STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175304	A. BUILDING _____ B. WING _____	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPORIA PRESBYTERIAN MANOR	2300 INDUSTRIAL ROAD EMPORIA, KS 66801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the finding of investigation of complaint 164946. This 2567 was electronically sent to the facility on 9/23/21.	F 000		
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: The facility reported a census of 37 residents with four selected for review which included three residents reviewed for pressure ulcers. Based on observation, interview and record review, the facility failed to ensure staff provided resident (R)2 and R3 pressure reducing measures as care planned, failed to ensure staff evaluated the pressure reducing measures as effective for these two of three residents reviewed for pressure ulcers. The facility also failed to ensure physician orders were in place for treatment and monitoring of R3's two left heel unstageable pressure ulcers.	F 686		

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

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F 686	Continued From page 1	F 686		

Findings included:

- Review of R3's "Physician Order Sheet," dated 08/16/21, revealed diagnoses of cerebral vascular accident (stroke,) history of fracture right tibia and fibula (bones in the lower leg) and history of left tibia fracture.

Review of the resident's "Significant Change Minimum Data Set" (MDS), dated 06/29/21, assessed the resident had severe cognitive impairment, and impairment in function range of motion in both lower extremities. The resident required extensive assistance of two staff for bed mobility and dependent on staff for transfers. The resident was at risk for pressure ulcer with no unhealed pressure ulcers. The resident had other open lesions to his foot.

The "Pressure Ulcer Care Area Assessment "(CAA)," dated 06/30/21, assessed the resident was non-weight bearing to bilateral lower extremities and spent most of his time in bed or in a chair. He had a difficult time maintaining positioning in bed and slides down in bed. He had immobilizers to his bilateral lower extremities and a friction wound to his right ankle.

The "Care Plan," reviewed 06/26/21, instructed staff to ensure his blue foam boots were in place to the right and left feet. The resident had a friction wound identified on 06/26/21. Staff to reposition the resident every two to three hours and ensure minimal friction during repositioning.

A "Skin Assessment," dated 09/09/21, documented the resident had a red open area

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F 686	Continued From page 2	F 686		

with irregular edges to his left heel, measuring 1.9 by 1.9 cm (centimeters) and to offload (keep the heal free of pressure) when not eating and apply skin prep and staged the area as a stage 2 pressure ulcer with light exudate (drainage).

A "Nurse's Note," dated 09/10/21 at 03:30 PM, documented the resident had two wounds on his left heel with the top wound with a slight opening with slight bleeding. This note documented the wounds were cleansed with skin cleanser and wrapped with soft kling (an elastic type of gauze dressing.) This note lacked documentation of measurements of either wound or staging of either wound.

Observation, on 09/15/21 at 10:15 AM, revealed the resident seated in his recliner in his room. His feet were positioned on the elevated foot rest of the recliner with pillows placed beneath his legs, from his knees downward. However, the left heel lay directly on the foot rest of the chair (the pillow did not have enough buoyancy to elevate his foot off the surface of the foot rest).

Observation, on 09/15/21 at 12:20 PM, revealed Licensed Nurse (LN) G, provided wound care to the resident. The resident had an undated gauze wrapped dressing to his left foot. LN G stated the wound nurse usually completed the dressing changes and LN G did not know when staff applied the dressing or for what reason. LN G stated staff should ensure the resident's heels were floated (raised without any direct pressure) and confirmed the pillow used was not effective as the resident's heels lay directly on the surface of the elevated recliner foot rest. LN G removed the gauze wrap and measured the two areas as

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F 686	Continued From page 3	F 686		

1 cm by 0.5 cm each. LN G stated she contacted the wound nurse for instruction on treatment for these areas. LN G then cleansed the areas with normal saline and applied Venelex (an ointment used to promote wound healing) and a gauze pad and wrapped the foot with the soft kling.

Observation, on 09/15/21 at 05:15 PM revealed Certified Nurse Aide (CNA) O and P, positioned the resident in his Broda chair (a type of chair with a strapping system designed for pressure reduction in the sitting position) and elevated the foot rest and placed pillows under his legs to elevate the heels. Interview, at that time with CNA O revealed the resident had used the blue foam heel protectors in the past, but thought he required pillows to elevate his heels at this time as the area on his heel reopened.

Observation, on 09/16/21 at 11:20 AM, revealed the resident seated in his recliner with the footrest elevated. The resident had pillows under his legs, but the left foot lay directly on the surface of the foot rest. Administrative Nurse E removed the dressing from the resident's left foot and noted red drainage on the gauze. LN, I measured the areas as 1.5 cm by 1.5 cm and 2 cm by 1 cm.

Interview, on 09/16/21 at 11:20 AM, with LN I confirmed the treatment administration record (TAR) lacked physician instruction for treatment of these wounds.

Interview, on 09/16/21 at 11:45 AM with Administrative Nurse F, confirmed the lack of treatment orders for these wounds on the TAR or in the medical record. Administrative Nurse F

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F 686	Continued From page 4	F 686		

stated she evaluated the wounds on 09/10/21 and staged them both as unstageable pressure areas. Administrative Nurse F stated the resident experienced discomfort with the foam heel protective boots, and so staff used pillows to offload the heels. Administrative Nurse F stated she would expect the charge nurse to notify the physician of the wounds and obtain treatment orders.

The facility policy "Skin Integrity: Pressure Ulcer/Injury Prevention, Nursing Intervention and Wound Treatment," revised 07/12/2021, instructed staff to daily document the checking of dressings and document monitoring for absence of edema (swelling,) redness, bogginess (mushy feeling of area) and drainage of the heel pressure ulcer.

The facility failed to assess this resident's two unstageable pressure ulcers with measurements at the time of discovery and failed to ensure staff awareness of treatments. The facility failed to evaluate the effectiveness of the planned pressure reducing measures for this dependent resident, to promote healing of the pressure ulcers.

- Review of resident (R)2's "Physician Order Sheet," dated 09/07/21, revealed diagnoses included history of femur (hip) fracture, Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), and chronic pain.

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F 686	Continued From page 5	F 686		

The "Significant Change Minimum Data Set" (MDS), dated 08/16/21, assessed the resident had severe cognitive impairment and required extensive assistance of two staff for bed mobility and transfers. The resident was at risk for developing pressure ulcers and had no unhealed pressure ulcers. The resident had pressure reducing devices in his chair and bed, and was on a turning and repositioning program.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 08/16/21, assessed the resident with no pressure injuries present and was in the bed or chair most of the time. The resident had a pressure relieving mattress and required extensive assistance for bed mobility.

The "Baseline Care Plan," dated 08/16/21, instructed staff to provide heel and elbow protectors and turn the resident every two hours.

The "Care Plan," revised 09/03/21, instructed staff to float the resident's right heel related to an unstageable pressure injury to the right heel.

The "Skin Assessment," dated 09/03/21, documented an unstageable 0.8 centimeter (cm) by 0.6 cm area to the resident's right heel

A "Physician's Order," dated 09/07/21, instructed staff to apply Venelex (an ointment use for wound healing) topical ointment daily to the resident's right heel and to wrap it for protection.

Observation, on 09/15/21 at 03:17 PM, revealed the resident seated in his recliner with the foot rest elevated. Licensed Nurse H provided wound care to the resident. LN H measure the closed

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F 686	Continued From page 6	F 686		

brown colored area on the resident's right heel, as 1.8 cm by 0.7 cm. LN H cleansed the area with normal saline, applied the Venelex and then wrapped the heel with soft gauze.

Interview, on 09/15/21 at 03:23 PM, with Certified Nurse Aide (CNA) N, revealed the resident sat in his recliner with feet elevated or in bed with feet elevated. CNA N stated the resident could sit in his wheelchair with foot pedals in the common dining area, so staff could observe him.

Observation, on 09/16/21 at 07:45 AM revealed the resident asleep in his bed. The resident had pillows under his knees, but his heels lay directly pressing on the mattress. Certified Medication Aide (CMA) R stated the resident did not like foam boots to protect his heels and confirmed that the pillow placement was ineffective for pressure relief as his heels lay directly on the bed.

Interview, on 09/16/21 at 11:15 AM, with Administrative Nurse F, revealed staff should place the pillows in such a way to elevate the resident's heels off the bed and should ensure the pillows did not become ineffective with the weight of the resident's legs.

The facility policy "Skin Integrity: Pressure Ulcer/Injury Prevention, Nursing Intervention and Wound Treatment," revised 07/12/2021, instructed staff to use heel protectors or pillows to support heels and reduce sheering effect.

The facility failed to ensure the offloading pillows contained enough buoyancy to maintain this dependent resident's heels off the bed to provide

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F 686	Continued From page 7 pressure relief adn to promote healing of the residents pressure ulcer.	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: The facility reported a census of 37 residents with four selected for review, which included three residents reviewed for falls. Based on observation, interview and record review, the facility failed to ensure staff utilized all fall interventions as care planned for one resident (R)2 of the three residents review for falls to prevent further falls. Findings included: - Review of resident (R)2's "Physician Order Sheet," dated 09/07/21, revealed diagnoses included history of femur (hip) fracture, Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), and chronic pain. The "Significant Change Minimum Data Set" (MDS), dated 08/16/21, assessed the resident had severe cognitive impairment and required	F 689		

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F 689	Continued From page 8	F 689		

extensive assistance of two staff for bed mobility and transfers. The resident had major surgery during the 100 days prior to admission and had a fracture related to a fall in the last six months prior to admission/reentry.

The "Fall Care Area Assessment" (CAA), dated 08/27/21, assessed the resident had a significant change in status due to right hip fracture that required surgical intervention.

The Care plan included the following fall interventions:

12/06/20, Assist the resident to wear nonskid socks at all times if not wearing shoes.
01/20/21, Motion sensor in the resident's room to alert staff of resident movements.
04/21/21, Ensure dycem (a type of nonslip material) is on the seat of his recliner. (A "Nurse's Note" dated 04/21/21, documented staff found the resident seated on the floor in front of his recliner, having slid down the recliner.)
08/12/21, Offer to put resident in a recliner in the living room after meals if he does not want to return to his room.

Observation, on 09/15/21 at 01:00 PM, revealed the resident seated in his recliner in his room. Certified Nurse Aide (CNA) Q placed the resident's noon meal on a bedside table and positioned it in front of the resident and assisted him to eat. Interview, at that time with CNA Q revealed the resident had a motion senor in his room but the resident did not usually try to get out of his recliner. CNA Q stated the resident usually sat in his wheelchair with foot pedals on in the common dining area.

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F 689	Continued From page 9	F 689		

Observation, on 09/15/21 at 05:35 PM, revealed the resident continued to sit in his recliner. CNA N and MM assisted the resident to stand and transfer into his wheelchair. The resident did not have nonskid socks on or shoes. The resident's recliner did not have dycem in the seat. After the resident was seated in the wheelchair, CNA N placed the resident's shoes on his feet.

Interview, on 09/15/21 at 05:40 PM, with CNA N revealed the resident did not usually try to get up out of his recliner but has tried to get up out of his wheelchair in the past. CNA N states the resident had a motion detector in his room. CNA N stated she did not know that the resident should have dycem in his recliner.

Interview, on 09/16/21 at 08:15 AM, with Certified Medication Aide (CMA) R, revealed the resident usually sat in his wheelchair or a recliner in the common dining area and CMA R did not know if he should have dycem in the recliner.

Interview, on 09/15/21 at 06:00 PM, with Administrative Nursing Staff D, revealed she would expect staff to follow the interventions in place on the "Care Plan."

The facility "Falls" policy, revised 11/05/2020 instructed staff resident's identified for risk of falls will have interventions implemented and documented on the "Care Plan." The "Fall Prevention Reference Sheet by Type of Fall," revised 11/05/2020, instructed staff to ensure proper footwear and non-skid pad if appropriate.

The facility failed to ensure staff implemented fall

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F 689	Continued From page 10 prevention interventions, as care planned for this confused at risk resident to prevent further falls.	F 689		