc. If there were any abnormal areas the staff were to document on a weekly wound note, or a free form note, and they would let him know about the area. Administrative Nurse D reported he makes weekly pressure injury review report based on EMR findings, his findings and wound care plus notes. The charge nurse initially would assess a wound then Wound Care Plus may assess again to determine the best treatment and write new orders for the nurses to follow. The licensed staff were to conduct a weekly skin

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assessment and there was a rolling schedule in the assessment tab of the EMR to indicate when the assessment was due. The nurses were to document any new or worsening skin issues in the weekly wound note, the skin note, or the skin observation tool. Administrative Nurse D stated he observed R102's skin when he admitted and the resident's coccyx had a stage one area documented he believed a stage two would have been more appropriate as the area had "layers of skin missing" and it was a "sliver" maybe one by three centimeters. However, the staff did not measure the pressure area. Administrative Nurse D stated the facility failed to measure the pressure area to the coccyx until 08/29/22 (18 days after admission), the staff did not complete the wound assessments, and the area to the coccyx should have been measured with the initial skin assessment and weekly thereafter. The assessment on 08/22/22 should have included the pressure ulcer to the coccyx. Administrative Nurse D stated he did not think a pressure area on the left buttocks was accurate, it was more of an excoriation (injury to the surface of the skin), and he had a general rash on his buttocks to the coccyx area. Administrative Nurse D stated there was not an initial treatment put in place to the pressure area on the coccyx, the staff assisted him up regularly and he liked to sit in the recliner, which was well cushioned. The staff regularly assessed and cleaned the area, he would often refuse to leave his room so the staff would turn him in bed. Administrative Nurse D stated R102 was "violently refusing" any assessments the first two weeks of his stay and the staff should have been documenting the refusals.

On 09/08/22 at 11:46 AM, Administrative Staff A

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F 686	Continued From page 28 stated he would expect a licensed nurse to document weekly on pressure injuries and other skin conditions. The facility policy "Pressure Ulcers/Skin Breakdown - Clinical Protocol" dated 04/2018, revealed the nursing staff and practitioner will assess and document and individual's significant risk factors for developing pressure ulcers. In addition, the nurse shall describe and document/report the following: full assessment of pressure sore including location, stage, length, width and depth, presence of exudate or necrotic tissue, pain assessment, resident's mobility status, current treatments including support surfaces, and all active diagnoses. The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. The facility failed to perform ongoing weekly skin assessments of a pressure ulcer on the resident's coccyx and failed to implement interventions to prevent further development of pressure areas for the resident.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		

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The facility reported a census of 42 residents with ten residents selected for review, including three reviewed for accident hazards. Based on observation, interview, and record review, the facility failed to assess, investigate, and implement a new intervention following a fall for one of the resident's, Resident (R)201, to prevent further falls.

Findings included:

- The "Medical Diagnosis" tab located in the electronic medical record (EMR) included diagnoses for Resident (R)201 of cerebral infarction, (stroke - damage to tissues in the brain due to a loss of oxygen to the area) dementia (progressive mental disorder characterized by failing memory, confusion), anxiety disorder (feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought).

The "Admission Minimum Data Set" dated 08/16/22 assessed R201 with a "Brief Interview of Mental Status" (BIMS) score of two, indicating severe cognitive impairment. She required assist of one staff for transfers and did not ambulate. R201's balance was unsteady and required staff assistance when moving from the bed to a chair/wheelchair. R201 used a wheelchair for locomotion. She did not have any falls in the six months prior to admission and did not have any falls since admission on 08/10/22.

The "Falls Care Area Assessment" dated 08/23/22, revealed R201 required extensive to

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total care with her activities of daily living (ADL's) and used a wheelchair. She had a diagnosis of dementia and was receiving hospice services. She would yell out and at times pinch the staff without any recent falls.

The "Baseline Care Plan" located in the binder at the nurse's desk, dated 08/10/22, revealed R201 required two or more staff assistance with transfers and ambulation did not occur. She used a wheelchair for mobility and was alert to self only. She did not have a history of falls and an air mattress was in place. The staff added a handwritten intervention, dated 08/23/22 for a fall mat to be in place related to her "Crawling" out of bed.

The "Change of Care Plan" form, dated 08/23/22 for R201, located in a binder at the nurse's desk, included a new care plan intervention of "Fall mat in place due to fall risk and behaviors" and the form included three staff signatures.

The "Progress Notes" dated 08/15/22 for R201, revealed the facility contacted the hospice provider about getting a high back reclining wheelchair to support her better and to prevent falls.

Review of the "Progress Notes" dated 08/10-08/30/22, lacked documentation that R201 had a fall or any identified bruising to her forehead or eye.

The "Fall Risk Assessment" dated 08/10/22 revealed a score of 25, indicating a high risk for falls, and R201 experienced 1-2 falls in the past three months.

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On 08/30/22 at 12:06 PM, observation of R201 revealed yellow and purple bruising above her right eye and purple bruising around the right eye. She was sitting in a wheelchair in the dining room area.

On 08/30/22 at 12:07 PM, Certified Nurse Aide (CNA) M stated the bruising on R201's head was from a fall about a week or so ago and "Bruising always looks worse before it looks better."

On 08/30/22 at 12:25 PM, Licensed Nurse (LN) H stated she had the last three days off and the bruising to R201's head and eye was not there the last time she worked. The report sheet indicated that she had a fall mat but not that she fell, and she was not told in report that R201 had a fall. LN H stated when a resident falls the charge nurse follows up on the fall for 72 hours, charts in the progress note a fall occurred, fills out a fall packet which included staff witness statements, fall risk management assessment, post fall checklist, and several other forms that include things for staff to look at such as lighting, the floor and the "Why's" of the fall. The staff then come up with a new fall intervention and place it on the resident's care plan.

On 08/30/22 at 02:36 PM, R201 was laying in her bed with fall mat on the floor beside the bed. The mattress had elevated sides, the call light was clipped to the fitted sheet near her shoulder, and she was hollering out "Water" repeatedly. Her water was across the room on the bedside table and out of her reach. The resident did not attempt to get out of the bed.

On 08/31/22 at 08:38 AM, Administrative Staff A stated there was not a fall report completed for

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R201, but he assumed the bruising was from a fall, and that she had falls frequently. There was not documentation about a fall. The staff did report to him they were aware of the falls, but they were not documenting them. Administrative Nurse D was aware of her falls.

On 08/31/22 at 10:06 AM, Administrative Nurse D had a post fall investigation, dated for 08/23/22 at 02:32 PM, and stated the staff completed the investigation today (8 days after the fall).

On 08/31/22 at 10:09 AM, LN G stated when a resident had a fall they were to be assessed for injuries, notification should be made to the doctor, the power of attorney, the Director of Nursing, and the fall paperwork completed. The nurse would complete a risk management assessment, a progress note, of what happened, neurological checks (assessment to determine an impairment with the nervous system) if the resident hit their head or could not tell me if they hit their head or not. LN G stated we are expected to come up with a new intervention when a resident has a fall. A change of care plan form is placed at the desk and that was how the staff were notified when a resident had a fall, and the form was kept at the nurse's station in a binder. The staff were to sign the form after reading it. LN G stated she was on duty as a charge nurse on 08/23/22 and R201 was not found on the fall mat on that date. The fall mat was put into place because of her behaviors of trying to get out of bed during LN G's shift. LN G was told the resident was found on the mat on 08/24/22 but she did not recall if it was during report or by Administrative Staff D. There was not a new fall intervention for the fall on 08/24/22.

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On 08/31/22 at 08:31 AM, Administrative Nurse D stated he was the charge nurse on 08/24/22. R201 was found on the fall mat on 08/24/22 at 02:30 PM. He received a text from Certified Medication Aide (CMA) R informing R201 had a "goose egg" on her right eye. Administrative Nurse D stated the aides picked her up off the fall mat before a nurse assessed her and the next time, he had seen her, she was sitting in her wheelchair and had a bruise above her eye. Administrative D stated "my intention was to follow-up but it slipped through the cracks." Administrative Nurse D stated he did not complete the fall packet at the time of the fall, which included vital signs, neurological checks, witness statement sheets, risk assessment, progress note, and physician notification. The neurological checks should have been done and the incident report completed today has the incorrect date, and the fall did not have a new intervention put into place. The staff should sign the care plan change form when they read it.

On 08/31/22 at 10:52 AM, CMA R stated she was on duty when R201 was found on the fall mat on 08/24/22. CMA R stated she was charting at the nurse's desk and CMA S walked by and said R201 was "On the ground." CMA R stated she notified Administrative Nurse D and he responded if R201 was not injured, not bleeding, and was on the fall mat to "Go ahead and get her up." CMA R stated she did not see a "Goose egg" until after her and CMA S assisted her up and into the wheelchair, which then, at 02:32 PM, she texted Administrative Nurse D about it. Later at 05:28 PM, Administrative Nurse D responded back to CMA R and said that he would look into it and he might need to change her care plan. CMA R stated the facility did not have her fill out a

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witness statement, however she was passing medications and her shift ended at 02:00 PM, but she helped on the hall and left after assisting to get R201 off the floor. CMA R stated R201 around 11:00 AM the staff assisted her to the bed, and she slept through lunch that day-if she was sleeping the staff let her sleep as she often would be "Screaming." CMA R stated a change of care plan form was done after a resident had a fall and she did not see one for the resident's fall on 08/24/22. The staff applied the bolster mattress to the bed the first week R201 was in the facility. CMA R stated she had seen R201 periodically throw her legs over the side of the bed and the bolster mattress kept her from moving her legs as far off the side of the bed.

On 08/31/22 at 11:42 AM, Administrative Staff A stated he would expect the staff to complete the fall packet following a fall, investigate the fall, and come up with a new intervention except unless a resident crawls out of their bed frequently and that was on the care plan. Administrative Staff A stated he would expect the nurse to assess a resident after a fall before the staff moved the resident off the floor as they needed to be deemed safe to be moved. The aide should grab the attention of the charge nurse and the nurse should make sure the resident did not have an injury and that it was safe for the staff to move the resident. The staff and resident should be interviewed to determine what happened and R201's fall on 08/24/22 was not handled appropriately.

On 08/31/22 at 11:52 AM, CMA S stated on 08/24/22 she found R201 twice on the floor, the first time her legs were "Thrown over" and she was getting on her knees trying to get out of the

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bed. With the help of another staff member whom she could not recall, assisted R201 back to bed, then CMA S went to the dining room to get another resident. CMA S stated two minutes later R201 was on the fall mat and she had been told as long as she was on the mat she was fine. CMA S stated a nurse did not assess R201 before her and CMA R assisted her off the floor. R201 was not saying she was hurting, and the staff assisted her to her wheelchair then took her to the nurse's station area with them. CMA S stated she had a "knot" on her forehead but did not notice any discoloration at that time and she worked until 06:00 PM and did not notice any discoloration to the area.

The facility policy "Fall Follow-Up Protocol" undated, included when a resident has fallen the caregiver present during the fall will stay with the resident and get someone to find the nurse after providing a safe place for the resident to lie while moving the resident as little as possible. If the staff did not witness the incident, the person that found the resident would remain with the resident until the nurse comes to assess the resident. The nurse will assess the resident for injury including: vital signs, skin, sensation, movement of lower extremities, neurological assessment, range of motion, resident report of pain or point of tenderness, signs and symptoms of a head injury and if un-witnessed neurological check protocol would be implemented, notification of the physician with assessment findings, notification of family, notification of the Administrator and Director of Nursing, document circumstances and notifications and findings of the assessment in the clinical record, document on the care plan with a new intervention to prevent further falls, complete an incident report with witness

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F 689	Continued From page 36 statements, and assess and document every shift for the next 72 hours of response to care plan interventions, assessment, observations, notifications, and evaluation and overall findings of the resident's status. The facility failed to assess, investigate, notify the physician/family/Administrator, implement neurological checks, document, implement a new care plan intervention, and perform fall follow-up after this cognitively impaired resident, R201, was found by staff on the fall mat in her room, with a large knot and bruising to the head, placing her at risk for further falls.	F 689		