STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175532	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avita Health and Rehab at Reeds Cove	2114 N 127th Court East Wichita, KS 67228

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 66 residents, with 10 residents sampled. Based on observation, interview, and record review, the facility failed to prevent the development of facility-acquired pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) on Resident (R)1's right and left buttock when staff failed to adequately monitor wounds after the initial development including measurements, presence of infection, drainage and effectiveness of treatments, failed to implement routine repositioning in the bed and the wheelchair until after the wounds progressed, and did not implement standard interventions such as low air loss mattress (a medical-grade mattress designed to prevent and treat pressure injuries by continuously circulating air to reduce moisture and heat buildup) until after the pressure ulcers worsened. The facility did not immediately implement nutritional interventions to address wound prevention or healing. As a result, R1 developed a facility-acquired Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) pressure injury and placed the resident at risk for the development of new pressure ulcers, and delayed healing and worsening of existing ulcers. Findings included: - R1's Electronic Health Record (EHR) revealed diagnoses of osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), weakness, and urinary tract infection (UTI- an infection in any part of the urinary system). The 01/28/25 admission Minimum Data Set (MDS) documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R1 required moderate assistance with activities of daily living (ADL) including transfers, bed mobility, and turning from side to side. The MDS documented R1 was at risk of developing pressure ulcers/injuries and was not on a turn and reposition schedule. The 02/04/25 Pressure Ulcer/Injury Care Area Assessment (CAA) triggered secondary to the potential for pressure ulcers. The CAA noted contributing factors included ADL impairment and incontinence and the risk factors included pain, development of pressure ulcers, skin conditions, and fluid deficit risk. The CAA noted a licensed nurse would assess R1's skin each week and place proper interventions in place to prevent skin breakdown; the skin was also assessed by caregivers with each bath and each time the resident was dressed. The CAA noted the physician would be notified of any abnormal findings and treatment orders are obtained and the dietitian was monitoring R1's food and fluid intake and implementing dietary interventions as necessary. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's Braden Scale (a formal assessment used to predict pressure ulcer risk) dated 01/15/25 documented R1 was at low risk for pressure injuries with a score of 18. The scale dated 01/23/25 documented R1 had no risk with a score of 19. The scales dated 02/06/25 and 02/23/25 recorded R1 was at low risk for pressure injuries with a score of 18. R1s Care Plan documented R1 did not want to develop any pressure injuries and included interventions dated 02/11/25 that directed staff to assist with repositioning for comfort as necessary. Staff were to assist R1 with bed mobility and transfers as necessary. The plan noted R1 would use a one-quarter side rail attached to the bed to assist him with repositioning. The plan noted R1's skin would remain intact and without redness or breakdown throughout the next review period and staff would provide a pressure-reducing mattress and wheelchair cushion. The plan directed staff to assist R1 with repositioning as needed. The Licensed Nurse were to complete skin and Braden Scale (a tool used to assess a patient's risk for developing a pressure injury) assessments per facility protocol. R1's Care Plan was updated on 03/03/25 with an intervention that directed staff to reposition R1 every two to three hours while the resident was in bed and to reposition or change location to the bed as needed when R1 was uncomfortable in his wheelchair. R1's Tasks in the EHR lacked a turn and repositioning program. R1's EHR revealed a Weekly Skin Data Collection Tool, completed weekly from 01/15/25 through 02/28/25, all documented R1 had no skin issues present. R1's EHR recorded a Progress Note dated 02/26/25 noting R1's representative called and informed the nurse that R1 told them he had a wound on his coccyx (area at the base of the spine). The note documented the nurse informed R1's representative that no new wounds for R1 were reported to nursing and nursing would follow up. R1's Physician's Orders documented an order dated 02/26/25 that directed staff to clean the coccyx wound with normal saline, apple Skin-prep (liquid skin protectant), and cover with a sacral border foam dressing. The order noted to change the dressing Monday, Wednesday, and Friday or as needed (PRN) for soiling or dislodgement. The order was discontinued on 02/26/25. R1's Medication Administration Record (MAR) and Treatment Administration Record (TAR) lacked evidence staff administered the treatment. R1's Physician's Orders documented an order dated 02/26/25 that directed staff to clean the coccyx wound with normal saline, cover with a sacral border foam dressing until healed, and change the dressing Monday, Wednesday, and Friday or as needed (PRN) for soiling or dislodgement. The order was discontinued on 02/27/25. R1's MAR/TAR lacked evidence that staff administered the treatment. A Progress Note dated 02/27/25 at 12:35 PM documented the nurse spoke to R1's representative and informed her that R1 did not have any new wounds. A Progress Note dated 02/28/25 at 05:46 AM recorded R1's skin was intact but also noted skin discolorations to the coccyx. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's 03/01/25 Weekly Skin Data Collection Tool documented small open wounds to the scrotum and bilateral buttocks and noted there was a treatment in place. The tool lacked measurements of the open areas, assessment of the peri-wound (skin surrounding the wound) and presence of drainage or signs of infection. R1's Physician's Orders documented an order dated 03/01/25 which directed staff to apply silver sulfadiazine cream (used to prevent and treat wound infections) to the right buttock topically every shift for wound care. The order was discontinued on 03/02/25. R1's Physician's Orders documented an order dated 03/01/25 which directed staff to apply silver sulfadiazine cream to the inner buttocks topically every shift for wound care. The order was discontinued on 03/02/25. R1's Physician's Orders documented an order dated 03/02/25 which directed staff to apply silver sulfadiazine cream to the buttocks, scrotum, and sacrum (large triangular bone/area between the two hip bones) topically every shift for wound care and apply to buttocks, scrotum, sacrum topically as needed for wound, ordered 03/02/25. The order continued through 03/25/25 when it was discontinued. A Progress Note dated 03/05/25 at 05:01 PM documented R1's buttocks wound started to open starting to open and had some bloody drainage. The note lacked evidence of physician notification. The 03/07/25 Weekly Skin Data Collection Tool documented an open area to R1's buttocks, scrotum, and sacrum with a treatment in place. The tool lacked measurements of the open areas, assessment of the peri-wound, presence of drainage or signs of infection. A Progress Note dated 03/07/25 at 08:38 AM documented staff assessed R1's sacral wound that morning; it was the same area the resident had problems with. The note documented the area reopened that day and staff applied Silvadene (silver sulfadiazine) cream to the affected areas and R1's sacral area was off-loaded with a big blue pad. The note lacked evidence of physician notification. R1's Physician's Orders documented an order dated 03/11/25 for a liquid protein supplement, 30 milliliters by mouth, twice daily for supplement and wound healing. The 03/14/25 Weekly Skin Data Collection Tool documented R1 had open areas on his bilateral (both sides) buttocks, sacrum, and peri area with a treatment in place. The tool lacked measurements of the open areas, assessment of the peri-wound, presence of drainage, or signs of infection. The 03/17/25 Mid-Kansas Wound provider assessment documented wound one on R1's left buttock was a chronic Stage 3 pressure injury acquired on 03/10/25. The assessment noted the wound measured 4.5 centimeters(cm) by 2.5 cm by 0.1 cm and had an area of 11.25 square (sq) cm, and a volume of 1.125 cubic cm as well as a small amount of serosanguinous (semi-thick blood-tinged drainage) drainage with a mild odor. The assessment noted wound two on R1's right buttock was a chronic Stage 3 pressure ulcer acquired on 03/10/25 that measured 9.25 cm by 6.5 cm by 0.1 cm and had an area of 59.8 sq cm and a volume of 5. 98 cubic cm; there was a small amount of serosanguinous drainage with a mild odor. The assessment noted both areas were debrided medical removal of dead, damaged, or infected tissue to improve the healing potential for the remaining healthy tissue) by the provider. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's Physician's Orders documented an order dated 03/19/25 that directed staff to cleanse the wounds with wound cleanser by applying to gauze and soaking the wound for five minutes with each dressing change; rinse with normal saline, then place alginate (dressing which forms a soft, gel that absorbs when it comes into contact with wound drainage) in the wound bed and cover with a bordered foam dressing one time a day on Monday, Wednesday, and Friday. A Progress Note dated 03/20/25 at 09:15 AM documented at approximately 09:00 AM that morning the Certified Nurse Aide (CNA) notified the nurse R1 had a large sore, skin spot on his bottom. The note documented the nurse looked at it and observed it looked like a large bruise spot, almost black. The note documented the nurse put a dressing over it in addition to the ordered cream and would notify the provider when the provider arrived. A Provider Note dated 03/21/25 documented that per staff, R1 had a worsening sacral wound; the wound nurse was contacted and given new wound orders. The note directed staff to follow up with the wound provider the following week. The 03/24/25 Mid-Kansas Wound wound provider assessment documented R1's wounds were measuring significantly larger. The assessment noted the left buttock chronic Stage 3 pressure injury acquired on 03/10/25 measured 8.5 cm by 3.5 cm by 0.1 cm and had an area of 29.75 sq cm and a volume of 2.975 cubic cm. with adipose (fat) tissue exposed and large amount of serosanguinous drainage with a mild odor. The assessment noted R1's right buttock chronic Stage 3 pressure ulcer acquired on 03/10/25 measured 13 cm by 6 cm by 0.1 cm and had an area of 78 sq cm and a volume of 7.8 cubic cm, with adipose tissue exposed and a small amount of serosanguinous drainage with a mild odor. A Provider Note dated 03/24/25 documented the provider saw R1 that day and the nurse reported R1 had a fever of 102.3 degrees Fahrenheit (F) (normal temperature is 98.6 degrees F), chills, and shaking. The note documented the wound provider saw R1 that morning and was concerned about the appearance and odor of the wound. The wound provider recommended sending R1 to the hospital with concerns of sepsis (a life-threatening systemic reaction that develops due to infections that causes inflammation throughout the entire body). R1 agreed and the staff contacted his representative. The note documented staff contacted Emergency Medical Services (EMS). The note also documented the provider suspected sepsis was secondary to the wound infection. R1's Physician's Orders documented an order dated 03/24/25 that directed staff to offload and rotate R1 every one-to-three hours for sacral wounds every shift. R1's Physician's Orders documented an order dated 03/24/25 that directed staff to admit R1 to the hospital for possible sepsis and wound debridement for wound care and change in condition. On 04/23/25, R1 remained in the hospital and was unavailable for observation. During an interview on 04/23/25 at 01:37 PM, CNA F reported she let the nurse know if a resident had a new skin issue. CNA F reported the nurse would let Administrative Nurse C know. CNA F reported a treatment would put in place right away and have seen the facility apply an air mattress right away on the resident's bed if there was a skin issue. During an interview on 04/23/25 at 03:30 PM, CNA G reported if a resident was on a turn and reposition schedule, it would be on the EHR for the staff to document that task. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 04/23/25 at 12:46 PM, Licensed Nurse (LN) E reported the nurse would assess any skin concerns, document it in her, and then notify the provider and get a treatment. LN E reported the nurse that provided the dressing change should measure the wound and document on the weekly skin tool. LN E said the wound care provider also completed measurements of a wound. During an interview on 04/23/25 at 01:55 PM, Administrative Nurse D reported the staff would report any skin concerns to the charge nurse and the CNAs also have a shower sheet and would document skin concerns on that sheet and report it back to the unit manager. Administrative Nurse D said the measurements of the wounds at the time when R1 was in the facility should have been completed by Administrative Nurse C. She reported that R1 did not have any open wounds when he was admitted and he was walking in the first unit he lived on, then R1 declined when he moved to the other unit. She could not recall when R1 received an air mattress. During an interview on 04/23/25 at 2:22 PM, Administrative Nurse C reported she had not completed wound assessments on R1 as the person who trained her did not correctly train her, so there was a gap of no wound assessments completed. Administrative Nurse C reported the first time she assessed R1's wounds was on 03/17/25 when Mid-Kansas Wound assessed the wounds. She reported the CNAs do not have a place to document on the EHR for the turn and reposition and said it was on the [NAME] (a nursing tool that gives a brief overview of the care needs of each resident), and the nurses were responsible to make sure the CNAs were repositioning the residents that required assistance. During an interview on 04/24/25 at 10:40 AM, Administrative Nurse B reported R1 admitted on [DATE] with no open areas. She said she reviewed the Weekly Skin Data Collection Tools and reported she expected staff to communicate with the unit managers, interdisciplinary team, and the wound care team when a wound was identified. Administrative Nurse B said she expected the nurse to let the CNAs know what residents required to be turned and repositioned. Administrative Nurse B stated she expected nurses to measure wounds when documenting in the EHR. She reported the facility started working on a Performance Improvement Plan (PIP- a formal document outlining specific steps for an employee to improve their performance) around mid-March (2025) as the facility identified the tracking of wounds on the documents was not effective. During an interview on 04/24/25 at 12:06 PM, Physician Assistant H reported she assessed R1's wounds near the end of his stay. She said she expected the nurses would be documenting the wounds weekly including measurements and progression of the wounds. Physician Assistant H reported she relied on Mid-Kansas Wounds to handle the wounds and if there was a concern with any wounds, she would get involved. Physician Assistant H said she expected the facility to have applied an air mattress on R1's bed sooner than it was but she could not recall the exact date R1 received the air mattress. Physician Assistant H reported the facility had not placed preventative measures to prevent the pressure ulcers R1 acquired. The facility's policy Wound Management dated 01/10/25 documented the facility is committed to providing a comprehensive wound management program to minimize the development of in-house acquired pressure ulcers. Any resident with a wound receives treatment and services with the resident's goals of treatment.