STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175544	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Rainbow Boulevard, LLC	3910 Rainbow Blvd, Suite 400 Kansas City, KS 66103

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 reported a census of 94 residents. The sample included five residents reviewed for skin alterations and 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). Based on record review, observation, and interview, the facility failed to identify timely and prevent a pressure ulcer for dependent resident, Resident (R) 2, who developed a sacral (large triangular bone/area between the two hip bones) wound which was not identified until four days after admission. This deficient practice placed R2 at risk for harm, including pain, potential infection, and worsening of their overall condition. Findings included: - The Electronic Medical Record (EMR) documented R2 admitted to the facility on [DATE] and had diagnoses of hemiplegia and hemiparesis following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting the right dominant side, Parkinson's disease (a movement disorder of the nervous system that worsens over time), seizures (a sudden, uncontrolled burst of electrical activity in the brain. It can cause changes in behavior, movements, feelings and levels of consciousness), muscle weakness (lack of strength in the muscles), and dementia (progressive mental disorder characterized by failing memory, confusion). The admission Minimum Data Set (MDS) assessment dated [DATE] documented R2 had a Brief Interview for Mental Status (BIMS) score of five, which indicated severe cognitive impairment. The MDS documented R2 was incontinent of bowel and bladder, dependent on staff for all activities of daily living (ADL) such as eating, bed mobility, toileting, and personal hygiene. The MDS documented R2 had one stage 3 (full-thickness pressure injury extending through the skin into the tissue below) pressure ulcer. The Pressure Ulcer Care Area Assessment (CAA) dated 02/20/25 recorded staff would provide skin inspections and a care plan would be developed to reduce, or manage the cause, contributing factors, or risk factors. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R2's Care Plan initiated on 02/14/25 documented the resident was at risk for alteration in skin integrity. The Care Plan's revised goal on 02/18/24 included R2 would remain free of any new skin impairment through the review date 06/04/25. R2's Care Plan directed staff to apply barrier cream per facility protocol to help protect skin from excess moisture, dietary consult as needed, ensure heals are elevated while the resident is lying in bed, monitor skin when providing care, notify the nurse of any changes in skin appearance, provide nutritional supplements as ordered, and a pressure reducing mattress. The Care Plan lacked documentation of any specific information and or treatment for R2's documented stage 3 sacral wound or other skin disruptions (i.e. maintaining good hydration, managing the resident's pain or discomfort, measures to offload pressure, preventing infection through proper hygiene, etc.). A review of the nurse's Initial/admission Data Assessment dated 02/14/25 recorded R2 had an excoriation (skin damage caused by scratching, rubbing, or other forms of abrasion) to the groin and abdominal fold. R2 had a left chest (wall) surgical incision, and sheering (when the skin and underlying tissue are pulled in opposite directions, often due to friction and pressure) to the inner buttock. The 02/14/25 admission Assessment lacked any detailed information (characteristics) regarding the groin excoriation, chest surgical incision, and/or inner buttock sheering. The evaluation did not record a stage 3 sacral wound. The EMR documented Physician Orders dated 02/14/25 for a wound care consult as needed (PRN) and to apply Zinc barrier cream to R2's buttocks and peri area every shift and PRN. On 02/18/24 this order was revised/reordered after the wound care team's evaluation on 02/18/24 to include cleansing R2's sacral wound with wound cleanser, patting it dry, and applying zinc barrier cream every day and night shift. The Daily Skilled Nurses' Notes from admission on [DATE] through 02/18/25 lacked documentation of an assessment and/or care provided for R2's stage 3 sacral pressure ulcer. A nurse Skin Observation dated 02/18/25 (four days after admission) recorded R2 had a sacral pressure ulcer and directed staff to see the wound care notes for staging. The report indicated the resident's family was notified on 02/18/25 (four days after admission and the initial admission assessment of 02/14/25). A Physician/Physician Assistant/Advanced Registered Nurse Practitioner Note (Physician, PA, ARNP) Wound Care Assessment dated 02/18/25 at 12:10 PM documented R2 presented to the hospital on [DATE] for right-sided weakness and altered mental status. Earlier in the month R2 was admitted to the hospital following a right frontal cerebral vascular accident (stroke). The resident required maximum assistance of two persons and discharge to a skilled nursing facility was recommended. A subsequent Hospital Admission dated 01/23/25, recorded R2 had a left parietal cerebral vascular accident and required the assistance of two to three people. The resident was stabilized, discharged from the hospital, and admitted to the facility for further medical care and rehabilitation under medical supervision. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The 02/18/25 Physician, PA, ARNP Note recorded an examination of the sacrococcygeal (refers to anything of, relating to, or affecting the sacrum and coccyx (tailbone)) area revealed a stage three pressure injury with scant drainage, no odor, induration, fluctuance, or overt infection. There was evidence of 100% granulation tissue (reddish connective tissue, evidence of healing). The surrounding wound was clean and dry and revealed a surrounding intact deep-tissue injury examination, Normothermic (normal temperature) upon palpation and mildly tender. The 02/18/25 Physician, PA, ARNP Note examination revealed an intact deep-tissue injury circumferentially (around) the stage three pressure injury. This area had persistent, non-blanchable (where skin does not lose its redness when pressure is applied) maroon discoloration and revealed a dark wound bed. This same 02/18/25 Physician, PA, ARNP narrative note recommended zinc oxide barrier paste to be applied to the sacrococcygeal, and bilateral buttocks twice daily and as needed for skin integrity and leave open to air; a low air loss mattress (LAL) surface set to patient's weight and comfort, if available, and if the patient is not a fall risk. If a fall risk, then LAL surface is not applicable for this patient, float heels with pillows or pillow boots as able, turn every two hours, and offload pressure as able. The Wound Care directed staff to avoid using briefs or fastening briefs while in bed to reduce the risk of skin breakdown due to moisture, friction, and heat. The Wound Summary Report located under the Wound tab in the EMR, dated 02/18/25 documented an active Stage 3 bright pink/red color wound with 100% new tissue grown, light serosanguinous (yellowish with small amount of blood) drainage, no signs or symptoms of infection, and measured 4.43 centimeters (cm) long by 0.5 cm wide and 0.10 cm deep. The Skin Observation dated 02/25/25 documented a one-word description, Buttocks, and directed staff to see the wound care notes for staging. The Skin Observation dated 02/28/25 documented (erroneously) that the resident had no skin issues. The Skin Observation dated 03/07/25 documented R2 had a sacral wound and recorded the Wound Team took pictures weekly and the family was notified on 03/07/25. No Braden scores (a tool used to determine a patient's risk of developing pressure sores) were recorded before 03/07/25. A Braden score of 13 was recorded on 03/07/25 which placed R2 at high risk for developing pressure sores. R2 was discharged to the hospital on 3/17/25 at 04:56 AM for a potential Hypertensive Crisis (elevated blood pressure). On 03/18/25 at 03:43 PM, Licensed Nurse (LN) G stated the nurses conducted a resident's skin assessment on admission by examining their skin during perineal care. LN G said, on admission to the facility, R2 had an excoriated bottom and a small opening between the buttocks that was dark in color and there was some evidence of shearing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 03/18/25 at 03:34 PM, Administrative Nurse E stated she was on vacation from 02/12/25 through 02/17/25. Administrative Nurse E acknowledged the initial skin assessment should be done within the first 24 hours of admission, and when residents were admitted to the facility their skin assessments were generally done within an hour of their arrival. Administrative Nurse E stated the floor nurses did the day-to-day dressing changes or treatments, and the Wound Care team rounded weekly. On 03/18/25 at 03:34 PM, Administrative Nurse D stated an unawareness of the delayed assessment for resident R2) Administrative Nurse D stated on admission the nurses should do a head to toe, review of the resident, and the guidance is to describe all areas of the resident's skin/wounds but not to give an etiology or cause. The nurses on the floor do not perform the staging of wounds. The Advanced Registered Nurse Practioner rounds with the nurses to ensure they don't miss anything. Administrative Nurse D stated nurses conducting the initial assessments of residents' skin needed re-education. Administrative Nurse D provided photographs, of R2's wounds dated 02/18/24 (taken four days after admission to the facility). On 03/18/25 at 03:34 PM, Administrative Staff A acknowledged the facility policy was not followed. Administrative Staff A stated they had a nurse covering while the wound care nurse was on vacation. Unfortunately, that nurse had already put in their termination notice as they were moving on. Administrative Staff A said the Director of Nursing resigned on 02/19/25 so several systems were not followed, but stated once identified the facility put corrective action into place immediately and had not had any issues since. A review of the facility's Wound Policy and Procedure revised May 2023 recorded the facility is committed to providing a comprehensive wound management program to promote the residents' highest level of functioning and well-being and to minimize the development of in-house acquired pressure ulcers unless the individuals clinical condition demonstrates they are unavoidable. The policy documents any wounds assessed will be captured in the PCC (electronic medical record) evaluation, to progress notes, or by completing wound rounds via (by way of) Quick Shot (within two to six hours of admission). The policy notes, that the admission wound assessment should include at a minimum an interview with the resident or family about a history of skin alterations and a physical evaluation to include skin alterations present on admission, skin discolorations, and any evidence of scarring or pressure points. A head-to-toe skin assessment is to be completed, and a Braden or Norton risk scale is to be completed. A comprehensive assessment would include: the location of the wound, length width, depth measurement in centimeters, and any tunneling and/or undermining. Appearance of the wound base type and percentage of tissue in the wound, drainage amount, and characteristics including color, consistency and odor, and appearance of wound edges. The policy further recorded the assessment should include a description of peri-wound condition and evaluation of the skin adjacent to the wound, presence or absence of new epithelium at wound skin, and an interim baseline care plan is developed. The facility failed to timely identify and prevent a pressure ulcer for R2, who was admitted to the facility on [DATE] with cognitive and mobility deficits. A subsequent wound assessment on 02/18/25 revealed R2 had a stage 3 sacral pressure ulcer and surrounding deep tissue injury. This deficient practice placed R2 at risk for pain, infection, and complications related to skin breakdown.