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LAKEPOINT EL DORADO, LLC	1313 S HIGH STREET EL DORADO, KS 67042

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Facility Resurvey. This 2567 was electronically sent to the facility on 8/19/21.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		

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

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§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 51 residents with 16 selected for review. Based on interview and record review, the facility failed to ensure the development of a base line care plan for one selected resident (R)55, within 48 hours of admission and to include the minimum healthcare information necessary to properly care for a resident.

Findings included:

- Review of R55's "Transfer Sheet," from acute care, dated 06/29/21, revealed diagnoses included congestive heart failure (a condition with low heart output and the body becomes congested with fluid) chronic kidney disease, profound bradycardia (low heart beat) and mitral regurgitation (backflow of blood into the heart chambers).
The resident expired on 07/03/21 before completion of the "Minimum Data Set (MDS)." (due on 07/12/21)

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F 655	Continued From page 2 The resident's medical record lacked a baseline care plan as required, within the first 48 hours following admission to the facility. A "Physician's Order," dated 06/29/21, instructed staff to obtain hospice services for the resident. Review of "Nurses' Notes," dated 06/29/21, revealed the resident was alert to family only, had diminished lung sounds, a productive cough and shortness of air. The resident had a urinary catheter in place with red colored output. The resident required assistance of two staff for bed mobility and transfer. A "Nurse's Note," dated 06/30/21, revealed the resident pulled out his urinary catheter and was sent to acute care for evaluation. The resident returned to the facility the same day. Interview, on 08/17/21 at 12:14 PM, with Administrative Nurse D, revealed she would expect staff to develop a baseline care plan within 48 hours and confirmed the lack of the baseline care plan with instructions for this resident with multiple health issues and care needs. The facility policy "Resident Directed Care Plan," undated, instructed staff to develop an interim temporary care plan at the time of admission. The facility failed to develop a baseline care plan for this resident as required within 48 hours of admission to the facility to include care instructions for this resident with multiple health issues and care needs.	F 655		
F 657	Care Plan Timing and Revision	F 657		

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F 657 SS=D	Continued From page 3 CFR(s): 483.21(b)(2)(i)-(iii)	F 657		

§483.21(b) Comprehensive Care Plans
§483.21(b)(2) A comprehensive care plan must be-
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 51 residents with 16 selected for review. Based on observation, interview and record review, the facility failed to review and revise the care plan for one resident (R)13, who developed stage three pressure ulcer to her coccyx and stage four pressure ulcer to her left shin, after determining

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the heel lift device caused the pressure injury to her shins.

Findings Included:

Review of R13's "Physician Order Sheet," dated 08/12/21, revealed diagnoses of thoracic (mid spine) and lumbar vertebra (lower spine) fracture, and peripheral autonomic neuropathy (nerve pain in the arms and legs.)

The "Admission Minimum Data Set" (MDS), dated 02/26/21, assessed the resident had normal cognitive function, required extensive assistance of two staff for bed mobility and transfer, no impairment in range of motion in her upper or lower extremities, was at risk for pressure ulcer development and with no current pressure ulcers. This MDS lacked documentation of pressure relieving devices used for the bed or chair. The resident received dressing care for moisture associated skin damage. The resident was always incontinent of bowel and bladder.

The "Quarterly Minimum Data Set" (MDS), dated 05/26/21, assessed the resident had moderate cognitive impairment, required extensive assistance of two persons for bed mobility and transfer, and no impairment in range on motion of the upper or lower extremities. The resident was at risk for pressure ulcers and had two stage two pressure ulcers. The resident had a pressure relieving device for the bed and chair and received pressure ulcer treatment. The resident was always incontinent of bowel and bladder.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 03/08/21, assessed the resident

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admitted to acute care with intractable (continuous) pain and debilitation (weakness.) The resident has known compression fractures (when forced together bone surfaces caused a bone to break) due to osteoporosis (thinning bones) with moisture associated wound due to incontinence. The resident had chronic pain.

The "Care Plan" reviewed 05/26/21, instructed staff to assist the resident to turn and position routinely every two to three hours, and to utilize pillows or wedges to maintain position in her bed or recliner. Staff were to ensure a cushion remained in her chair and pressure reducing mattress on the bed as standard protocol. Staff were to monitor the resident's skin daily. An entry dated 04/19/21, documented the resident developed two stage two pressure ulcers to her left outer skin from the heel lifter. An entry dated 07/06/21, documented the resident developed a stage two pressure ulcer to her coccyx and right buttock that progressed to a stage three pressure ulcer. The care plan lacked alternative methods for off loading her heels or pressure relief measures for her shins.

Review of the physician orders revealed the following:

03/21/21 Use heel float while in bed (a device that elevates the heels off the surface of the bed.)
06/09/21 Cleanse ulcers to the left outer shin with normal saline, apply Med honey (a honey-based substance used to treat wounds) and cover with an Optifoam (a type of foam dressing) dressing twice a week.

Review of the "Physician Progress Notes," from

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04/26/21 through 08/13/21, revealed the physician made frequent adjustments to pain medications.

A "Physician Progress Note," dated 05/13/21, revealed the resident's wounds were healing and the physician increased R13's gabapentin (a medication used to treat nerve pain) dose increased due to peripheral neuropathy.

A "Physician Progress Note," dated 06/09/21, revealed the resident developed wounds on both of her legs and experienced pain with movement. The right leg wound was much deeper with poor circulation.

A "Nurses' Note" dated 05/17/21, documented the resident developed two stage two pressure ulcers to her left outer shin from the heel lifter on her bed. One ulcer measured 3.0 centimeters (cm) by 0.7 cm by 0.2 cm with 80 % (percent) necrotic (dead) tissue in the wound bed and 20% slough (dead cells that accumulate) tissue. The lower pressure ulcer measured 2.3 cm by 1.5 cm by 0.2 cm. This wound bed had 70% necrotic tissue and 30% granulated tissue with moderate amount of serosanguinous (blood and clear fluid) drainage. The right calf stage two pressure ulcer measured 3.5 cm by 0.7 cm and staff cleaned all pressure ulcers with normal saline. The staff applied Silver Alginate (a substance with silver used to heal wounds) and covered it with an Optifoam dressing. This note documented staff removed the heel lifter from her bed.

A "Nurses' Note," dated 06/07/21, documented the resident developed two pressure ulcers to her left outer shin from the heel lifter, which

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measured as 1.5 cm by 0.5 cm by 0.2 cm and 1.0 cm by 1.0 cm by 0.2 cm. The wounds had 100% granulated (healing) tissue in the wound beds with a moderate amount of bloody drainage. The resident also had a stage two pressure ulcer to her right calf measuring 1.1 cm by 0.8 cm by 0.3 cm. Staff cleansed all wounds with normal saline and Silver Alginate and applied a foam dressing.

The "Wound Identification and Assessment" tab in the electronic medical record, documented the following wounds:

04/19/21 Deep tissue injury to left outer shin 1.5 cm by 0.5 cm.
04/26/21 Left shin stage two, 2 cm by 6 cm by 0.1 cm.
05/03/21 Left shin 3 cm by 1.2 cm by 0.1 cm.
05/13/21 Right posterior shin stage two partial thickness pressure ulcer measuring 4.5 cm by 2.1 cm by less than 0.1 cm with serous (clear/light yellow) drainage.
06/29/21 The right calf ulcer as a stage three full thickness pressure ulcer measured as 5.5 cm by 2.5 cm by 0.4 cm with moderate bloody drainage and rolled edges.
07/30/21 The right calf ulcer healed.
07/30/21 Left shin 1 cm by 0.7 cm by 0.2 cm with a large amount of bloody exudate (drainage), with rolled edges, a partial thickness stage two pressure ulcer.
08/06/21 left lateral shin stage four 100% beefy red with bloody exudate, rolled edges, and measured 8 cm by 1.5 cm by 0.5 cm.
08/10/21 Left lateral shin 9.5 cm by 2 cm by 0.5 cm with bloody exudate stage four pressure ulcer.

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Observation on 08/11/21 at 02:42 PM revealed the resident positioned on her back in her bed with an off-loading heel device in place on her bed.

Observation on 08/12/21 at 08:00 AM revealed the resident positioned in her bed on her back with an off-loading heel device in place on her bed.

Observation on 08/12/21 at 12:00 PM revealed the resident in bed with the off-loading heel device in place. Licensed Nurse (LN) I donned gloves and assisted the resident to turn and provided incontinent care for urine and stool. The resident had a dressing to her coccyx and with the same gloved hands, removed the dressing to reveal an open area approximately 2 cm by 1 cm with yellow slough

Observation on 08/12/21 at 01:28 PM revealed Administrative Nurse E placed the dressing supplies directly on the resident's bed. Administrative Nurse E washed her hands, applied gloves, and removed the resident's dressing to her left shin area. With the same gloved hands Administrative Nurse E cleansed the open area and measured it as 10 cm by 3 cm by 0.5 cm. The area was beefy red in color with a band of yellow white slough approximately 1 cm width extending the 10 cm length of the wound.

Interview on 08/12/21 at 02:00 PM with Administrative Nurse E revealed the resident always had the off-loading heel device in place on her bed, but thought the device caused the injury to her lower legs and probably should be

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removed from use. Administrative Nurse E confirmed at that time, the resident had a standard pressure reducing mattress that all residents were provided.

Interview on 08/12/21 at 02:30 PM with Administrative Nurse D revealed she did not know staff were still using the off-loading heel device. Administrative Nurse D stated she did not know the history of the resident's wounds, but staff should utilize other methods to relieve pressure if the off-loading heel device caused the injury.

Interview on 08/12/21 at 2:30 PM with Physician GG revealed the resident had severe pain that limited movement and she was adjusting pain medications for resident comfort. Physician GG confirmed the pressure area on the resident's left leg was severe and staff should provide measures to limit pressure. Physician GG confirmed the resident's coccyx open area required treatment with Medihoney and dressing changes.

Interview on 08/16/21 at 04:30 PM with Administrative staff D revealed she expected staff to provide interventions for pressure relief and when the determination that the device offloading heel device in question may have caused the pressure areas on the resident's shins, the device should be discontinued from use new interventions added to the care plan.

Interview, on 08/17/21 at 11:40 AM, with administrative Nurse F, revealed any staff can update the care plan with new interventions.
The facility policy "Pressure Ulcer Management,"

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F 657	Continued From page 10 undated, instructed staff to identify risk factors for the development of pressure ulcers. An immediate plan to reduce a resident's risk of pressure ulcers or to treat an existing pressure ulcer will be developed and implemented. The facility policy "Resident Directed Care Plans," undated, instructed staff to establish goals and appropriate interventions as well as ongoing evaluations with revisions. The care plan may be amended to ensure the resident receives appropriate care and services. The facility failed to review adn revise the plan of care for this resident related to the continued use of the offloading heel device that caused the resident's bilateral skin ulcerrs, and the lack of providing alternative pressure reliving measures for this dependent resident who developed pressure ulcers.	F 657		
F 686 SS=G	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	F 686		

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by:
The facility reported a census of 51 residents with 16 selected for review, which included four residents reviewed for pressure ulcers. Based on observation, interview, and record review, the facility failed to ensure appropriate pressure relieving interventions were in place for one resident (R)13, who had a worsening pressure ulcer on her lateral (side) shin area. In addition, the facility failed to provide sanitary pressure ulcer dressing changes for three residents, R13, R49 and R3, also reviewed for pressure ulcers.

Findings Included:

Review of R13's "Physician Order Sheet," dated 08/12/21, revealed diagnoses of thoracic (mid spine) and lumbar vertebra (lower spine) fracture, and peripheral autonomic neuropathy (nerve pain in the arms and legs.)

The "Admission Minimum Data Set" (MDS), dated 02/26/21, assessed the resident had normal cognitive function, required extensive assistance of two staff for bed mobility and transfer, no impairment in range of motion in her upper or lower extremities, was at risk for pressure ulcer development and with no current pressure ulcers. This MDS lacked documentation of pressure relieving devices used for the bed or chair. The resident received dressing care for moisture associated skin damage. The resident was always incontinent of bowel and bladder.

The "Quarterly Minimum Data Set" (MDS), dated 05/26/21, assessed the resident had moderate cognitive impairment, required extensive assistance of two persons for bed mobility and

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transfer, and no impairment in range on motion of the upper or lower extremities. The resident was at risk for pressure ulcers and had two stage two pressure ulcers. The resident had a pressure relieving device for the bed and chair, and received pressure ulcer treatment. The resident was always incontinent of bowel and bladder.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 03/08/21, assessed the resident admitted to acute care with intractable (continuous) pain and debilitation (weakness.) The resident has known compression fractures (when forced together bone surfaces caused a bone to break) due to osteoporosis (thinning bones) with moisture associated wound due to incontinence. The resident had chronic pain.

The "Care Plan" reviewed 05/26/21, instructed staff to assist the resident to turn and position routinely every two to three hours, and to utilize pillows or wedges to maintain position in her bed or recliner. Staff were to ensure a cushion remained in her chair and pressure reducing mattress on the bed as standard protocol. Staff were to monitor the resident's skin daily. An entry dated 04/19/21, documented the resident developed two stage two pressure ulcers to her left outer shin from the heel lifter. An entry dated 07/06/21, documented the resident developed a stage two pressure ulcer to her coccyx and right buttock that progressed to a stage three pressure ulcer.

Review of the physician orders revealed the following:

03/21/21 Use heel float while in bed (a device

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that elevates the heels off the surface of the bed.)
06/09/21 Cleanse ulcers to the left outer shin with normal saline, apply Medihoney (a honey-based substance used to treat wounds) and cover with an Optifoam (a type of foam dressing) dressing twice a week.

Review of the "Physician Progress Notes," from 04/26/21 through 08/13/21, revealed the physician made frequent adjustments to pain medications.

A "Physician Progress Note," dated 05/13/21, revealed the resident's wounds were healing and the physician increased R13's gabapentin (a medication used to treat nerve pain) dose increased due to peripheral neuropathy.

A "Physician Progress Note," dated 06/09/21, revealed the resident developed wounds on both of her legs and experienced pain with movement. The right leg wound was much deeper with poor circulation.

A "Nurses' Note" dated 05/17/21, documented the resident developed two stage two pressure ulcers to her left outer shin from the heel lifter on her bed. One ulcer measured 3.0 centimeters (cm) by 0.7 cm by 0.2 cm with 80 % (percent) necrotic (dead) tissue in the wound bed and 20% slough (dead cells that accumulate) tissue. The lower pressure ulcer measured 2.3 cm by 1.5 cm by 0.2 cm. This wound bed had 70% necrotic tissue and 30% granulated tissue with moderate amount of serosanguinous (blood and clear fluid) drainage. The right calf stage two pressure ulcer measured 3.5 cm by 0.7 cm and staff cleaned all pressure ulcers with normal saline. The staff

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applied Silver Alginate (a substance with silver used to heal wounds) and covered it with an Optifoam dressing. This note documented staff removed the heel lifter from her bed.

A "Nurses' Note," dated 06/07/21, documented the resident developed two pressure ulcers to her left outer shin from the heel lifter, which measured as 1.5 cm by 0.5 cm by 0.2 cm and 1.0 cm by 1.0 cm by 0.2 cm. The wounds had 100% granulated (healing) tissue in the wound beds with a moderate amount of bloody drainage. The resident also had a stage two pressure ulcer to her right calf measuring 1.1 cm by 0.8 cm by 0.3 cm. Staff cleansed all wounds with normal saline and Silver Alginate and applied a foam dressing.

The "Wound Identification and Assessment" tab in the electronic medical record, documented the following wounds:

04/19/21 Deep tissue injury to left outer shin 1.5 cm by 0.5 cm.
04/26/21 Left shin stage two, 2 cm by 6 cm by 0.1 cm.
05/03/21 Left shin 3 cm by 1.2 cm by 0.1 cm.
05/13/21 Right posterior shin stage two partial thickness pressure ulcer measuring 4.5 cm by 2.1 cm by less than 0.1 cm with serous (clear/light yellow) drainage.
06/29/21 The right calf ulcer as a stage three full thickness pressure ulcer measured as 5.5 cm by 2.5 cm by 0.4 cm with moderate bloody drainage and rolled edges.
07/30/21 The right calf ulcer healed.
07/30/21 Left shin 1 cm by 0.7 cm by 0.2 cm with a large amount of bloody exudate (drainage), with rolled edges, a partial thickness stage two

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pressure ulcer.
08/06/21 left lateral shin stage four 100% beefy red with bloody exudate, rolled edges, and measured 8 cm by 1.5 cm by 0.5 cm.
08/10/21 Left lateral shin 9.5 cm by 2 cm by 0.5 cm with bloody exudate stage four pressure ulcer.

Observation on 08/11/21 at 02:42 PM revealed the resident positioned on her back in her bed with an off-loading heel device in place on her bed.

Observation on 08/12/21 at 08:00 AM revealed the resident positioned in her bed on her back with an off-loading heel device in place on her bed.

Observation on 08/12/21 at 12:00 PM revealed the resident in bed with the off-loading heel device in place. Licensed Nurse (LN) I donned gloves and assisted the resident to turn and provided incontinent care for urine and stool. The resident had a dressing to her coccyx and with the same gloved hands, removed the dressing to reveal an open area approximately 2 cm by 1 cm with yellow slough. At that time LN I stated the resident had an order for barrier cream to her buttocks and applied the cream with the same gloved hands to the area around the open area. LN I stated she would need to check the orders for further care and that the wound nurse would be providing wound care to her lower extremities.

Observation on 08/12/21 at 01:28 PM revealed Administrative Nurse E placed the dressing supplies directly on the resident's bed.

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Administrative Nurse E washed her hands, applied gloves, and removed the resident's dressing to her left shin area. With the same gloved hands Administrative Nurse E cleansed the open area and measured it as 10 cm by 3 cm by 0.5 cm. The area was beefy red in color with a band of yellow white slough approximately 1 cm width extending the 10 cm length of the wound. Administrative Nurse E removed her gloves, and without performing hand hygiene, donned a clean pair of gloves and applied Medihoney from the tube and attempted to rub it into the wound with her gloved hand.

Observation on 08/16/21 at 02:56 PM revealed LN G and CNA Q prepared to provide dressing changes to the resident's pressure ulcers. LN G placed the dressing supplies directly on the resident's bed. LN G washed her hands, donned gloves, and removed the dressing from the resident's right lower leg (shin) and cleansed it with normal saline. The area contained an area of healed skin with thin scab formation. LN G squirted Medihoney onto the outside of the dressing package, applied the Medihoney to the scabbed area with a swab, and then applied a dressing. With the same gloved hands, LNG removed the dressing from the resident's left leg and cleansed the wound with normal saline. LN G again squirted the Medihoney to the outside of the dressing package, applied the Medihoney with a swab, and then applied a dressing. The resident's coccyx did not contain a dressing over the open area with slough, to which LN G applied barrier cream.

Interview on 08/12/21 at 02:00 PM with Administrative Nurse E revealed the resident

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always had the off-loading heel device in place on her bed, but thought the device caused the injury to her lower legs and probably should be removed from use. Administrative Nurse E confirmed at that time, the resident had a standard pressure reducing mattress that all residents were provided.

Interview on 08/12/21 at 02:30 PM with Administrative Nurse D revealed she did not know staff were still using the off-loading heel device. Administrative Nurse D stated she did not know the history of the resident's wounds, but staff should utilize other methods to relieve pressure if the off-loading heel device caused the injury.

Interview on 08/12/21 at 2:30 PM with Physician GG revealed the resident had severe pain that limited movement and she was adjusting pain medications for resident comfort. Physician GG confirmed the pressure area on the resident's left leg was severe and staff should provide measures to limit pressure. Physician GG confirmed the resident's coccyx open area required treatment with Medihoney and dressing changes.

Interview on 08/16/21 at 04:30 PM with Administrative staff D revealed she expected charge nurses to perform hand hygiene with donning and doffing gloves and provide wound care in a sanitary manner. Administrative staff D revealed she expected staff to provide interventions for pressure relief and when the determination that the device in question may have caused the pressure areas on the resident's shins, the device should be discontinued from

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use.

The facility policy "Hand Hygiene," undated, instructed staff to remove gloves promptly after use, before touching non-contaminated items, environmental surfaces, and before caring for another patient. Staff instructed to decontaminate hands after removing gloves by appropriate hand hygiene.

The facility policy "Pressure Ulcer Management," undated, instructed staff to identify risk factors for the development of pressure ulcers. An immediate plan to reduce a resident's risk of pressure ulcers or to treat an existing pressure ulcer will be developed and implemented.

The facility failed to ensure staff provided appropriate pressure reducing measures for this resident by continued use of the off loading heel device that caused the bilateral shin ulcers, lack of providing an alternating pressure reducing air mattress and unsanitary dressing changes for this dependent resident who developed a stage three pressure ulcer to her coccyx and a stage four pressure ulcer to her left shin.

- The "Physician Order Sheet" (POS), dated 07/08/21, documented Resident (R)49 had diagnoses which included: malignant neoplasm of upper lobe of lung (lung cancer) and dementia (progressive mental disorder characterized by failing memory, confusion).

The admission "Minimum Data Set" (MDS), dated 04/21/21, documented the resident had a Brief

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Interview for Mental Status (BIMS) score of 15, indicating the resident had intact cognition. He was at risk for the development of pressure ulcers (PU) and had one, stage IV (has exposed bone, tendon or muscle), present upon admission to the facility.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 04/21/21, documented the resident had a stage IV PU, present on admission. Staff were to provide care for the area, as ordered.

The quarterly "MDS," dated 07/20/21, documented the resident had a BIMS score of 15, indicating intact cognition. He was at risk for the development of PUs and had one, stage IV PU, present upon admission.

The care plan for PUs, dated 07/28/21, instructed staff to treat the PU, as directed.

Review of the resident's electronic medical record (EMR), under the "Orders" tab, revealed an order, dated 08/11/21, which included: Cleanse back wound with soap and water daily. Pack wound with aquacel ribbon (a soft, sterile, hydrophilic non-woven ribbon dressing composed entirely of hydrocolloid fibres) and cover with an optifoam silicone (a dressing which absorbs drainage to provide an optimal healing environment for a wound).

On 08/17/21 at 07:40 AM, Administrative Nurse E entered the resident's room to do a dressing change to the wound on his back. Nurse E washed her hands and put on gloves. The wound was cleansed with wound cleanser and patted dry with gauze pads. Nurse E then

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applied the aquacel ribbon, cut to fit, and applied the silicone dressing to the area. Nurse E then removed her gloves and washed her hands with soap and water. Nurse E failed to remove her gloves and wash her hands after cleansing the wound and before applying the aquacel ribbon and the clean dressing to the wound. This practice would promote infection and decline in pressure ulcers/wounds.

On 08/17/21 at 07:45 AM, Administrative Nurse E stated she performed dressing changes using this method.

On 08/16/21 at 04:30 PM, Administrative Nurse D stated, she would expect staff to provide a sanitary dressing change and utilize proper hand hygiene while changing wound dressings. Nurse D stated, she sees a need for skills assessment and education on wound care in the facility.

The facility policy for "Hand Hygiene", undated, included: Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before caring for another resident.

The facility failed to use appropriate hand hygiene while changing the dressing to this dependent resident's stage IV PU, which promotes infection and wound decline.

- The signed "Physician Order Sheet" (POS), dated 07/08/21, documented R3's diagnoses included diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) with diabetic

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neuropathy (disease or dysfunction of one or more peripheral nerves, typically causing numbness or weakness), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) with behavioral disturbance

A significant change "Minimum Data Set" (MDS), dated 11/02/20, documented R3's "Brief Interview for Mental Status" (BIMS) score was 11, indicating moderate cognitive impairment. He required extensive assistance with bed mobility.

A "Pressure Ulcer/Injury Care Area Assessment," dated 11/04/20, documented R3 was at risk for pressure injury because of poor mobility, incontinence, and his disease processes.

A quarterly MDS, dated 05/05/21, documented R3 had two stage 2 pressure ulcers.

A "Wound ID and Assessment," dated 04/08/21, documented R3 had pressure injury to his left buttock.

R3's skin care plan, dated 06/14/21, instructed staff to treat the left buttock wound as per physician orders.

A signed POS, dated 06/14/21, instructed staff to clean the pressure ulcer area with normal saline and cover it with an optifoam dressing (a soft dressing designed to absorb wound drainage) twice a week until the area healed.

On 08/16/21 at 09:40 AM, Licensed Nurse (LN) H entered R3's room and performed hand hygiene

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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	F 689		

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supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 51 residents with 16 residents sampled, including three residents reviewed for accidents. Based on observation, interview and record review, the facility failed to place foot pedals on the wheelchair of one Resident (R)24, while being transported and failed to place anti-lock brakes on one R 21's wheelchair as planned to prevent further falls.

Findings included:

- Review of Resident (R)24's electronic medical record, under the "Admissions" tab, included the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion) and muscle weakness.

The quarterly "MDS," dated 06/16/21, documented the resident had a BIMS score of 6, indicating severe cognitive impairment. He required extensive assistance of two staff for transfers and supervision with setup help of one staff for locomotion on the unit in his wheelchair.

The admission "Minimum Data Set" (MDS), dated 03/19/21, documented the resident had a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. He required extensive assistance of one staff for locomotion on the unit with the use of his wheelchair and required extensive assistance of two staff for transfers. He had no impairment in functional range of motion (ROM).

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The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 03/19/21, documented the resident required assistance with ADLs due to generalized weakness and decreased safety awareness.

The care plan for ADLS, dated 03/24/21, instructed staff the resident was dependent on staff for most ADLs. He required two staff assistance for transfers with the use of a hoyer (full body) lift and was unable to ambulate due to his knees "giving out".

Review of the "Fall Investigation Report", provided by the facility, revealed on 08/04/21 at approximately 11:30 AM, Certified Nurse Aide (CNA) PP propelled the resident in his wheelchair in the hall, when the resident's feet went down to the floor, stopping the wheelchair and propelling the resident out of the wheelchair and onto the floor, face down and partially on his right hip. Licensed Nurse (LN) H responded to the resident and assessed him. The resident had two scratches on his forehead from where his eyeglasses hit. This area was treated per facility protocol. The resident had his normal ROM and denied pain. The following day, a dark purple bruise appeared beneath the resident's left eye as well as a bruise to his right shoulder. No other injuries from the fall were noted. Staff assisted the resident back up into the wheelchair and he was taken to his room. The facility intervention for the fall was to place foot pedals on the resident's wheelchair when staff were propelling him.

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On 08/12/21 at 09:55 AM, CNAs O and OO prepared the resident for the day. Staff transferred the resident from bed to his wheelchair with the use of the hoyer lift. The staff placed foot pedals on the resident's wheelchair before he was taken to the dining room for breakfast.

On 08/16/21 at 12:14 PM, CNAs O and OO took the resident to his room to lie down. Staff transferred the resident from his wheelchair to the bed with the use of the hoyer lift.

On 08/11/21 at 11:27 AM, the resident stated he received the black eye from a fall from his wheelchair. The resident stated a staff member had been propelling him in his wheelchair when his feet fell down to the floor causing him to fall out of the wheelchair, hitting his face on the floor.

On 08/12/21 at 08:08 AM, CNA PP stated, on the day of the fall, he had been propelling the resident in his wheelchair from the front door down the hall. There were no foot pedals on the wheelchair and the CNA instructed the resident to hold his feet up. The CNA PP stated the resident had weakness in his right leg and his feet had dropped to the floor, bringing the wheelchair to a complete stop. The resident continued forward when the wheelchair stopped, falling onto the floor. CNA PP stated the resident had fallen onto his face, landing on his glasses, causing two small cuts between his eyes on his forehead. The CNA stated he immediately notified the nurse on duty of the fall.

On 08/12/21 at 09:55 AM, CNA O stated, staff will put foot pedals on the resident's wheelchair when

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they are propelling him. At times the resident will propel himself and staff will put the footpedals in a bag on back of the wheelchair at that time. The CNA stated the resident had weakness in his legs.

On 08/16/21 at 03:01 PM, CNA NN stated, staff should put foot pedals on the resident's wheelchair when propelling him.

On 08/16/21 at 01:44 PM, LN H stated, staff had been propelling the resident in his wheelchair when his feet got heavy and went down to the floor. The foot pedals were not on the wheelchair. The resident tumbled forward onto the floor, hitting his face on the floor. The glasses hit his forehead causing two small areas. By the following day the resident developed a dark bruise underneath his left eye and a bruise to his right shoulder. LN H stated the resident did have weak legs but was able to propel himself at times in his wheelchair.

On 08/17/21 at 12:02 PM, Administrative Nurse D stated, staff should be using foot pedals when propelling a dependent resident.

The facility policy for "Restorative Plan for Wheelchair Mobility", updated 01/03/19, included: Staff should provide appropriate foot support for each resident using a wheelchair as a mobility device.

The facility failed to place foot pedals on the wheelchair of this dependent resident while propelling him in the facility causing him to fall to the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175124	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT EL DORADO, LLC	1313 S HIGH STREET EL DORADO, KS 67042

(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
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- The signed "Physician Order Sheet" (POS), dated 07/01/21, documented R21 had the following diagnoses: cerebral infarction (also known as a stroke) refers to damage to tissues in the brain due to a loss of oxygen to the area), subdural hematoma (collection of blood on the surface of the brain), and dementia (progressive mental disorder characterized by failing memory, confusion) in other diseases.

A significant change "Minimum Data Set" (MDS), dated 09/17/20, documented R21's "Brief Interview for Mental Status" (BIMS) score was 3, indicating severe cognitive impairment. She required extensive assistance with bed mobility, transfer, dressing, toileting, and personal hygiene.

A "Falls Care Area Assessment," dated 09/18/20, documented R21 had a change due to decline in cognitive functioning, communication, and a decline in her ability to perform activities of daily living. A fall in August resulted in a subdural hematoma and she required hospitalization. Her speech was unclear at times. She sometimes has difficulty making herself understood and difficulty understanding others. She has a history of poor visual depth perception.

R21's current fall care plan, included the following interventions:
Wheelchair with auto-lock brakes provided by her hospice, dated 11/19/20.
High back reclining wheelchair provided by her hospice, dated 0523/21.

On 08/12/21 at 08:31 AM, R21 was in her bed,

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her wheelchair parked in front of the sink. The wheelchair did not have a high back and lacked auto-lock brakes.

On 08/16/21 at 07:34 AM, R21 was in her bed with her wheelchair parked in front of the sink. The wheelchair did not have a high back and lacked auto-lock brakes.

On 08/16/21 at 01:12 PM, R21 sat in her wheelchair in the East lobby. R21 arose unassisted, and stood unsteadily in front of her wheelchair. Certified Nurse Aide (CNA) O and CNA OO rushed to assist her to stabilize in the standing position, and then to return to a seated position.

On 08/16/21 at 10:29 AM, CNA O stated R21 had a different wheelchair with a high back but hospice brought the wheelchair she was currently using because the high back wheelchair one was not working right. Each CNA has a "Care Sheet" in their pocket which identifies care planned interventions, including the interventions in place for falls, and auto-lock brakes are included in R21's fall care plan. Her new chair does not have auto-lock brakes.

On 08/16/21 at 11:15 AM, CNA reported R21 was ready to get up. We are waiting for her wheelchair to get back. They are putting the auto-lock brakes on it.

On 08/16/21 at 01:14 PM, Licensed Nurse (LN) H stated R21 was care planned to have anti-rollbacks on her wheelchair. The back of the high back chair back broke, so they brought this other one. LN H verified the wheelchair lacked

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the auto-lock brakes until the auto-lock brakes were installed, which happened after CNA O reviewed R21's fall interventions on 08/16/21 at 10:29 AM.

On 08/16/21 at 02:30 PM, CNA NN stated R21 got a different wheelchair about a month ago. The new wheelchair was smaller and had foot pedals that raise up. Prior to that, she had a high back wheelchair.

On 08/17/21 at 12:02 PM, Administrative Nurse D talked to hospice staff and they were saying they did not swap out the wheelchair. They did not know if someone swapped out the old chair and where they put it. Administrative Nurse D would expect it to be there and if staff changed it out they should communicate that so the staff could update that.

An undated facility policy titled "Resident Directed Care Plans," documented it is the responsibility of every member of the interdisciplinary team to read, understand and follow the comprehensive, resident-directed care pan and report any changes, no matter how slight or significant to the interdisciplinary team for immediate care plan revision.

The facility failed to ensure interventions remained in place to prevent falls for this resident, when the care planned fall intervention of anti-lock brakes were not installed by staff on the new wheelchair, when the staff changed the wheelchairs for this resident.