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	05/04/2023

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 60 residents, the sample included 17 residents, with two reviewed for activities of daily living (ADL). Based of observation, record review, and interview, the facility failed to provide appropriate cares to include grooming for Resident (R) 34, observed wearing dirty clothes for two out of four days on survey, and failed to assist R34 during meal service as he ate his meal with a knife only. This placed the resident at risk for poor hygiene and injury while eating with the knife. Findings included: - The Electronic Medical Record (EMR) for R34 documented diagnoses of dementia without behavioral disturbance (progressive mental disorder characterized by failing memory and confusion), need for assistance with personal care, other symptoms and signs involving cognitive functions and awareness, and other symptoms and signs involving appearance and behavior. R34's Quarterly Minimum Data Set (MDS), dated [DATE], documented R34 had severely impaired cognition, and required extensive assistance of two staff for personal hygiene, toileting, dressing, transfers, and bed mobility. The MDS further documented R34 required extensive assistance of one staff for eating. The Care Plan, dated 03/16/23, initiated on 09/03/20, documented R34 could eat independently after set up, preferred to wear a clothing protector, the staff were to anticipate and meet the resident's needs, and remind R34 the importance of hygiene. On 05/01/23 at 12:11 PM, observation revealed R34 sat at the dining table eating the noon meal with a knife. Further observation revealed staff did not notice he ate with the knife until the surveyor told them. On 05/02/23 at 11:26 AM, observation revealed R34, sat at the dining table eating the noon meal, did not have on a clothing protector. Further observation revealed R34 was unshaven, hair appeared disheveled on the top of his head, and he had multiple dried food stains on his black sweat pants and green short sleeved shirt. On 05/04/23 at 11:45 AM, observation revealed R34, sat in the dining room, hair disheveled, left sock pulled down, almost off his foot, and black sweat pants appeared/looked dirty with dry food stains. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/03/23 at 11:41 AM, Certified Nurse Aide (CNA) M stated R34 should always look presentable but did have times he would become combative. CNA M further stated, he should not have had a knife to eat, as he usually required a spoon to eat. On 05/03/23 at 08:50 AM, Licensed Nurse (LN) G stated if R34's clothing were dirty, staff should change them as he always would be dressed nice and liked to look good, prior to his admission to the facility. LN G said the staff should not allow him to eat his meals with a knife. On 05/04/23 at 01:39 PM, Administrative Nurse D stated staff should have corrected R34 while eating with a knife and stated R34's clothes should be changed if they are dirty and although R34 was at times combative, the staff should try to keep him clean. The facility's Meal Supervision and Assistance policy, dated 09/9/20, documented the resident would be prepared for a well-balanced meal in a calm environment, location of his/her preference and with adequate supervisor and assistance to prevent accidents. Provide adequate nutrition and assure an enjoyable event. The included identifying hazard and risk, implementing interventions to reduce hazards and risk, and monitoring for effectiveness and modifying interventions when necessary. The facility's Promoting/Maintaining Resident Dignity, dated 01/01/2020, documented staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. The policy further documented groom and dress residents according to resident preferences. The facility failed to provide appropriate cares for grooming for cognitively impaired R34, who had dirty clothes, two out of four days on survey, and failed to assist R34 during meal service as he ate his meal with a knife. This placed the resident at risk for poor hygiene and injury while eating with the knife.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 60 residents. The sample included 17 residents with one reviewed for positioning and two reviewed for skin issues. Based on observation, record review, and interview the facility staff failed to provide care and treatment in accordance with professional standards of practice when staff failed to monitor and provide care for Resident (R)9's venous ulcers (a shallow wound that develops on the lower leg when the leg veins fail to return blood back toward the heart normally) and staff failed to complete weekly skin assessments, and failed to change her lower legs dressing, when the odiferous serosanguinous drainage seeped through her to her outer dressing. Staff further failed to provide instructions for staff on how to care for R12's skin tear and/or to monitor her skin tear. Staff failed to reposition R44 when she leaned over to the right without support. This placed the residents at risk for inappropriate care. Findings included: - R9's Electronic Medical Record EMR documented R9 had diagnoses of diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), venous insufficiency(a condition in which the flow of blood through the veins is blocked, causing blood to pool in the legs) of the lower legs with ulcer (an open sore),dementia (progressive mental disorder characterized by failing memory, confusion), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). R9's Annual Minimum Data Set (MDS), dated [DATE], documented R9 had a Brief Mental Status (BIMS) of 14, which indicated intact cognition. The MDS documented R9 required extensive staff assistance with bed mobility, transfers, toilet use, personal hygiene, and dressing, supervision with eating and locomotion on and off unit. The MDS documented had two venous ulcers. R9's Activities of Daily Living (ADLs) Care Area Assessment CAA, dated 04/14/23, documented R9 required extensive staff assistance with bed mobility, had venous ulcer to leg, risk for further decline in ADLS. R9's Skin Integrity Care Plan, revised 01/11/23, instructed staff to provide preventative measure that would keep her skin intact, avoid over during the skin, ensure R9 received adequate protein and increase caloric intake. R9's Venous Insufficiency Care Plan, revised 01/11/23, instructed staff to elevate R9's feet when resting, ensure she had on proper fitting footwear, and inspect R9's foot/ankle/calf skin for changes (redness, purple tinge, tenderness, areas with no sensation. The April 2023 Medication Administration Record (MAR) instructed staff to monitor R9's dressing to the right shin and left lower leg every shift and replace if it was missing or soiled. The MAR had check marks on every shift every day. R9's Clinical Record documented the hospice nurse scheduled to visit the facility to change R9's dressing Monday, Wednesday, and Friday. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R9's Clinical Record from 04/01/23 to 04/30/23, revealed documentation staff notified hospice once regarding R9's wound dressings had come off, and the hospice nurse came to the facility and provided a dressing change for R9's lower leg wounds. The clinical record lacked documentation regarding facility staff providing R9 a dressing change in between hospice nurse's routine dressing changes. The Weekly Skin Assessments from 04/01/23 to 04/30/23 lacked documentation regarding odor, size, color of R9 s lower leg wounds. On 05/01/23 at 8:42 AM, observation revealed R9 sat in a wheelchair in the hall outside her room, odor noted, wound dressings seeping to the outside of the dressings with serosanguinous (a thin and watery fluid that is pink in color) drainage. Further observation revealed staff asked the resident to go on down to the dining room for breakfast and R9 stated she had been trying to get the nurse to change her lower leg dressings all weekend because they were saturated and smelled. On 05/01/23 at 10:30AM, observation revealed the resident lying in bed and the Hospice Nurse (HP) lifted her right foot to reveal a wet area on the mattress where the wound dressing had touched the mattress. The HP removed the residents dressings, which were saturated with serosanguineous drainage. On 05/02/23 at 02:20 PM, Licensed Nurse (LN) H stated staff was unaware of the treatment for R9's ulcers on her lower legs due to the hospice nurse was trying different dressing changes, but if R9's dressings needed to be changed staff could call the hospice nurse anytime to come to facility and provide the dressing changes. On 05/04/23 at 09:15 AM, LN G stated staff placed check marks on the MAR if they checked R9's dressing to see if it was intact, if staff changed the dressing, they would record the dressing change in the progress notes. On 05/04/23 at 11:39 AM, Administrative Nurse D stated the facility staff should change R9's dressing as needed. The facility's Wound Treatment Management Policy, implemented on 01/01/2020, documented to promote wound healing of various type of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Dressing changes would be provided outside the frequency parameters if the dressing is soiled or is wet. The facility staff failed to provide R9's dressing changes for her lower leg wounds, when the dressing became saturated, odoriferous, and seeped serosanguinous drainage into the outer layer of the dressing. This placed the resident at risk for infection. 32360 - The Electronic Medical Record (EMR) for R12 documented diagnoses of traumatic brain injury (an injury that affects how the brain works), unsteadiness on feet, impulse disorder (urges and behaviors that are excessive and/or harmful to oneself or others), and muscle weakness. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12's Annual Minimum Data Set (MDS), dated [DATE], documented R12 had intact cognition and required extensive assistance of two staff for toileting, personal hygiene, extensive assistance of one staff for dressing. The assessment further documented R12 had no skin issues. The Care Plan, dated 03/30/23, documented a potential for skin tears related to fragile skin and directed staff to identify potential causative factors and eliminate, resolve, when possible, keep skin clean and dry, use lotion on dry scaly skin, monitor/document location, size and treatment of skin tear and report abnormalities, failure to heal, signs and symptoms of infections, to the physician, and treatment as ordered, The EMR lacked documentation how R12 received the skin tear to his left forearm or treatment of the skin tear. On 05/01/23 at 08:11 AM, observation of R12's left forearm had a gauze dressing partially exposing a healing skin tear with steri-strips. On 05/03/23 at 11:52 AM, Certified Nurse Aide (CNA) M stated while she assisted R12 in the bathroom, he got angry and swung his arm back and obtained the skin tear from the grab bar on the wall by the toilet. On 05/03/23 at 09:00 AM, Licensed Nurse (LN) G stated they just keep his skin tear covered, but was unable to address how R12 received the skin tear. On 05/04/23 at 12:34 PM, Administrative Nurse D stated R12 obtained the skin tear after a fall and verified the fall investigation did not address R12 received a skin tear at the time of the fall or any treatment he received for the skin tear. 05/04/23 at 01:39 PM, Administrative Nurse D stated she would expect a thorough investigation related to the skin tear and the treatment be placed on the Medication Administration Record (MAR). The facility's Wound Treatment Management policy, dated 01/01/2020, documented wound treatments would be provided in accordace with physician orders, including the cleansing method, type of dressing, and frequency of dressing change and treatments would be documented on the treatment administration record. The facility failed to monitor a skin tear for R12. This placed the resident at risk for infection. - The Electronic Medical Record (EMR) for R44 documented diagnoses of stiffness of unspecified shoulder and hand, diabetes mellitus type two (a chronic condition that affects the way the body processes blood sugar glucose), and neurocognitive disorder with lewy bodies (a disease associated with abnormal deposits of a protein in the brain). R44's Quarterly Minimum Data Set (MDS), dated [DATE], documented R44 had severely impaired cognition and required extensive assistance of 2 staff for bed mobility, transfer, dressing, locomotion on and off the unit, toileting, and personal hygiene. The MDS further documented R44 had no functional impairment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan, dated 02/23/23, documented R44 had limited physical mobility and received cervical stretching to improve stretching and directed staff to lay R44 down after meals as she allows and keep the resident within visual of nursing when in her wheelchair. The Occupational Therapy Progress Report, dated 04/14/23, documented R44, dependent upon her wheelchair, had stiffness in her shoulder and hand. The progress report documented R44 would increase her ability to achieve and maintain forward head posture from 9 to 7 to set up while seated in her wheelchair to achieve proper joint alignment. On 05/01/23 at 09:51 AM, observation revealed, R44 in her room, seated in her wheelchair, her body leaned to the right with her right arm at her side, wedged tight between her side, and the right arm rest. On 05/02/23 07:08 AM, observation revealed, R44's feet, off the foot pedals, body leaned to the right and slightly forward without support to keep her straight in her wheelchair. On 05/03/23 at 08:45 AM, observation revealed, R44, body leaned to the right and slightly forward, and both feet wedged between the foot pedals. On 05/03/23 at 11:46 AM, Certified Nurse Aide (CNA) M stated R44 leaned to the right a lot and she had wanted therapy to put something in the wheelchair for support, but that had not happened yet. CNA M further stated staff reposition R44 when she leaned to the right. On 05/03/23 at 01:00 PM, Consultant Staff HH stated if R44's hips were not positioned back in the wheelchair, she would lean to the right. Consultant Staff HH further stated he had an in-service for the staff to show them how she was to be positioned in the tilt wheelchair and would expect them to make sure she was positioned correctly. On 05/04/23 at 01:39 PM, Administrative Nurse D stated staff should make sure R44 was positioned correctly in the wheelchair, so she did not lean and make sure staff tilted the wheelchair back to reposition her. The facility's Turning and Repositioning policy, dated 01/01/2020, directed staff to provide adequate seat tilt to prevent sliding forward, ensure the feet are properly supported on footrests, utilize positioning devices as needed to maintain posture, and if the resident was unable to make position changes on their own, reposition every 1-2 hours as tolerated. The facility failed to provide the necessary cares and services to ensure appropriate wheelchair positioning for R44, placing the resident at risk for pain and decreased function.

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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** 32360 The facility had a census of 60 residents. The sample included 17 residents, with four reviewed for pressure ulcers. Based on observation, record review, and interview, the facility failed to prevent ulcers for two sampled residents: Resident (R) 54, who obtained a facility acquired stage 3 (full thickness tissue loss) and R208, who obtained a facility acquired stage 2 (shallow with a reddish base) pressure ulcer. The facility further failed to ensure weekly monitoring of skin conditions to assess wound status including wound bed, healing, and effectiveness of treatments for R54 and R208. This deficient practice placed those residents at risk for delayed healing or worsened wounds. Findings included: - The Electronic Medical Record (EMR) for R54 had diagnoses of hypertension (high blood pressure), asthma (a respiratory condition in which the bronchial airways in the lungs become narrowed and swollen, making it difficult to breath), and need for assistance with personal care. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R54 had intact cognition, depended upon two staff for transfers and toileting, required extensive assistance of two staff for bed mobility, and extensive assistance of one staff for dressing, eating, and personal hygiene. The MDS further documented R54 had lower functional impairment on one side, at risk for skin breakdown, pressure device for bed and chair, no turning or repositioning program, and had moisture associated skin damage (MASD). The Pressure Ulcer Care Area Assessment (CAA), dated 12/18/22, documented R54 had the potential for pressure ulcers due to the need for extensive assistance with bed mobility, frequently incontinent with urine and always incontinent with bowel. The CAA further documented R54 had MASD and did not have a pressure ulcer but was at risk. The Braden Scale Assessment, (formal assessment for predicting pressure ulcer risk) dated 12/04/22, 12/12/22, 01/04/23, 01/12/23, and 04/10/23, revealed R54 was a moderate risk for breakdown. The Skin Integrity Care Plan, dated 03/23/23, originally dated 12/13/22, directed staff to educate R54 and family to the causes of skin breakdown, encourage to report pain that may prevent repositioning monitor nutrition intake. The update, dated 01/23/23, directed staff to not massage reddened body prominence, ensure adequate protein intake, observe, and assess weekly, refer to dietician with skin concerns, use commercial moisture barrier on skin as indicated, and use pressure redistribution surface to bed and wheelchair, if indicated. The Nutritional Assessment, dated 03/16/23, documented R54 had no supplements, snacks available, and intact skin. The Skin and Wound Evaluation, dated 04/14/23, documented R54 had a stage 3 pressure ulcer on his coccyx (a small triangular bone at the base of the spinal column), which measured 0.8 centimeter squared (cm2) area, 1.5 centimeter (cm) long x 0.9 cm wide, in house acquired, and unknown on how long it was present. The skin evaluation lacked documentation of wound bed, type of odor or drainage, periwound and surrounding tissue, treatment, and modalities. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Physician Order, dated 04/18/23, directed staff to administer amoxicillin-clavulanic acid (an antibiotic to treat infections), 875-125 milligrams (mg), one by mouth every 12 hours, daily for 10 days, for infection. The Physician Order, dated 04/19/23 (five days after finding the pressure ulcer) , directed staff to apply padded foam to sacral/coccyx area and monitor for increased discoloration, decreased blanching, open area, warmth, redness, bleeding, and drainage, every day shift for skin integrity. The Physician Order, dated 04/22/23, directed staff to apply duoderm (a waterproof dressing) or padded foam and monitor for increased discoloration, decreased blanching, open area, warmth, redness, bleeding and drainage, every day shift for skin integrity. The Skin and Wound Evaluation, date 04/21/23, documented R54 had a stage 3 pressure ulcer on his coccyx, which measured 2.5 cm2 area, 2.9 cm length, 1.2 cm wide, in house acquired, unknown how long it was present. The skin evaluation lacked documentation of wound bed, type of odor or drainage, periwound and surrounding tissue, treatment, and modalities. The EMR documented R54 was discharged to the hospital for respiratory infection on 04/22/23. On 05/03/23 at 09:48 AM, Dietary Consultant GG stated she knew R54's skin was reddened but did not know of the pressure ulcer. Dietary Consultant GG further stated she was in the facility on 04/18/23 and the paperwork provided from the facility documented to review his chair for skin issue, but she failed to do so. Dietary Consultant GG stated she would have recommended vitamins for him but since it was already a stage 3, she did not know if it would have helped. On 05/03/23 at 11:14 AM, Administrative Nurse E stated, she was out of the facility when the pressure ulcer was found and unsure why it took several days to obtain treatment for the pressure ulcer. On 05/03/23 at 11:44 AM, Certified Nurse Aide (CNA) M stated R54 did not have any skin breakdown prior to his discharge. CNA M further stated he was not feeling well and required a lot of assistance. On 05/04/23 at 01:39 PM, Administrative Nurse D stated the skin assessments should have been completed at the time of assessment and treatment for the pressure ulcer should not have been delayed. Administrative Nurse D further stated, she had been out of the facility for training and would make sure the whole team meet with the Registered Dietician when reviewing residents. The facility's Pressure Injury Prevention and Management policy, dated 01/01/2020, documented the facility was committed to the prevention of unavoidable pressure injuries and the promotion of healing of existing pressure injuries. The policy further documented the facility would establish and utilize a systemic approach for pressure injury prevention and management, including prompt assessment and treatment, intervening to stabilize, reduce or remove underlying risk factors, monitoring the impact of the interventions, and modifying the interventions as appropriate. The facility failed to implement preventative interventions, and delayed treatment of a facility acquired stage 3 pressure ulcer, this placed the resident at risk for further skin breakdown. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	26768 - R208's Electronic Medical Record documented diagnoses of type 2 diabetes (chronic condition that affects the way the body processes blood sugar (glucose), paraplegia (he loss of muscle function in the lower half of the body, including both legs), obesity (overweight), leukemia (cancer of blood-forming tissues, hindering the body's ability to fight infection), and chronic pain. The Admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R208 required supervision for eating, limited staff assistance for hygiene, dressing, and extensive assistance for transfers, bed mobility, and locomotion. The MDS documented rejection of care daily, R208 had one Stage 2 (partial thickness loss of dermis (skin) presenting as a shallow open ulcer with a red or pink wound bed, intact or ruptured blister) pressure ulcer (PU), lesion on foot, and Moisture Associated Skin Damage (MASD). The MDS documented interventions were pressure relief to chair and bed, nutrition, pressure ulcer care, dressings, and ointments. The Pressure Ulcer Care Area Assessment (CAA), dated 04/11/23, documented the resident had a Stage 2 PU to the coccyx and multiple wounds. The assessment stated R208 required extensive assistance with bed mobility and was always incontinent of bowel, placing him at risk for further pressure ulcers and worsening of his wounds. The Skin Care Plan, dated 04/06/23, directed staff to educate R208 on the causes of skin breakdown, which included frequent repositioning and staff were to encourage him to report pain that may prevent repositioning. The facility would provide a low air loss mattress (check function) and treatment as ordered. The 04/08/23 update documented the air mattress was changed twice this day. The 04/20/23 update stated all staff were provided education on air mattress function. The Progress Note, dated 04/05/23 at 06:55 PM, documented R208 arrived at the facility per facility transport, in a wheelchair, and able to verbalize needs. Devices to include air mattress and wheelchair, wound care to left heel and left knee. The Admission Nursing Assessment, dated 04/06/23 at 04:02 AM, lacked documentation of any redness or open skin to R208's buttocks or coccyx. The Progress Note, dated 04/06/23 at 04:03 AM, documented staff assessed the resident for a low air loss mattress and put the mattress in place for R208 for optimal pressure reduction, positioning, and safety per assessed needs of this resident. The Progress Note, dated 04/08/23 at 05:01 PM, documented R208 complained off and on today of his bed not working and staff changed the settings multiple times. Staff were unable to keep the mattress inflated fully and placed a new one on his bed. R208 refused initially to switch mattresses, but finally agreed. The Physician Order, dated 04/08/23, directed staff to apply skin prep to the coccyx (tailbone) region, cover with foam for protection, and monitor and change daily as needed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Progress Note, dated 04/11/23 at 08:53 AM, documented the physician saw R208 with telemedicine on 04/07/23. The physician ordered for staff to continue current care, and Wound Care to evaluate a pressure ulcer of buttock, Stage 2. The note stated the order was faxed to the wound care clinic. The facility's Wound Evaluation, dated 04/12/23, (seven days after admission) documented a right buttock wound measuring 7.44 centimeters (cm) by 1.23 cm. The evaluation lacked any further characteristics or assessment. The Treatment Administration Record (TAR), documented on 04/12/23 staff added Check function of air mattress every shift. The Progress Note, dated 04/13/23 at 04:34 AM, documented R208 did not want to participate in wound care and declined a nursing assessment to coccyx and the reddened skin there. The Progress Note, dated 04/15/23 at 01:36 AM, documented R208 refused wound dressing changes after multiple attempts made by this nurse. The Weekly Skin Check, dated 04/17/23, documented foam to coccyx for redness. The Weekly Skin Check, dated 04/21/23, was incomplete, without measurement or description. The Wound Evaluation, dated 04/21/23 (nine days after the last evaluation), documented a right buttock wound measuring 7.77 cm by 3.73 cm. The evaluation lacked any further characteristics or assessment. The Discharge Assessment, dated 04/27/23, documented R208 required wound care daily to left foot, coccyx, buttocks with bordered foam dressing, April 2023 Grievance Log lacked documentation for R208's concerns. On 05/03/23 at 10:08 AM, Maintenance Staff U stated he had fixed an air mattress last month. He reported the air mattress for R208 had a kink in the air line and he removed the air mattress put new one on. On 05/02/23 at 10:25 AM, R208 stated the air bed failed, deflated, and staff left him on the deflated air mattress all weekend. He stated the pressure caused a new open area on his buttocks. On 05/03/23 at 12:13 PM, CNA N stated she worked the first and second day R208 was admitted to the facility. CNA N stated staff changed his air mattress the first day he was here within a couple of hours of arrival due to three air lines in the mattress did not fill. She stated R208 did not like the larger air mattress and thought it was going flat, but he liked to sit up 90 degrees which caused pressure on his bottom. CNA N stated staff changed the whole mattress five times and maintenance staff changed settings on the motor several times in attempt to please him. On 05/03/23 at 12:20 PM, Licensed Nurse (LN) I stated she did not see any open areas on R208's buttocks, just discoloration. She reported skin care interventions included an air mattress, float heels, and skin prep to buttocks every three days. (continued on next page)

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	05/04/2023

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 - Actual harm Residents Affected - Few	On 05/04/23 at 10:20 AM, Administrative Nurse D stated the measurements indicated the wound got bigger. Administrative Nurse D stated when staff noted there was a problem with the air mattress staff offered the resident other mattresses. She stated R208 was non-compliant with wound care and refused skin assessments and treatment. The facility's Pressure Ulcer Prevention and Management policy, dated 01/01/20, stated the facility would establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment, reduce or remove underlying risk factors, monitoring the impact of interventions and modifying interventions as appropriate. Assessment of pressure injuries would be performed by a licensed nurse weekly and the staging of pressure injuries would be clearly identified to ensure correct coding on the MDS. The facility failed to prevent the development of a pressure ulcer after placing R208 on a faulty air mattress, placing R208 at risk for a pressure injury.