STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175172	A. Building B. Wing	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Healthcare and Rehab Topeka	2515 SW Wanamaker Road Topeka, KS 66614

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** 39752 The facility identified a census of 90 residents. The sample included three residents reviewed for pressure injuries/ulcers (PI-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). Based on record review, interviews, and observations, the facility failed to provide wound treatments as ordered for Resident (R) 1. The facility failed to follow wound care orders for a Stage 4 (a deep wound that reaches the muscles, ligaments, or even bone) PI when they failed to ensure proper placement, and function of the wound vac (a vacuum-assisted wound treatment that applies gentle suction to a wound to help it heal), and failed to provide dressing changes as ordered. The facility failed to routinely assess and monitor the wound for worsening or signs and symptoms of infection. Subsequently, R1 required hospitalization due to the wound worsening and development of infection in the wound. Findings included: - R1's Electronic Medical Record (EMR), under the Diagnosis tab listed diagnoses of pressure ulcer of unspecified site stage four, local infections of the skin and subcutaneous (beneath the skin) tissue, sepsis (a systemic reaction that develops when the chemicals in the immune system release into the blood stream to fight an infections which cause inflammation throughout the entire body instead. Severe cases of sepsis can lead to the medical emergency, septic shock), paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), and type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). The Entrance Minimum Data Set (MDS) documented R1 admitted to the facility on [DATE] . The Admission MDS dated [DATE] recorded R1 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R1 required extensive assistance of two staff for personal hygiene and bed mobility and was totally dependent upon two staff for transfers, toileting and dressing. The MDS recorded R1 had one Stage 4 pressure ulcer and was at risk for pressure injuries. The MDS further recorded R1 did not reject evaluation or cares during the look back period. The Alteration in Skin Integrity Care Plan initiated 02/24/22 directed staff to assess the wound weekly, and document wound measurements, wound bed appearance, odor, drainage, and surrounding tissue. It directed staff to monitor daily for signs and symptoms of infections, provide a pressure reducing device on the bed, and to refer to wound care specialist as needed. (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The hospital Discharge Orders dated 02/23/22 ordered the following treatment to the sacral (large triangular bone between the two hip bones) PI: facility to place negative pressure wound therapy dressing (NPWT-wound vac). NPWT will need to continue with NPWT dressing changed three times a week upon discharge. Cleanse the wound gently with normal saline, apply Santyl (a prescription enzyme used to help break up and remove dead skin and tissue of a wound) nickel thick to wound bed, apply barrier ring or hydrocolloid (type of wound dressing) to the edges of the wound if necessary, apply drape to peri-wound and skin over which foam will be tracked. Place black foam loosely into wound bed, track foam to appropriate, non-bony site, cover foam with drape and apply tracking pad. Apply wound vac at the physician ordered rate and pressure. The hospital Discharge Orders further directed if the wound vac failed, staff should attempt to patch leaks with an extra drape. If the wound vac failed for more than two hours, the order directed staff to remove the wound vac dressing and replace it with a wet to dry dressing which needed to be changed daily and as needed. The Weekly Wound assessment dated [DATE] documented one wound on the sacrum, a Stage 4 pressure ulcer with length of 12 by width of 11 by depth of 2.5. The wound had50 percent (%) granulation tissue (tissue formed during wound healing), 25 % of slough (dead tissue, usually cream or yellow in color), and 25 % black/brown eschar (dead tissue). Wound treatment order to cleanse with normal saline, apply black foam to wound bed, and wound vacuum on -125 millimeters of mercury (mmHg- the amount of negative pressure applied by the wound vac) continuous. The length, width, and depth lacked the unit of measurement (ie. centimeters, millimeters or inches) used. The Wound Documentation dated 02/24/22 at 01:09 PM entered late on 02/25/22 at 01:011 PM by Licensed Nurse (LN) G documented the sacrum pressure ulcer with length of 12 by width of 11 by depth of 2.5, a stage four. The length, width, and depth lacked the unit of measurement used. The wound had moderate amount of exudate (fluid that leaks out of body vessels and tissues) present, exudate was serosanguineous (semi-thick reddish drainage), with no odor present. Treatment order was to cleanse with normal saline, apply black foam to wound bed, 125 mmHg continuous, and R1 tolerated assessment and dressing change well. R1's clinical record lacked evidence of any further Weekly Wound Assessment documents or documentation of wound measurements, wound bed and peri-wound appearance after 02/24/22 through his discharge on 03/11/22. The Weekly Skin Monitoring assessment dated [DATE] documented no new skin alterations noted. It lacked mention of the Stage 4 PI. The Physical Therapy: PT Evaluation and Plan of Treatment dated 02/24/22 at 02:10 PM documented R1 did not have a wound vacuum on yet, but R1 reported he should have one on. Clinical Impression of R1 documented no sitting was performed due to the potential to cause shear or friction on the wound. It further documented when the wound was better managed, therapy would work on slide board transfers. Documented indicated R1 refused to sit until wound care addressed the wounds. The Progress Note dated 02/25/22 at 12:43 PM documented R1 had a Stage 4 PI on his coccyx (small triangular bone at the base of the spine). The note lacked comment about a wound vacuum or dressing. The Orders tab documented a Physician's Order entered on 02/23/22 with a start date of 02/25/22 for collagenase ointment (Santyl) 250 units/gram to apply to the coccyx wound topically every Monday, (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Wednesday, and Friday. Review of the February 2022 Medication Administration Record/Treatment Administration Record (MAR/TAR) revealed staff recorded the collagenase as administered to the coccyx by LN G on 02/25/22 at 04:49 PM and at 02:26 PM on 02/28/22. Further review of the February 2022 MAR/TAR revealed no wound dressing orders. The Comprehensive Care Path dated 02/28/22 at 04:43 AM documented R1's skin monitoring was stable. The care path lacked documentation of the wound, wound dressing or wound vac. The Occupational Therapy: Therapy Addendum dated 03/01/22 at 12:24 PM documented R1 had many concerns that he wanted to report. The note did not document the concerns or that the concerns were reported to the appropriate facility staff. The Physician Progress Note dated 03/01/22 at 01:12 PM documented R1 had a Stage 4 PI. The note lacked any further documentation regarding the PI and /or the treatment order. The Comprehensive Care Path dated 03/02/22 at 01:43 AM documented R1 received skilled services for infection treatment and further documented skin monitoring was stable. The note lacked any documentation of stage four decubitus ulcer. The Weekly Skin Monitoring assessment dated [DATE] documented no new skin alterations noted. It lacked mention of the Stage 4 PI. The Care Plan Meeting Note dated 03/03/22 at 02:16 PM documented R1 received wound care daily. The Orders tab documented a Physician's Order dated 03/02/22 which directed wound vac/negative pressure at negative 125 millimeters of mercury (mmHg) to sacrum three times a week every Monday, Wednesday, and Friday and as needed for wound care. Apply Santyl to wound bed, cover with black foam and wound vac at negative 125 mmHg continuous. Another order dated 03/02/22 directed staff to change the wound vac/negative pressure cannister weekly and as needed every day every seven days for wound care. The Weekly Skin Monitoring assessment dated [DATE] documented no new skin alterations noted. It lacked mention of the Stage 4 PI. The Orders tab documented a Physician's Order dated 03/04/22 which directed staff to check wound vacuum/negative pressure for placement and proper function each shift. Maintain negative pressure at 125 mmHg. The Comprehensive Care Path dated 03/05/22 at 04:43 AM documented skin monitoring stable and wound vacuum in place. The Comprehensive Care Path dated 03/07/22 at 01:43 AM documented R1's skin monitoring was stable. The wound on sacrum had a wound vacuum in place. R1 was compliant with dressing changes. R1 had open wounds not applicable with coccyx with moderate drainage from wound site with no clinical signs and symptoms of infection present. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Occupation Therapy: OT Therapy Progress Report dated 03/09/22 at 04:05 PM documented R1 made many complaints that his wound vacuum was not working correctly, and nursing had been notified each time. The Occupation Therapy: Therapy Addendum dated 03/09/22 at 06:19 PM documented R1's wounds had not been looked at recently and R1's wound vacuum was not working. R1 was rolled and noted to have a paper chuck (disposable protective pad) underneath him with wound drainage on it. Therapy notified nursing of R1's condition and Administrative Nurse D would be notified as well. Review of R1's March 2022 MAR/TAR revealed a lack of evidence that staff changed the wound vac dressing, and collagenase ointment applied on two scheduled dates, 03/07/22 and 03/09/22. R1's March 2022 MAR/TAR lacked evidence that staff changed the wound vac dressing on an as needed basis from 03/04/22 through 03/14/22. Review of R1's March 2022 MAR/TAR revealed the wound vac cannister was not changed on the scheduled day of 03/09/22 and lacked evidence it was changed on an as needed basis from 03/04/22 through 03/14/22. R1's March 2022 MAR/TAR lacked evidence that staff assessed the wound vac for placement and proper function on day shift of 03/07/22, 03/08/22, and 03/09/22. The Physical Therapy: PT Discharge Summary dated 03/11/22 documented R1 discharged to the hospital due to wounds. R1 had a wound vac to the sacral wound that worked inconsistently. R1's clinical record lacked evidence the physician ordered wet to dry dressing was ever transcribed and/or implemented. On 03/09/22 R1's representative reported an incident that occurred on 03/08/22. R1's representative reported an unidentified physical therapist attempted to do therapy with R1. When the therapist rolled R1 over in bed, R1's linens were saturated due to the wound vac leaking. R1's representative stated R1 was paralyzed and unable to tell the linens were wet or how long how the wound vac leaked. On 03/11/22 Consultant II reported R1 arrived at the acute care hospital with a wound vac dressing completely saturated with drainage. Consultant II reported when hospital staff removed the wound vac dressing, staff observed the wound was not properly cleaned and worsened in condition. On 03/17/22 at 03:00 PM Administrative Nurse D stated R1 came from the hospital with a wound vac on his wound. She revealed the facility admitting nurse assessed the resident's skin and then the wound nurse followed up with a detailed assessment of the wounds the second day the resident was in the facility. Administrative Nurse D spoke to LN G about a referral to a wound care specialist for R1 and she stated R1 wanted to be evaluated by the wound care specialist but discharged before the evaluation occurred. Administrative Nurse D further stated that if there was blanks on the MARS/TARs, she would print out missing entry report to see what documentation was missed and then ask the nurses that could be reached to sign off on it. Administrative Nurse D stated she thought all treatments were completed, but the nurse just forgot to sign off on it. Administrative Nurse D stated she performed spot checks on the residents that had wound treatments ordered. Administrative Nurse D stated she did not document which residents were checked nor the dates and times of the checks. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 03/17/22 at 03:45 PM Certified Nurse Aide (CNA) M stated if a resident had a wound vac that did not appear to be plugged in or running, she notified the charge nurse. On 03/17/22 at 04:40 PM LN H stated when a physician ordered a wound vac, she checked the rate the vacuum was to be set and applied the dressing as ordered. LN H stated if there was not an order for a wound treatment, she contacted the doctor. LN H stated the facility corporate office received the admission orders, then emailed the orders to the facility. The corporate office ordered the necessary equipment, including wound vacs, which were then sent to the facility. LN H stated admission orders were entered by the admitting nurse, unit nurse, or at times Administrative Nurse D. LN H then stated orders were double checked by Administrative Nurse D. LN G stated all treatment administrations were documented on the MAR/Tar and if it was not documented, then it was not done. On 03/21/22 at 01:17 PM Consultant Nurse JJ stated R1's wound was in horrible condition when he arrived at the hospital. She stated the dressing was completely saturated and dripping and the black foam adhered to R1's wound bed. The facility's Ulcer/Skin Breakdown Clinical Protocol revised 10/2021 documented the medical provider would examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions, assist staff to identify the type, and characteristics of an ulcer. The policy further documented the wound care specialist/medical provider would order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings, and application to topical agents. The policy documented a licensed nurse would assess the pressure ulcer weekly and keep the physician informed of progress with prescribed treatments. Staff were directed to have wounds examined weekly to assess and document findings, there would be daily documentation reflecting if dressing was intact, drainage noted, pain associated with the wound, and odor and condition of surrounding skin which is visual around the dressing. The facility failed to ensure R1's treatment orders were implemented, failed to ensure wound assessments occurred to describe and record measurements of the wound and effectiveness of treatments and failed to monitor and ensure the wound vacuum functioned properly. This deficient practice resulted in R1 readmitting to the hospital for worsening and infection of the wound.