STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175200	A. Building B. Wing	01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kenwood View Healthcare and Rehabilitation Center	900 Elmhurst Blvd Salina, KS 67401

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 69 residents with three residents reviewed for wounds. Based on record review, observation, and interview the facility failed to identify and provide appropriate intervention to prevent pressure ulcers (injury to skin and underlying tissue resulting from prolonged pressure on the skin) and failed to involve the physician, implement treatment orders, and consistently monitor wound status to promote healing, and prevent infection. Resident (R) 1, who was severely cognitively impaired, required extensive staff assistance for activities of daily living (ADL) and had contractures (abnormal fixed tightening of muscle, tendons, ligaments, or skin) developed a skin alteration on her right knee on 11/01/22. The facility identified the skin alteration on multiple subsequent skin assessments which were not performed routinely and were documented inconsistent with the Skin-Wound Assessments. The wound was noted to have slough (dead tissue usually cream or yellow in color) and redness on 11/21/22 though the record lacked physician notification or involvement and staff did not implement any treatments or interventions aimed to help heal and or prevent further skin injury. On 12/19/22 the wound had black eschar (dead tissue) formation and continued with redness all around the wound, but staff failed to involve the physician and/or implement orders to treat. On 01/03/23 the wound had further deteriorated and on 01/05/23 a wound consult was conducted, and the wound care team identified R1 had a stage 4 pressure injury (deep pressure wound reaching the muscles, ligaments, or bones) to her left knee, which was inflamed, and red. Treatment orders were written on 01/05/23 though the facility did not implement the treatment orders until 01/13/23. On 01/14/23, R1 became lethargic, hyperglycemic (elevated blood sugar levels), and the left knee was swollen and painful. R1 was admitted to the hospital with sepsis (potentially life-threatening condition that occurs in response to an infection), cellulitis (bacterial skin infection), and osteomyelitis (bone infection) of the left knee. This deficient practice placed R1 in Immediate Jeopardy. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), major depressive disorder (major mood disorder), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). (continued on next page)

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.

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

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 was severely cognitively impaired and had long and short-term memory problems. The MDS further documented R1 was totally dependent on two staff for transfers, locomotion on and off the unit, toileting, personal hygiene, and bathing. R1 required extensive assistance of two staff for bed mobility and eating. The MDS also documented R1 was at risk for developing pressure wounds, did not have any pressure wounds, had an open lesion, had a pressure reducing device for her chair, had a pressure relieving mattress, was not on a turning/repositioning program, and was not receiving any dressing applications. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 06/27/22, documented R1 had short- and long-term memory loss and was unable to complete the Brief Interview for Mental Status (BIMS) testing due to R1 being rarely/never understood and rarely/never demonstrated understanding. The assessment documented R1 as requiring extensive to total assist with all of her activities of daily living. The Pressure Ulcer/Injure CAA, dated 06/27/22, documented R1 as at risk for pressure ulcers due to requiring extensive assistance with bed mobility. The CAA documented R1 was always incontinent of bowel and bladder and had a significant weight loss. The ADL Care Plan, revised 05/23/22, directed staff to transfer R1 with a total body lift with two staff assistance, encourage R1 to allow brief and clothing changes as needed, and to assist R1 with ADL tasks like bathing, grooming, dressing, etc. The Skin Prevention Care Plan, dated 05/13/21, directed staff to assess R1's skin weekly by a licensed nurse, perform a Braden Scale (risk for pressure ulcer scale) on admission, quarterly and with acute changes, document changes such as skin color and turgor; ensure R1 had a pressure reduction mattress and pressure relieving cushion in her tilt/recline chair, and to perform treatments per order. The Braden Scale for Predicting Pressure Sore Risk, dated 10/20/22, documented R1 was at high risk for developing pressure ulcers. The assessment documented R1 had very limited ability to respond to pressure related discomfort, R1's skin was very moist, R1 was chair fast, R1's ability to change and control her body position was very limited, and R1's nutrition was very poor. The Weekly Skin Assessment, dated 10/26/22 documented R1's skin as intact and no new skin concerns were identified. The Nurse's Note, dated 10/29/22, documented R1 had a skin tear to the outside of her left knee measuring five centimeters (cm) by three cm as well as a bruise to her upper lip measuring roughly 1 cm by 0.5 cm. The site to the knee was cleaned and covered due to the nurse being unable to approximate the skin tear. The staff left a message with R1's guardian and a faxed R1's primary care physician. The Weekly Skin Check, dated 11/01/22, documented R1 had new skin concerns that were identified. Staff documented R1 as having redness with a scab to the front of her knee and bruising to the front of her right and left lower extremities. The note recorded staff notified R1's primary care physician of the new skin concern, but lacked evidence staff notified R1's representative. The Physician Order Sheet, dated 11/01/22, documented a new order for staff to monitor R1's reddened area with scab to the left knee and to monitor for increased redness, warmth, swelling, bleeding, or drainage every shift. The order had a start date of 11/01/22. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Weekly Skin Check, dated 11/02/22, documented R1 had a new skin concern identified. Staff documented R1 as having a skin tear to the front of her left thigh and a skin tear to her rear left lower leg. The note recorded staff notified R1's primary care physician of the new skin concern, but lacked evidence the staff notified R1's representative. The Weekly Skin Check, dated 11/09/22, documented R1 had previously identified areas of skin alteration. Staff documented R1 as having a skin tear to her outer left knee/thigh, a skin tear to the back of her left lower extremity, bruising to her bilateral lower extremities, bruising to the top of her right lip, a red/scab to her left knee, a small scab and bruise to her outer right calf, and intermittent redness of her groin. The record lacked evidence of notification to R1's primary care physician or responsible party. The Weekly Skin Check, dated 11/16/22, documented R1 had previously identified areas of skin alteration. Staff documented R1 as having a skin tear to her outer left knee/thigh, a skin tear to the back of her left lower extremity, bruising to her bilateral lower extremities, bruising to the top of her right lip, a red/scab to her left knee, a small scab and bruise to her outer right calf, and intermittent redness of her groin. No notification to R1's primary care physician or responsible party was made. The Weekly Skin Check, dated 11/18/22, documented R1 had a new skin concern identified. R1 had a hematoma (accumulation of blood) to her right forearm, which measured 8cm by 6 cm. R1's primary care physician and responsible party were both notified of the new skin concern. The Nurse's Note, dated 11/19/22, documented R1 continued to have a large hematoma to her right forearm and a scab to her left knee. The nurse noted the skin tear site to the left side of R1's knee was healed. The Skin/Wound Assessment, dated 11/21/22, documented R1 had a new skin alteration to her left knee. R1's left knee skin alteration measured 1.39 cm by 1.11 cm. The area had yellow slough with redness noted all around the peri-wound. There was no treatment in place and no evidence R1's primary care physician was notified of the deteriorating skin alteration to R1's left knee. The Weekly Skin Check, dated 11/24/22, only documented R1 had a previously identified area with a hematoma to her right forearm. The Weekly Skin Check, dated 11/30/22, documented R1's skin was intact and there were no areas of concern noted. The Nurse's Note, dated 11/30/22, documented during rounds R1 was noted to have a left knee scab that was tender, slightly swollen, and R1 cried out when the nurse touched the wound. The area had some warmth to the touch and it was not draining or bleeding. The surrounding skin was swollen and red. The scab appeared soft and cracking and pale in color. The skin tear to R1's left outer knee/thigh was healed and intact. The skin tear to the back of R'1 left lower leg/calf had some scabbed edges with no draining, bleeding or surrounding redness. The record lacked evidence R1's primary care physician was notified of the changes in R1's skin alteration to her left knee. The record indicated there was no treatment being performed to R1's left knee. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Weekly Skin Check, dated 12/07/22, documented R1 had a previously identified areas to her skin. R1 had a skin tear to the back of her left lower extremity, bruising to her bilateral upper and lower extremities (purple/brown/red), a red/scab to her left knee, a small scab and bruise over her right calf, and an intermittent reddened groin. The record lacked evidence of notification to R1's primary care physician or responsible party. The Weekly Skin Check, dated 12/13/22, documented R1 had previously identified areas to her skin. R1 had a skin tear to the back of her left lower extremity, bruising to her bilateral upper and lower extremities (purple/brown/red), a red/scab to her left knee, a small scab and bruise over her right calf, and an intermittent reddened groin. The record lacked evidence of notification to R1's primary care physician or responsible party. The Skin/Wound Assessment, dated 12/19/22, documented R1's left knee wound measured 2.24 cm by 2.16 cm. R1's wound to her left knee had black eschar to the wound bed with peeling skin. There was redness all around the wound. The record lacked evidence of notification to R1's primary care physician or responsible party regarding the worsening wound to the left knee. The Weekly Skin Check, dated 12/22/22, documented R1 had a previously identified areas to her skin. R1 had a skin tear to the back of her left lower extremity, bruising to her bilateral upper and lower extremities (purple/brown/red), a red/scab to her left knee, a small scab and bruise over her right calf, and an intermittent reddened groin. The record lacked evidence of notification to R1's primary care physician or responsible party. The Weekly Skin Check, dated 12/28/22, documented R1 had a previously identified areas to her skin. R1 had a skin tear to the back of her left lower extremity, bruising to her bilateral upper and lower extremities (purple/brown/red), a red/scab to her left knee, a small scab and bruise over her right calf, and an intermittent reddened groin. The record lacked evidence of notification to R1's primary care physician or responsible party. The Weekly Skin Check, dated 01/03/23, documented R1 had a previously identified areas to her skin. R1 had a skin tear to the back of her left lower extremity, bruising to her bilateral upper and lower extremities (purple/brown/red), a red/scab to her left knee, a small scab and bruise over her right calf, and an intermittent reddened groin. The record lacked evidence of notification to R1's primary care physician or responsible party. The Skin/Wound Assessment, dated 01/03/23, documented the wound to R1's left knee measured 3.16 cm by 2.49 cm and was deteriorating. There was white slough covering the wound bed and redness all around the wound. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Wound Care Skin Integrity Evaluation, dated 01/05/23, documented the wound care company that the facility had evaluate pictures of wounds placed in the EMR, came to the facility to personally evaluate R1's left knee wound because they saw deterioration in the wound from the pictures. The evaluation documented R1 had a full thickness wound to her left knee. The left knee wound had moderate amount of exudate (fluid that leaks out of body vessels and tissues), measured 3.2 cm by 2.5 cm, and had serosanguinous (clear/bloody) drainage. The wound bed was 40% red with hypo-granulation tissue, 30% with yellow slough that was mucinous (soft/slimy) and 30 % black, soft eschar. The peri-wound (area around the wound) was inflamed, reddened, firm, excoriated, and fragile. The wound care specialist ordered a dressing change every other day to ensure dressing integrity and moist wound healing environment. The order directed for silver alginate (an anti-microbial dressing) to the wound bed to promote autolytic debridement (using the body's own defense mechanisms and fluids to liquefy eschar, slough, and other forms of necrotic tissue) and address the suspected critical colonization as evidenced by the increase in wound drainage, recalcitrant wound, and redness in the peri-wound. The order was written to cleanse the wound per facility protocol, apply skin protectant to the peri-wound, cut and fit silver calcium alginate to the wound bed, cover with non-bordered heel foam and secure with six-inch tape, and change every other day and as needed. The Treatment Administration Record (TAR), dated January 2023, lacked the wound care specialist orders for wound care from the visit on 01/05/23. The Nurse's Note, dated 01/09/23, documented R1's left knee was swollen, red, with thick scabbed edges. The wound was tender as noted by R1 was grinding her teeth and grabbing at staff's hands and fingers. Underlying connective tissue was visible and the wound was warm to the touch. The Weekly Skin Check, dated 01/10/23, documented R1 had new skin concerns that had been identified. The assessment documented R1 had stage 1 pressure ulcer (pressure injury where skin is red or discolored but not open) to her right hip, a fingernail mark to her right lower extremity, a skin tear to her right lower extremity, a skin tear to her left knee, a stage 4 pressure ulcer to her left knee, a skin tear to her front left lower extremity, a skin tear to the back of her left lower extremity, and stage 1 pressure ulcer to her right heel and a stage 1 pressure ulcer to her left heel. No measurements were provided. The Skin/Wound Assessment, dated 01/13/23, documented R1's left knee wound was deteriorating and measured 3.44 cm by 2.62 cm. The wound bed was 80% yellow slough and 20% eschar with redness noted all around the wound. The Nurse's Note, dated 01/13/23, documented R1 appeared to be lethargic, opened her eyes to her name and responded slowly with movements and responses. The Alert Note, dated 01/14/23, documented the on-line medical service was called regarding R1's increased lethargy, blood sugars ranging from 114 to 547, decreased appetite, multiple wounds to bilateral lower extremities, knee would that was red, swollen, and painful to the touch. The video conference call did not work so the nurse called into the on-line medical service on the phone and it was recommended to send R1 to the emergency room for evaluation of sepsis. R1's responsible party was notified and agreed for R1 to be sent to the emergency room and would meet R1 there. R1 was transported to the local emergency room . (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Alert Note, dated 01/14/23, documented R1 was being admitted to the local hospital with the diagnoses of sepsis, cellulitis, and osteomyelitis. The emergency room Department Report, dated 01/14/23, documented R1 presented to the emergency room s with concern for potential sepsis. The emergency room doctor documented he reviewed R1's prior medical record, specifically the last two visits by R1's primary care physician. Review of the chart indicated on the 11/18/22 visit, R1's primary care physician mentioned a skin tear to R1's left knee. Review of the chart indicated on the 12/23/22 visit R1's primary care physician, no wounds were mentioned. The report documented R1 had an exposed patella (knee) bone on the left knee. R1's white blood count (indicates infection) was elevated at 16.3. R1 appeared to be volume depleted on exam. The General Surgery Progress Note, dated 01/15/23, documented R1 had obvious osteomyelitis of the patella and intravenous (IV) antibiotics needed to be continued with local wound care. The Patient Transfer Form, dated 01/19/23, documented R1 was being transferred back to the facility. The transfer form documented R1 was being transferred back to the facility with the diagnosis of Methicillin Resistant Staphylococcus Aureus (MRSA-difficult to treat bacterial infection) osteomyelitis of the left knee. The transfer form directed the facility to administer IV Vancomycin (antibiotic) to R1's peripherally inserted central catheter (PICC) for six weeks and the dosage was to be per trough (the lowest level of the antibiotic in the blood) and kidney function. The facility was directed to clean R1's left knee with wound cleanser and cover with Xeroform (a type of wound dressing that can help keep wounds clean and promote healing), and then cover the Xeroform with a Mepilex (bordered dressing) daily. The transfer form ordered for R1's partial and full thickness wound to her lower extremities (not the knee wound) were to wash with CarraKlenz (a gentle, emulsifying, and safe solution for removing organic material, debris, and dead tissue from wounds) and pat gently dry then apply Mepilex bordered foams over the wounds. Pulsate mattress with turning regiment of at least every two hours at 30-degree intervals with TAPs system (a turn and position material that stays under the patient) in place using wedges. The transfer form continued to instruct the facility to float R1's heels with pillows as best as they could, pad bony prominences with pillows upon turning to make sure knees and feet are not pushing against each other, and if not contraindicated keep head of R1's bed below 30 degrees. On 01/23/23 at 11:00 AM, observation revealed R1 lying in bed on her left side in a fetal position due to contractures to her upper and lower extremities. There was a mattress along the wall of the left side of R1's bed. R1 was up against the mattress with her knees touching the mattress. R1 was dressed in a hospital gown with a sweater on her upper body. R1 did not respond to verbal stimuli. On 01/23/23 at 01:00 PM, observation revealed R1 laying in a fetal position on her left side. R1 was clear up against the mattress along the wall and the left side of her bed. R1 raised her head to her name and looked at this surveyor. On 01/23/23 at 03:30 PM, observation revealed R1 laying in a fetal position on her left side with her forehead and nose, hands, and knees against the mattress along the wall and the left side of her bed. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/23/23 at 10:30 AM, Administrative Nurse D stated that she had started taking pictures of R1's knee on 11/21/22 and that was when the area to R1's left knee was new. Administrative Nurse D stated she was unsure why the floor nurses did not monitor R1's knee wound better and notify the physician. Administrative Nurse D stated the wound care specialist company the facility has on staff monitor the EMR for pictures of wounds and when the wound care specialist saw the wound had deteriorated from 11/21/22, 12/19/22, and 01/03/22 when pictures had been taken the wound care specialist came to the facility on [DATE] personally to visualize the wound. The wound specialist ordered a dressing change every other day to R1's left knee. Administrative Nurse D stated that she herself ordered the supplies for the dressing change that day, but the dressing supplies did not arrive to the facility until 01/12/23. Administrative Nurse D stated she thought R1's left knee wound have happened, because R1 was up against the wall in her room and her left knee was rubbing against the wall. Administrative Nurse D stated someone, she did not know who or when, put a mattress against the wall between R1's bed and the wall to protect R1's knees. On 01/23/23 at 02:00 PM, Certified Nurse's Aide (CNA) M stated R1 was not on a turning/repositioning program, but she just did it when she was working because she knew R1 could not reposition herself. CNA M stated she did not know what R1's care plan said about repositioning. On 01/23/23 at 02:30 PM, Licensed Nurse (LN) G stated the nurses were covering the left knee wound to keep R1 from picking at it. LN G stated she did not know why the wound deterioration was not reported to the physician, because she was only there two days a week. The facility's Wound Treatment Management, policy, dated 01/01/20, documented it was the facility's policy to promote wound healing of various types of wounds, to provide evidence-based treatments in accordance with standards of practice and physician orders. In the absence of treatment orders, the licensed nurse will notify the physician to obtain treatment orders. The effectiveness of treatments will be monitored through on-going assessment of the wound. Considerations for needed modifications include lack of progression toward healing and changes in the characteristics of the wound. The facility's Skin Assessment policy, dated 01/01/20, documented it was the facility's policy to perform full body skin assessments as part of the facility's systematic approach to pressure injury prevention and management. A full body, or head to toe, skin assessment will be conducted by a licensed nurse or registered nurse upon admission/re-admission and weekly thereafter. The assessment may also be performed after a change in condition or after newly identified pressure injury. Facility staff are to note any skin conditions such as redness, bruising, rashes, blisters, skin tears, open areas, ulcers, and lesions. Assessments will be documented in the EMR and include date and time of the assessment, name and title of person completing the assessment, document observations, document type of wound, describe the wound (measurements, color, type of tissue in wound bed, drainage, odor, pain), and document other information as indicated. The facility failed to identify and provide appropriate interventions to prevent pressure ulcers and failed to involve the physician, implement treatment orders, and consistently monitor wound status to promote healing, and prevent infection. This deficient practice placed R1 at risk for hospitalization , infection, and long-term treatment for infection. The facility implemented the following corrections to address the immediacy which was verified on 01/24/23: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. A facility wide skin sweep was completed on 1/23/23 to ensure that all active wounds in the facility were appropriately assessed and had current treatment. 2. The skin sweeps were reviewed by management nurses on 01/24/23 to ensure current pressure wounds were assessed and up to date with current assessments. 3. On 1/23/23, a Regional Consultant reviewed the Braden assessment for current residents. A preventative care plan was initiated for active residents and interventions placed on the Kardex for direct care staff for focus on prevention of pressure ulcers. 4. On 1/23/23, a Regional Consultant reviewed resident orders for those with pressure wounds to ensure that they had current treatment in place. If the treatment was not effective, a nurse requested a new treatment. 5. The charge nurses, and management nurses notified the physician and families to ensure they were aware of the current pressure ulcers for each resident affected on 1/24/23 by 1000. 6. As of 1/24/23, facility was implementing shower sheets to be completed with resident's shower that nursing assistants document skin integrity concerns on to report to the charge nurse on duty; the charge nurse will complete the wound protocol and sign off and turn into nursing management. 7. The facility held an Ad Hoc QAPI meeting on 1/24/23. The Administrator, ADON, Regional Consultant, Resident Care Coordinator and Medical Director attended. After removal of the immediacy, the citation remained at a scope and severity of a G