STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065356	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF COLORADO SPRINGS	2490 INTERNATIONAL CIR COLORADO SPRINGS, CO 80910

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 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure two (#2 and #9) out of four residents reviewed out of nine sample residents were provided prompt efforts by the facility to resolve a grievance. Specifically, the facility failed follow-up timely with grievances from Resident #2 and Resident #9. Findings include: I. Facility policy and procedure The facility policy and procedure, dated 5/6/19 was provided by the nursing home administrator (NHA) on 3/11/2020 at 10:30 a.m. The policy read in pertinent part: Residents and their families have the right to file a complaint without fear of reprisal. Upon request, the facility must give a copy of the grievance policy to the resident. Residents' rights should be protected when voicing complaints to maximize the quantity of life for each individual and promote customer satisfaction with facility care and services. Immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source and /or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the executive director; and as required by state law. The executive director (NHA) and or designee is responsible for ensuring that all grievances and concern and comment reports have been reviewed and addressed in a timely manner and that concerned individuals feel that some type of resolution has been communicated, achieved and maintained. II. Resident #9 A. Resident status Resident #9, [AGE], was admitted on [DATE], according to the March 2020 computerized physician orders(CPO), [DIAGNOSES REDACTED]. The 2/10/20 minimum data set (MDS) assessments, revealed the resident was cognitively intact with a brief interview of mental status (BI[CONDITION]) score of 13 out of 15. B. Resident interview Resident #9 was interviewed on 3/11/2020 at 10:55 a.m. She said it had been about two months ago since she reported two of her dresses were missing. She said she had not heard anything from staff whether they were found. She said her granddaughter gave her the dresses and she was disappointed they were missing. She said she hoped the staff would find the dresses because they came from Hawaii and she loved them. C. Record review Resident #9's concern/grievance form dated 1/14/2020 was reviewed. It documented the resident was missing two dresses: one red and one blue in color with purplish flowers. It documented laundry/ housekeeping staff was designated to investigate and follow-up with the resident. It further documented investigation findings: No luck finding the items-will continue to search" dated [DATE]. It also documented on [DATE], that the resident was asked if her dresses were found and the resident said no. (22days from the initial investigation). There was no additional documentation after [DATE] in the record that the resident or the resident representative was contacted regarding the above grievance until 3/11/2020 when the facility was made aware during survey.(see facility follow-up below). D. Staff interviews The social service director (SSD), was interviewed on 3/11/2020 at 11:15am. She said the NHA was the grievance coordinator. She said when a resident filed a grievance, the grievance form would be turned in to the NHA. She said based on the nature of the complaint, the NHA would assign it to the designated department supervisor to investigate and resolve the concerns. She said all staff were aware to report all grievances filed to the NHA. The housekeeping supervisor was interviewed on 3/11/2020 at 1:20 a.m. She said if she receive a concern card regarding missing clothing, it would take about two weeks to look for the items. If the items can not be found, she would follow-up with the resident or representative to see if they would like to purchase another one, then the facility would reimburse the resident. She said she received the concern card in her box. She said they searched the laundry, the lost and found and other residents' closets but did not find the dresses. She said she followed up with the resident and told her that they did not find the dresses but will continue to search for them. She said it was an oversight that she did not communicate and timely resolve the resident's concern. She said regarding missing clothing, it usually took her about two weeks to resolve the concern, but this one took a longer time because she just forgot about it. She said this morning (3/11/2020) the NHA asked her if she had a grievance card for resident #9. She said when she checked in her office the card was there. She said then she called and followed up with the resident's son. The NHA was interviewed on 3/11/2020 at 2p.m. She said if a resident or family filed a grievance, the staff would turn it in to her office. She said it would take about 24 hours to resolve a grievance depending on what it was. She said if it was regarding missing clothing it would take about two weeks to reach a resolution. She said when she received the grievances, she would review them and based on what the grievance was, she would assign it to the supervisor of that department to investigate and follow up with the supervisor. She said for Resident #9 grievance, she was not aware the resident had filed a grievance. She said she got to know when she was made aware by the survey team. She said she inquired from the laundry supervisor about the resident's grievance and asked her to follow-up with the resident's son. E. Follow-up On 3/11/2020, it was documented on the grievance form that the resident's son was called regarding the missing dresses. It documented the resident's son was told they would reimburse him if he wanted to purchase new dresses for his mother. However, there was no response documented from the resident and resident representative that they were satisfied with the resolution. III. Resident #2 A. Resident status Resident #2, [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the March 2020 CPO, [DIAGNOSES REDACTED]. The 1/20/2020 MDS assessment revealed the resident was cognitively intact with a BI[CONDITION] score of 15 out of 15. She required extensive assistance from one person for bed mobility, dressing and personal hygiene. She required extensive assistance from two people for transfers and toileting. The resident had verbal behavioral symptoms, including threatening, screaming and cursing, directed towards others and a rejection of care that occurred one to three days during the assessment period. B. Resident interview The resident was interviewed on 3/11/2020 at 5:46 p.m. via telephone from the hospital. She said a certified nurse aide (CNA) #1 had come into her room a day or two following her wound clinic appointment. She said CNA #1 grabbed her left great toe intentionally and squeezed it after she had told her it was infected. She said it was very painful. She said she told the nurse practitioner (NP). She said she felt the facility did not do anything. She said CNA #1 continued to care for her after the incident. She said the head nurse came into her room and asked her why she no longer wanted CNA #1 take care of her. She said she told her CNA #1 squeezed her left great toe. She said she felt the facility staff did not believe her because CNA #1 continued to come into her room and care for her. She said she did not trust CNA #1 and did not want her around. She said, I am not a liar and it hurts my feelings they don't believe me. She said she was worried that if she complained now, she would not get the care she needed. The resident was interviewed again on 3/13/2020 at 2:10 p.m. She said she returned to the facility from the hospital on [DATE]. She said CNA #1 came into her room with another CNA to assist her. She said she did not say anything because she was worried. C. Resident representative interview The resident's representative was interviewed on 3/11/2020 at 4:47 p.m. She said she lived out of state but spoke to the resident every day, sometimes two to three times a day and the resident told her everything that was going on that day. She said she would call or email the facility about the resident's concerns but they were slow to get back to her if they did at all. She said the facility told her the resident was

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

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.

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F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) manipulative. She said she thought this was the reason the facility did not take the resident's concerns seriously. The resident's representative was interviewed again on 3/13/2020 at 11:35 a.m. She said Resident #2 had returned from the hospital on [DATE]. She said the facility continued to allow CNA #1 to care for the resident. She said the resident did not want to say anything because she was afraid the staff would not take care of her. She said she would contact the facility to reiterate she did not want CNA #1 caring for the resident. D. Visitor interview A frequent visitor to the facility was interviewed on [DATE]20 at 3:20 p.m. She said she visited with Resident #2 a couple times a month. She said Resident #2 mentioned concerns to her that she presented to the facility, including her mattress being uncomfortable, staff not taking the lids off her food items at meal time and the mechanical lift foot plate hurting her feet. She said she thought the facility did not always address Resident #2 concerns promptly and to the satisfaction of the resident. She said Resident #2 had not mentioned any concerns with CNA #1. E. Record review Grievance forms from or submitted on behalf of Resident #2 were requested from the facility on 3/11/2020 at 9:02 a.m. No grievance forms were provided by the facility. The facility provided copies of emails from Resident #2's representative from [DATE] until [DATE]. Review of these emails revealed no mention of the concerns the frequent visitor had (see above interview) or the concerns Resident #2 had with CNA #1. The 2/22/2020 nursing progress note revealed Resident #2 reported to the nurse she did not want the CNA working to care for her. It indicated Resident #2 wanted to speak with a supervisor. A typed statement from the nursing home administrator (NHA) and unit manager (UM) #1, dated [DATE]20 was provided by the facility on 3/11/2020 at 9:02 a.m. The statement consisted of an interview with the resident asking why she no longer wanted to work with CNA #1. This statement indicated the resident told them she did not want CNA #1 caring for her because she pinched her toe on her left foot the day after she came back from her wound appointment for her left foot. The statement went on to say the resident changed her story and said it was an accident but she still did not want CNA #1 in her room. This interview was completed five days after Resident #2 requested to speak to a supervisor. The daily staffing assignments from 2/11/2020 until 3/13/2020 were reviewed on 3/13/2020 at 3:45 p.m. They revealed CNA #1 was assigned to care for Resident #2 on the day of the allegation 2/22/2020. It also indicated CNA #1 had been assigned to care for Resident #2 three times since notifying the nursing management on [DATE]20 that she no longer wanted CNA #1 in her room and caring for her. F. Staff interviews The NHA was interviewed on 3/11/2020 at 11:15 a.m. She said they did not fill out grievance forms for Resident #2 since all communication was done with Resident #2's representative via email. The NHA was interviewed again on 3/13/2020 at 2:32 p.m. She said she had not restricted CNA #1 from caring for Resident #2 because after she told the resident if she would not allow CNA #1 to assist caring for her it would increase the time she would have to wait for care. She said Resident #2 agreed at that time to allow CNA #1 to care for her. The NHA said she did not have documentation of this encounter with Resident #2. According to this statement, provided by the NHA on 3/13/2020 at 4:42 p.m., dated [DATE]20 and signed by the NHA and UM #1, a follow up interview was done with Resident #1 explaining the increase in time she would have to wait for care to be provided if she did not allow CNA #1 to care for her. It indicated Resident #2 decided at that time she would be okay with CNA #1 coming into her room as long as she was not the primary care provider. This statement was not completed until 3/13/2020 (during the survey process) after the NHA indicated she did not have documentation of the encounter.
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure one (#2) out of four residents was kept free from abuse out of nine sample residents. Specifically, the facility failed to ensure Resident #2 was kept free from physical abuse by a staff member. Findings include: I. Facility policy and procedure The Abuse and Neglect policy and procedure, revised 1/21/19 and last reviewed [DATE]5/19, was provided by the nursing home administrator (NHA) on 3/9.2020 at 5:12 p.m., revealed in pertinent part: It is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property and exploitation. Investigation and Protection: It is the policy of this facility that reports of abuse (abuse, neglect, mistreatment, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated. Residents have the right to live at ease in a safe environment without the fear of retaliation when allegations are reported. Procedure: - Following the identification of alleged abuse, the resident(s) receive prompt medical attention as necessary and the resident(s) are protected during the course of the investigation to prevent recurrence. Staff will respond immediately to protect the alleged victim(s)/other and integrity of the investigation. - The alleged victim will be examined for any sign of injury, including a physical examination or psychosocial assessment, if needed. Caution must be used in handling evidence that could be used in a criminal investigation. - When an incident or suspected incident of resident abuse and/or neglect, injury of unknown source, exploitation, or misappropriation of resident property is reported, the administrator/designee will investigate the occurrence. Protection will be provided to the alleged victim and other residents, such as room or staffing changes as needed to protect the resident(s) from the alleged perpetrator. - The administrator/designee will complete an Incident Report and will utilize the Incident Investigation Questionnaire Form to document the investigation. - The written summary of the investigation should include, but is not limited to: - A review of the incident, an interview with the person(s) reporting the incident, interviews with any witnesses to the incident, an interview with the resident if appropriate, a review of the resident's medical record, an interview with the employee(s), as needed, a review of the employee file, as needed. Interviews with staff members on all shifts having contact with the resident at the time of the incident. I interview with the resident's roommate, family, and/or visitors who may have information regarding the incident. Interviews (from) other residents who received care or services from the alleged perpetrator, and a review of all circumstances surrounding the incident. - If the accused individual is an employee, the alleged perpetrator will be removed from the resident care areas immediately and placed on suspension pending the results of the investigation. Retaliation by staff is abuse, regardless of whether harm was intended, and must be cited. - If the accused abuser is another resident, the residents must be separated while investigating the incident. Interventions must be implemented to assure the safety of all residents. - The result of the investigation will be recorded on the Incident Investigation Questionnaire. Any additional information documents including interviews and record reviews will be attached to the Incident Follow-Up and Recommendation Form. II. Resident #2 A. Resident status Resident #2, [AGE], was admitted on [DATE], discharged to the hospital on [DATE], readmitted on [DATE] and discharged to the hospital again on [DATE] and readmitted [DATE]. According to the March 2020 computerized physician orders [REDACTED]. The 1/20/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required extensive assistance from one person for bed mobility, dressing, and personal hygiene. She required extensive assistance from two people for transfers and toileting. The resident had verbal behavioral symptoms including threatening, screaming and cursing directed towards others, and rejection of care that occurred one to three days during the assessment period. These behaviors were not present during the previous assessment period in October 2019. B. Resident interview The resident was interviewed on 3/11/2020 at 5:46 p.m. via telephone from the hospital. The resident said certified nurse aide (CNA) #1 went to her room a day or two following her wound clinic appointment. She said CNA #1 grabbed her left great toe intentionally and squeezed it after the resident told her it was infected. She said it was very painful. She said, when she hollered out, CNA #1 turned and walked away. The resident said she told the nurse practitioner (NP). She said she felt the facility did not do anything. She said CNA #1 continued to care for her after the incident. She said she also told the nurse she did not want CNA #1 in her room. The resident said the head nurse came into her room and asked her why she no longer wanted CNA #1 take care of her. She said she told her CNA #1 squeezed her left great toe. She said she felt the facility staff did not believe her because CNA #1 continued to come into her room and care for her. She said she did not trust CNA #1 and did not want her around. The resident said, I am not a liar and it hurts my feelings they don't believe me. She said she was worried that if she complained now, she would not get the care she needed. The resident was interviewed again on 3/13/2020 at 2:10 p.m. She said she returned to the facility from the hospital on [DATE]. She said CNA #1 came into her room with another CNA to assist her. She said she did not say anything because she was worried. She said she told her daughter as soon as she called. She said she still did not trust CNA #1 and did not want CNA #1 to care for her. She said she was worried the other CNA's would be mad at her since they were friends with CNA #1. C. Resident representative interview The resident's representative was interviewed on 3/11/2020 at 4:47 p.m. She said she lived out of state but spoke to the resident every day, sometimes two to three times a day and the resident told her everything that was going on that day. She

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) said she would call or email the facility about the resident's concerns but they were slow to get back to her if they did at all. She said the facility told her the resident was manipulative. She said she thought this was the reason the facility did not take the resident's concerns seriously. The resident's representative was interviewed again on 3/13/2020 at 11:35 a.m. She said the resident had returned from the hospital on [DATE]. She said the facility continued to allow CNA #1 to care for the resident. She said the resident did not want to say anything because she was afraid the staff would not take care of her. She said she would contact the facility to reiterate she did not want CNA #1 caring for the resident. D. Record review The behavior care plan, initiated on 8/27/18 and last revised 2/18/2020, revealed a history of the resident making accusations against staff. It indicated the resident made inappropriate statements about staff members. She preferred specific staff members to assist her with her activities of daily living (ADLs). The interventions included: - To assist the resident to develop more appropriate methods of coping and interacting; - Encourage the resident to express feeling appropriately; - Care to be provided in pairs; and, -Provide education that her request to only allow specific staff members to assist her may delay her care. The NP progress note on 2/13/2020 revealed the resident's left toe had a scab near the great toenail. The toe was very tender and there was purulent drainage from under the scab. The NP documented during the pain assessment, the resident stated someone squeezed her toe earlier that day. The resident said prior to that incident her toe did not hurt. She said the resident could not offer any details about the squeezing. The resident's pain was isolated to the site of the scab on the left great toe. The resident's medical record was reviewed on [DATE]20 at 3:25 p.m. It did not reveal documentation the NP had reported the incident on 2/13/2020 between the resident and CNA #1. The investigation for this incident was requested from the facility on 3/11/2020 at 9:02 a.m. The facility provided a typed statement from the NHA and unit manager (UM) #1, dated [DATE]20. The written statement consisted of an interview with the resident asking why she no longer wanted to work with CNA #1. This statement indicated the resident told them she did not want CNA #1 caring for her because she pinched her toe on her left foot the day after she came back from her wound appointment for her left foot. The statement went on to say the resident changed her story and said it was an accident but she still did not want CNA #1 in her room. This interview occurred 14 days after the resident informed the NP of the incident. The review did not include interviews from CNA #1, other residents or staff members. Daily staffing assignment sheets from 2/11/2020 until 3/13/2020 were reviewed on 3/13/2020 at 3:45 p.m. They revealed CNA #1 was assigned to care for Resident #2 on the day of the allegation 2/13/2020. It indicated CNA #1 was assigned to care for the resident six different days from 2/13-[DATE]20 after the resident had made the allegation to the NP. The assignment sheets also documented CNA #1 had been assigned to care for Resident #2 three times since notifying the nursing management on [DATE]20 that she no longer wanted CNA #1 in her room and caring for her. E. Staff interviews The NP was interviewed on 3/11/2020 at 10:52 a.m. She said she did not take the resident's statement of someone squeezing her toe as an allegation of assault at that time. She said she thought the resident was talking about when a staff member was providing care that they accidentally squeezed her foot. She said the resident complained about the care she received from the staff often. She said she did not question the resident any further about this and she did not report it to the NHA. The NHA was interviewed on 3/13/2020 at 2:32 p.m. She said because the resident changed her story she did not feel like it was an allegation of abuse and it did not need to be investigated further. She said she had not restricted CNA #1 from caring for Resident #2 because after she told the resident if she would not allow CNA #1 to assist caring for her it would increase the time she would have to wait for care. She said Resident #2 agreed at that time to allow CNA #1 to care for her. The NHA said she did not have documentation of this encounter with Resident #2. According to this statement, provided by the NHA on 3/13/2020 at 4:42 p.m., dated [DATE]20 and signed by the NHA and UM #1, a follow up interview was done with Resident #1 explaining the increase in time she would have to wait for care to be provided if she did not allow CNA #1 to care for her. It indicated Resident #2 decided at that time she would be okay with CNA #1 coming into her room as long as she was not the primary care provider. This statement was not completed until 3/13/2020 (during the survey process) after the NHA indicated she did not have documentation of the encounter. The NHA was interviewed on 3/13/2020 at 2:35 p.m. She said the allegation CNA#1 squeezed Resident #2's toe causing her pain would be treated and investigated as an allegation of abuse. The NHA, social service director (SSD) and UM #1 were interviewed on 3/13/2020 at 2:52 p.m. The SSD said she and the UM talked to Resident #2 regarding the allegation. She said the resident told them the incident occurred the day after her wound clinic visit. She said CNA #1 bent down and pinched her toe. She said the resident did not believe it was done intentionally to hurt her but it did cause pain. She said the resident told them she was not afraid of the CNA or any other staff. The NHA said Resident #2 had a history of [REDACTED]. She said they tried to have all staff go into the resident's room in pairs to provide care. She said CNA #1 had worked on Resident #2's hallway for several years and had a good rapport with all the residents including Resident #2 until recently. The NHA said it would not be fair to the other resident's on the hall to move CNA #1's work assignment. She said that left the other CNA assigned to the floor and the nurse to care for Resident #1. She said this could cause a delay in care provided to Resident #1. She said she had received an email that day from Resident #1's daughter requesting CNA #1 not care for her mother any longer. She said they would honor that request but would tell the daughter and the resident that it could delay the resident's care. The NHA said the accusation had been reported to the state agency on 3/13/2020 at 2:42 p.m. She said the physician, ombudsman and medical director were all notified. The NHA said CNA #1 was not scheduled to work again until [DATE]20. She said CNA #1had been contacted via telephone and had been informed of her suspension pending the investigation.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to report an alleged violation of abuse to the facility administrator or designated representative and State Survey Agency for one (#2) out of nine sample residents. Specifically, the facility failed to ensure an allegation of physical abuse with Resident #2 by a staff member was reported to the facility's administrator and State Survey Agency. Cross reference F600 for failure to prevent abuse and F610 for failure to investigate an allegation of abuse Findings include: I. Facility policy and procedure The Abuse and Neglect policy and procedure, last revised 1/21/19 and last reviewed [DATE]5/19, was provided by the nursing home administrator (NHA) on [DATE]20 at 5:12 p.m., revealed in pertinent part: Reporting and Response This facility does not condone resident abuse and/or neglect by anyone. This includes, but is not limited to: staff members, other residents, consultants .All personnel will promptly report any incident of resident abuse and/or neglect. Procedure -All residents, families, resident representatives, and visitors are encouraged to immediately report incidents of suspected resident abuse and/or neglect to the facility administrator. -All associates are mandated to immediately report suspected resident abuse and/or neglect to their immediate supervisor and or facility representative. -All alleged or suspected violations involving mistreatment, abuse, neglect, injuries of unknown origin will be immediately reported to the administrator and/or director of nursing. -Facilities must ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment . are reported to the administrator of the facility and to other officials .in accordance with State law. II. Resident #2 A.Resident status Resident #2, [AGE], was admitted on [DATE], discharged to the hospital on [DATE], readmitted on [DATE] and discharged to the hospital again on [DATE] and readmitted [DATE]. According to the March 2020 computerized physician orders [REDACTED]. The 1/20/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BI[CONDITION]) score of 15 out of 15. She required extensive assistance of one person for bed mobility, dressing and personal hygiene. She required extensive assistance of two people for transfers and toileting. The resident had verbal behavioral symptoms, including threatening, screaming and cursing, directed towards others and a rejection of care that occurred one to three days during the assessment period. These behaviors were not present during the previous assessment period in October 2019. B. Resident interview The resident was interviewed on 3/11/2020 at 5:46 p.m. via telephone from the hospital. She said a certified nurse aide (CNA) #1 went into her room a day or two following her wound clinic appointment. She said CNA #1 grabbed her left great toe intentionally and squeezed it after she had told her it was infected. She said it was very painful. She said when she hollered out, CNA #1 turned and walked away. She said she told the nurse practitioner (NP). She said she felt the facility did not do anything. She said CNA #1 continued to care for her after the incident. She said she also told the nurse she did not want CNA #1 in her room. She said the head nurse came into her room and asked her why she no longer wanted CNA #1 take care of her. She said she told her CNA #1 squeezed her left great toe. She said she felt the facility staff did not believe her because CNA #1

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) continued to come into her room and care for her. She said she did not trust CNA #1 and did not want her around. She said, I am not a liar and it hurts my feelings they don't believe me. She said she was worried that if she complained now, she would not get the care she needed. The resident was interviewed again on 3/13/2020 at 2:10 p.m. She said she returned to the facility from the hospital on [DATE]. She said CNA #1 went her room with another CNA to assist her. She said she did not say anything because she was worried. She said she told her daughter as soon as she called. She said she still did not trust CNA #1 and did not want CNA #1 to care for her. She said she was worried the other CNA's would be mad at her since they were friends with CNA #1. C. Resident representative interview The resident's representative was interviewed on 3/11/2020 at 4:47 p.m. She said she lived out of state but spoke to the resident every day, sometimes two to three times a day and the resident told her everything that was going on that day. She said she would call or email the facility about the resident's concerns but they were slow to get back to her if they did at all. She said the facility told her the resident was manipulative. She said she thought this was the reason the facility did not take the resident's concerns seriously. The resident's representative was interviewed again on 3/13/2020 at 11:35 a.m. She said her mother had returned from the hospital on [DATE]. She said the facility continued to allow CNA #1 to care for the resident. She said the resident did not want to say anything because she was afraid the staff would not take care of her. She said she would contact the facility to reiterate she did not want CNA #1 caring for her mother. D. Record review The behavior care plan, initiated on 8/27/18 and last revised [DATE], revealed a history of the resident making accusations against staff. It indicated the resident made inappropriate statements about staff members. She preferred specific staff members to assist her with her activities of daily living (ADL). The interventions included: -To assist the resident to develop more appropriate methods of coping and interacting; -Encourage the resident to express feeling appropriately; -Care to be provided in pairs; and -Provide education that her request to only allow specific staff members to assist her may delay her care. The NP progress note on 2/13/2020 revealed the resident's left toe had a scab near the great toenail. It indicated it was very tender and there was purulent drainage from under the scab. The NP documented during the pain assessment, the resident stated someone squeezed her toe earlier that day. The resident said prior to that incident her toe did not hurt. She said the resident could not offer any details about the squeezing. It indicated the pain was isolated to the site of the scab on the left great toe. The resident's medical record was reviewed on [DATE]20 at 3:25 p.m. It did not reveal documentation the NP had reported the incident on 2/13/2020 between the resident and CNA #1. E. Staff interviews The NP was interviewed on 3/11/2020 at 10:52 a.m. She said she did not take the resident's statement of someone squeezing her toe as an allegation of assault at that time. She said she thought the resident was talking about when a staff member was providing care that they accidentally squeezed her foot. She said the resident complained about the care she received from the staff often. She said she did not question the resident any further about this and she did not report it to the NHA. The NHA was interviewed on 3/13/2020 at 2:32 p.m. She said she first became aware of the squeezing incident after the resident was interviewed on [DATE]20 to inquire why she would no longer allow CNA #1 to provide her care. She said during the interview the resident changed her story and indicated the incident was an accident so she did not feel like it was an allegation of abuse and it did not need to be investigated further.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to have evidence all alleged violations of potential abuse were thoroughly investigated and failed to ensure residents were protected from further potential abuse and/or mistreatment after allegations of abuse and/or mistreatment were known, involving three (#5, #8 and #2) out of four residents reviewed out of nine sample residents. Specifically, the facility failed to - Identify a potential abuse incident and conduct a thorough investigation of alleged resident to resident altercation between Resident #5 and #8. - Failed to protect Resident #5 and Resident #8 from additional potential abuse following the altercation; and, - Identify an allegation of alleged staff to resident physical abuse and conduct a thorough invetigation of the incident for Resident #2. Findings include: I. Facility policies and procedures The Abuse and Neglect policy and procedure, last revised 1/21/19 and last reviewed [DATE]5/19, was provided by the nursing home administrator (NHA) on [DATE]20 at 5:12 p.m., revealed in pertinent part: Investigation and Protection: -It is the policy of this facility that reports of abuse (abuse, neglect, mistreatment, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated. Residents have the right to live at ease in a safe environment without the fear of retaliation when allegations are reported. Procedure: -Following the identification of alleged abuse, the resident(s) receive prompt medical attention as necessary and the resident(s) are protected during the course of the investigation to prevent recurrence. Staff will respond immediately to protect the alleged victim(s)/other and integrity of the investigation. -The alleged victim will be examined for any sign of injury, including a physical examination or psychosocial assessment, if needed. Caution must be used in handling evidence that could be used in a criminal investigation. -When an incident or suspected incident of resident abuse and/or neglect, injury of unknown source, exploitation, or misappropriation of resident property is reported, the administrator/designee will investigate the occurrence. Protection will be provided to the alleged victim and other residents, such as room or staffing changes as needed to protect the resident(s) from the alleged perpetrator. -The administrator/designee will complete an Incident Report and will utilize the Incident Investigation Questionnaire Form to document the investigation. -The written summary of the investigation should include, but is not limited to: -A review of the incident, an interview with the person(s) reporting the incident, interviews with any witnesses to the incident, an interview with the resident if appropriate, a review of the resident's medical record, an interview with the employee(s), as needed, a review of the employee file, as needed. Interviews with staff members on all shifts having contact with the resident at the time of the incident. I interview with the resident's roommate, family, and/or visitors who may have information regarding the incident. Interviews (from) other residents who received care or services from the alleged perpetrator, and a review of all circumstances surrounding the incident. -If the accused individual is an employee, the alleged perpetrator will be removed from the resident care areas immediately and placed on suspension pending the results of the investigation. Retaliation by staff is abuse, regardless of whether harm was intended, and must be cited. -If the accused abuser is another resident, the residents must be separated while investigating the incident. Interventions must be implemented to assure the safety of all residents. -The result of the investigation will be recorded on the Incident Investigation Questionnaire. Any additional information documents including interviews and record reviews will be attached to the Incident Follow-Up and Recommendation Form. II. Resident #5 A. Resident status Resident #5, age 86, was admitted on [DATE]. According to the March 2020 computerized physician orders [REDACTED]. The 2/4/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. She required extensive assistance of two persons with bed mobility, transfers, dressing, toilet use, and personal hygiene. She required set-up assistance with locomotion on and off the unit, and eating. The MDS indicated the resident did not exhibit any behaviors or rejections of cares. B. Resident interview Resident #5 was interviewed on [DATE]20 at 5:27 p.m. she said she had a problem with her old roommate always telling her to turn her television down. She said on the night that she yelled at Resident #8, she had enough. She said she meant it when she said she was going to kick her (expletive), and she should have been afraid of her. The resident said the CNA working told both of the resident's to stop yelling. She said she was not moved to a new room, nor did any staff talk to her about the incident until Monday, when the social service director spoke with her. The resident said she does not currently have a roommate, so she listens to her television as loud as she likes. C. Record review Potential abuse allegation The 1/12/2020 behavior note documented the following: [DATE] at around 2030 (8:30 p.m.) CNA (certified nurse aide) notified this nurse about residents #5 and #8. CNA stated Resident #8 was asking nicely to Resident #5 to turn the television down because it was too loud but before she could even finish saying, Resident #5 interrupted her and was yelling, don't be hollering like the last time or I'll come and beat your (expletive) . Resident #8 got so upset and started yelling back to Resident #5. CNA told both residents to stop yelling to each other. The [DATE] Psychosocial note documented the following: SW (social worker) met with resident after receiving report that she had been verbally aggressive toward her roommate after roommate had requested that she lower the volume of her television. Resident acknowledged having been verbally aggressive and stated that she realized this type of behavior is inappropriate and nonconstructive. She stated that she does lower her television volume when her roommate enters the room, but that her roommate requests it to be lowered so quickly that sometimes she doesn't have time to react before her roommate becomes upset. SW asked resident if she would be willing to wear headphones while her roommate is in the room and she stated that she would not. Resident was agreeable to try to be more patient with roommate and work out disagreements in a more peaceful manner. Unit manager, DON (director of nursing), and ED/NHA (nursing home administrator) updated and aware.

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	065356	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF COLORADO SPRINGS	2490 INTERNATIONAL CIR COLORADO SPRINGS, CO 80910

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) III. Resident #8 A. Resident status Resident #8, [AGE], was initially admitted on [DATE] and readmitted on [DATE]. According to the March 2020 computerized physician orders [REDACTED]. The 2/ 0 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status score of 13 out of 15. She required assistance of one person with bed mobility, transfers, dressing, toilet use, and personal hygiene. She required set-up assistance with locomotion on and off the unit, and eating. The MDS indicated the resident did not exhibit any behaviors or rejections of cares. B. Resident interview Resident #8 was interviewed on [DATE]20 at 4:41 p.m. She said she recalled the incident with Resident #5, and she was glad they were no longer roommates. The resident said she was not afraid of Resident #5 now, but at the time she was unsure if Resident #5 was actually going to hit her or not. She said the incident was ridiculous and at their age they should not be acting like that. The resident said nobody talked with her the day of the incident (Saturday), but on Monday the social worker spoke with her and offered her a room change. C. Record review The [DATE] Psychosocial note documented the following: SW met with resident after receiving notification that roommate had been verbally aggressive toward her when resident requested that she lower the volume on her television on the evening of 1/11. Resident appeared indifferent and stated that she wasn't afraid of roommate. She reported that last night (1/12) was peaceful and quiet. SW asked resident if she had thought any more about moving to a different room and resident stated that she had and asked a few questions about room and hall. Resident appeared to be in overall good spirits and laughed and joked throughout interactions. She stated intention to continue to consider her options for room change and will report back. SW also met roommate separately. D. Staff interviews The social services director (SSD) was interviewed on [DATE]20 at 8:30 a.m. She said a note was left for her on Saturday [DATE]20, but she did not get the note until [DATE] (Monday) when she returned to the facility, regarding the verbal aggression between Resident #5 and Resident #8. The SSD said she was not the abuse coordinator for the facility, and the NHA was the abuse coordinator. The SSD said there were continuing issues between Resident #5 and Resident #8 and the television volume, the SSD said both residents seemed happier to not be roommates. The SSD said the NHA should have been notified on [DATE]20, and both residents should have been separated on [DATE]20 to ensure both of their safety. The NHA was interviewed on [DATE]20 at 1:00 p.m. She said her team determined it was not abuse on the night of [DATE]20. She said she was made aware of the verbal altercation on [DATE] (Monday), and had no comment if she should have been notified on [DATE]20 when the incident occurred. The NHA said the CNA defused the situation, and she did not think any additional steps needed to be taken. Registered nurse (RN) #1 was interviewed on [DATE]20 at 2:49 p.m. She said she recalled the incident between Resident #5 and #8, but she was not present in the room at the time of the incident. She said the CNA working that evening had told her Resident #5 told Resident #8 that she was going to hit her if she did not turn down her television. The RN said the CNA handled the situation by telling the resident to stop. The RN said the NHA was the facility abuse coordinator, but she did not call her on [DATE]20 following the verbal incident between Resident #5 and #8. The RN said looking back on the incident, she should have called the NHA on [DATE]20 to report the verbal abuse. IV. Resident #2 A. Resident status Resident #2, [AGE], was admitted on [DATE], discharged to the hospital on [DATE], readmitted on [DATE] and discharged to the hospital again on [DATE] and readmitted [DATE]. According to the March 2020 computerized physician orders [REDACTED]. The 1/20/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BI[CONDITION]) score of 15 out of 15. She required extensive assistance of one person for bed mobility, dressing and personal hygiene. She required the extensive assistance of two people for transfers and toileting. It indicated the resident had verbal behavioral symptoms, including threatening, screaming and cursing, directed towards others and a rejection of care that occurred one to three days during the assessment period. These behaviors were not present during the previous assessment period in October 2019. B. Resident interview The resident was interviewed on 3/11/2020 at 5:46 p.m. via telephone from the hospital. She said a certified nurse aide (CNA) #1 had come into her room a day or two following her wound clinic appointment. She said CNA #1 grabbed her left great toe intentionally and squeezed it after she had told her it was infected. She said it was very painful. She said when she hollered out, CNA #1 turned and walked away. She said she told the nurse practitioner (NP). She said she felt the facility did not do anything. She said CNA #1 continued to care for her after the incident. She said she also told the nurse she did not want CNA #1 in her room. She said the head nurse came into her room and asked her why she no longer wanted CNA #1 take care of her. She said she told her CNA #1 squeezed her left great toe. She said she felt the facility staff did not believe her because CNA #1 continued to come into her room and care for her. She said she did not trust CNA #1 and did not want her around. She said, I am not a liar and it hurts my feelings they don't believe me. She said she was worried that if she complained now, she would not get the care she needed. The resident was interviewed again on 3/13/2020 at 2:10 p.m. She said she returned to the facility from the hospital on [DATE]. She said CNA #1 came into her room with another CNA to assist her. She said she did not say anything because she was worried. She said she told her daughter as soon as she called. She said she still did not trust CNA #1 and did not want CNA #1 to care for her. She said she was worried the other CNA's would be mad at her since they were friends with CNA #1. C. Resident representative interview The resident's representative was interviewed on 3/11/2020 at 4:47 p.m. She said she lived out of state but spoke to the resident every day, sometimes two to three times a day and the resident told her everything that was going on that day. She said she would call or email the facility about the resident's concerns but they were slow to get back to her if they did at all. She said the facility told her the resident was manipulative. She said she thought this was the reason the facility did not take the resident's concerns seriously. The resident's representative was interviewed again on 3/13/2020 at 11:35 a.m. She said her mother had returned from the hospital on [DATE]. She said the facility continued to allow CNA #1 to care for the resident. She said the resident did not want to say anything because she was afraid the staff would not take care of her. She said she would contact the facility to reiterate she did not want CNA #1 caring for her mother. D. Record review The behavior care plan, initiated on 8/27/18 and last revised [DATE], revealed a history of the resident making accusations against staff. It indicated the resident made inappropriate statements about staff members. She preferred specific staff members to assist her with her activities of daily living (ADL). The interventions included: -To assist the resident to develop more appropriate methods of coping and interacting; -Encourage the resident to express feeling appropriately; -Care to be provided in pairs; and -Provide education that her request to only allow specific staff members to assist her may delay her care. The NP progress note on 2/13/2020 revealed the resident's left toe had a scab near the great toenail. It indicated it was very tender and there was purulent drainage from under the scab. The NP documented during the pain assessment, the resident stated someone squeezed her toe earlier that day. The resident said prior to that incident her toe did not hurt. She said the resident could not offer any details about the squeezing. It indicated the pain was isolated to the site of the scab on the left great toe. The resident's medical record was reviewed on [DATE]20 at 3:25 p.m. It did not reveal documentation the NP had reported the incident on 2/13/2020 between the resident and CNA #1. The investigation for this incident was requested from the facility on 3/11/2020 at 9:02 a.m. The facility provided a typed statement from the nursing home administrator (NHA) and unit manager (UM) #1, dated [DATE]20. The written statement consisted of an interview with the resident asking why she no longer wanted to work with CNA #1. This statement indicated the resident told them she did not want CNA #1 caring for her because she pinched her toe on her left foot the day after she came back from her wound appointment for her left foot. The statement went on to say the resident changed her story and said it was an accident but she still did not want CNA #1 in her room. This investigation occurred 14 days after the resident informed the NP of the incident. The review did not include interviews from CNA #1, other residents or staff members. E. Staff interviews The NP was interviewed on 3/11/2020 at 10:52 a.m. She said she did not take the resident's statement of someone squeezing her toe as an allegation of assault at that time. She said she thought the resident was talking about when a staff member was providing care that they accidentally squeezed her foot. She said the resident complained about the care she received from the staff often. She said she did not question the resident any further about this and she did not report it to the NHA. The NHA was interviewed on 3/13/2020 at 2:32 p.m. She said because the resident changed her story she did not feel like it was an allegation of abuse and it did not need to be investigated further. She said she had not restricted CNA #1 from caring for Resident #2 because after she told the resident if she would not allow CNA #1 to assist caring for her it would increase the time she would have to wait for care. She said Resident #2 agreed at that time to allow CNA #1 to care for her. The NHA said she did not have documentation of this encounter with Resident #2. According to this statement, provided by the NHA on 3/13/2020 at 4:42 p.m., dated [DATE]20 and signed by the NHA and UM #1, a follow up interview was done with Resident #1 explaining the increase in time she would have to wait for care to be provided if she did not allow CNA #1 to care for her. It indicated Resident #2 decided at that time she would be okay with CNA #1 coming into her room as long as she was not the primary care provider. This statement was not completed until

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) 3/13/2020 (during the survey process) after the NHA indicated she did not have documentation of the encounter.
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to develop and revise comprehensive care plans for each resident that included the instructions needed to provide effective and person-centered care for two (#2 and #5) residents out of nine sample residents. Specifically, the facility: Failed to ensure Resident #2's comprehensive care plan was revised and updated: -After blisters developed on the right foot; -When being treated for [REDACTED]. Failed to ensure Resident #5 had a comprehensive care plan which addressed potential verbally abusive behavior towards roommates. Findings include: I. Resident #2 A. Resident #2 status Resident #2, [AGE], admitted [DATE], discharged to the hospital [DATE] and readmitted [DATE] then discharged to the hospital again on [DATE] and readmitted [DATE]. According to the March 2020 computerized physician orders [REDACTED]. The 1/20/2020 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BI[CONDITION]) score of 15 out of 15. She required extensive assistance of one person for bed mobility, dressing and personal hygiene. She required extensive assistance of two people for transfers and toileting. The MDS indicated the resident was at risk for developing pressure ulcers. The resident did not have any ulcers, wounds or skin problems identified during the assessment period. B. Record review 1. Care plan The care plan, initiated 8/27/18 and last revised on 2/22/19, revealed the resident had a potential for alteration in skin integrity related to frequent urinary incontinence, limited mobility and pain. She required more than one staff to assist with transfers, toileting and bathing. The goal was to maintain intact skin with no skin breakdown. Interventions included: -Weekly skin check; -Clean and dry skin after each incontinent episode; and, -Pressure reducing mattress. The care plan did not include any interventions to prevent skin breakdown, current skin integrity issues, treatment or interventions for the resident's current skin integrity issues. 2. Blisters to right foot The 11/29/19 nursing progress note revealed the resident had a new blister in between her right great toe and the second toe. It indicated the root cause was from the way the resident's toes overlapped and caused friction. The resident did not complain of any pain or discomfort to the blister. The November 2019 CPOs revealed the following physician order: -Cleanse between the second and third toe with wound cleanser and pat dry. Apply [MEDICATION NAME] and leave open to air or cover with a dressing if the resident wishes - ordered 11/29/19. The resident's medical record was reviewed on [DATE]20 at 1:30 p.m. It did not reveal the care plan was updated with this newly identified skin integrity issue to the right foot. 3. Fungal infection to right foot The 12/9/19 nurse practitioner (NP) progress note revealed the resident had fungal debris between her toes with slight swelling of the toes. It indicated the resident's toe alignment made the toes fit very tightly together. There was a small five millimeter (mm) wound due to a cracking of the skin between the second and third digits of the right foot. It indicated the plan was to apply [MEDICATION NAME] to the wound and cover with a foam dressing after applying an athlete ' s foot cream to the foot and in between the toes for ten days. The resident's medical record was reviewed on [DATE]20 at 1:30 p.m. It did not reveal the care plan was updated with this change in status and treatment to the right foot. 4. Right foot [MEDICAL CONDITION] with infected ulcer The [DATE]20 admission/readmission collection tool revealed the resident had been hospitalized with a [DIAGNOSES REDACTED]. It indicated the right foot great toe, second toe, and third toes each had one by one centimeter (cm) reddened open areas. The [DATE] NP progress note revealed the resident had right foot [MEDICAL CONDITION] that presumably started in the small wound between her second and third toe. The right foot had two wounds with scant drainage. One wound was between the second and third toes and the other was on the top of the great toe. The toes had some swelling and the foot had some discoloration but no warmth. It indicated the resident frequently refused treatments, wound care and an exam prior to hospitalization after the resident returned to the facility the resident was ordered an antibiotic. Dressing changes were to be done daily with [MEDICATION NAME] and [MED] ([MEDICATION NAME] non-adherent dressing). The resident was encouraged to allow the dressing changes daily approximately thirty minutes after her pain medication was administered for maximum pain relief. The resident's medical record was reviewed on [DATE]20 at 1:30 p.m. It did not reveal the care plan was updated with this newly identified skin integrity issue to the right foot, treatment recommendations or interventions to prevent further breakdown and promote wound healing. 5. Bunions and ingrown toenail The 2/11/2020 wound clinic progress note revealed the ulcer at the base of the first and second toes of the right foot were well-healed. It indicated the resident had large medial bunions (bony bump that develop on the inside of the foot at the big toe joint) on both feet with small shallow ulcers noted. The resident also had a left great ingrown toenail. The ulcers on her bunions were debrided (removal of damaged tissue), cleansed with saline and dressed with absorbent foam dressings. The left great toenail was partially removed, cleansed with saline, treated with antibiotic ointment and gauze. The instructions given to the facility included: - Clean the left great toe with saline daily, apply [MEDICATION NAME] and cover with a band aid for one week; -Apply small foam dressing on the two medical bunions and change two times a week; -A&D ointment to dry, intact skin on both feet; -Start [MEDICATION NAME] (an antibiotic) 500 milligrams (mg) one tablet by mouth three times daily for 10 days; and -Follow up in three weeks. The resident's medical record was reviewed on [DATE]20 at 1:30 p.m. It did not reveal the care plan was updated with these newly identified skin integrity issues to either feet, treatment recommendations, or interventions to prevent further breakdown or promote wound healing. 6. Blood blister on right buttock According to [DATE] nurses notes, the resident had a new complaint of pain to her buttocks. The assessment revealed a 1.5 centimeter (cm) by 1.5 cm dark purple area that appeared as a blood blister with redness and induration (hardening of the tissue) surrounding it. The [DATE] NP progress note revealed the blood blister had evolved and was larger than previous being approximately 1 cm by 2.5 cm. The area was darker than the surrounding tissue with no clear open area. The area was depressed approximately 1 to 2 millimeters (mm). There was redness and induration on the proximal end of the darkened area. It indicated the etiology was unknown, however the resident did mention to the provider that the wound clinic moved her with a slide board. The NP ordered the resident was to lay down at least one hour after each meal to give the buttock area rest from the wheelchair. The wheelchair cushion was evaluated by therapy and reported as an excellent pressure relieving cushion. The resident was asked to not sit on a towel which was her common habit. Review of the record revealed the care plan was not updated with this newly identified skin integrity issue. No interventions were included to prevent further skin breakdown or promote wound healing including the recommendations from the NP on [DATE]. The 2/25/2020 wound clinic progress note revealed the resident was referred to the wound clinic for evaluation of pressure injury wounds on her right buttock and sacral region. It indicated there was an ulcer on the right medial buttock and two smaller ulcers in the fold of the buttock which were smaller but deeper with some slough in the distal ulcer. The ulcer to the right buttock measured 3.9 cm length by 2.4 cm width by 0.1 cm depth and was covered in yellow eschar. It had a large amount of serosanguinous (consisting of both blood and serous fluid) drainage. It indicated the right buttock ulcer was debrided (removal of damaged tissue). Recommendations from the wound clinic included: -Obtain a low air loss mattress and minimize time spent on her back; -Obtain a 2-view x-ray of her sacrum for screening purposes; -Obtain laboratory work consisting of a complete blood count (CBC), c-reactive protein (CRP) and erythrocyte sedimentation rate (ESR)- used to determine inflammation and infection; -Remove the dressing to the coccyx/buttock and rinse with saline. Apply a nickel thick amount of [MED] (an enzymatic [MEDICATION NAME] ointment), cover with gauze, an absorbent dressing and secure with tape daily; and -Follow up in one week on [DATE]. The [DIAGNOSES REDACTED]. Review of the record revealed these recommendations were not care planned. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 3/11/2020 at 11:00 a.m. She said the MDS coordinator was responsible for updating the care plans. Registered nurse (RN) #2 was interviewed on 3/11/2020 at 11:05 a.m. She said all staff used to be responsible to update the care plan but the management team felt like the wrong kind of information was being added to the care plans so now only the MDS coordinator was supposed to update the care plans. Unit manager (UM) #1 was interviewed on 3/11/2020 at 12:20 p.m. She said each time the resident had a new skin issue, including the blisters to the right foot, the fungal infection to the right foot, the [MEDICAL CONDITION] to the right foot, the ingrown toenail to the left foot and the blood blister to the residents bottom, the care plan should have been updated with the issue and interventions to prevent further breakdown and promote healing. She said any of the nursing staff could update the care plan but the nursing management team was primarily responsible for keeping the care plans up to date. The director of nursing (DON) was interviewed on 3/11/2020 at 3:30 p.m. She said the care plan should be updated with any newly identified skin issues. She said any nurse could update the care plan but the nurse managers were primarily responsible for updating the nursing care plans.

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) II. Resident #5 A. Resident #5 status Resident #5, age 86, was admitted on [DATE]. According to the March 2020 computerized physician orders [REDACTED]. The 2/4/2020 MDS assessment revealed the resident was cognitively intact with a BI[CONDITION] score of 15 out of 15. She required extensive assistance of two persons with bed mobility, transfers, dressing, toilet use, and personal hygiene. She required set-up assistance with locomotion on and off the unit, and eating. The resident did not exhibit any behaviors or rejections of cares. B. Record review The comprehensive care plan, last reviewed on [DATE], was reviewed during the survey on [DATE]20 at 4:00 p.m. The resident did not have a behavior care plan regarding the resident's potentially verbally abusive behavior towards roommates. C. Staff interviews The nursing home administrator (NHA) and social service director (SSD) were interviewed on [DATE]20 at 1:00 p.m. The social worker said she was responsible for most behavior care plans, and Resident #5 should have a behavior care plan, with interventions. The NHA said she did not believe the resident needed a behavior care plan, and did not think everything needed to be care planned.
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** Based on interviews and record review, the facility failed to provide treatment and care in accordance with professional standards of practice of one (#2) out of nine sample residents. Specifically the facility failed to: - Promptly identify issues with Resident #2's skin integrity and initiate appropriate treatment timely; - Consistently monitor Resident #2's skin integrity issues; - Follow through with recommendation made from the wound clinic for Resident #2's wounds; - Ensure orders were transcribed appropriately to Resident #2's record and completed; and - Update Resident #2's care plan with newly identified skin integrity issues and implement newly identified interventions. Cross-reference F657, care plan timing and revision. Findings include: I. Facility policy and procedure The Documentation and Assessment of Wounds Policy and Procedure, effective 10/3/19, was provided by the director of nursing (DON) on 3/11/2020 at 10:31 a.m. It revealed in pertinent part, - A thorough wound assessment should consist of objective criteria and measurements that promote accurate, consistent comparisons to determine the extent of the wound and the effectiveness of wound healing. - Comparison of assessment results to previous findings helps to monitor, communicate, treat, and document wound healing progression or complications. - Observe the general condition of the wound. Note the wound's shape and anatomic location as well as the presence of necrotic tissue and odor. Assess the color of the wound. Measure the wound size. Assess the surrounding area of skin for [DIAGNOSES REDACTED]tous (red) but intact skin, indurated (hard) skin, boggy (soft) tissue or macerated (white) skin. - If appropriate, identify the cause of the wound to ensure proper wound treatment. Apply the appropriate wound care treatments and dressing, as indicated and ordered. II. Resident #2 A. Resident status Resident #2, [AGE], was admitted [DATE], discharged to the hospital [DATE], readmitted [DATE], discharged to the hospital on [DATE] and readmitted again on [DATE]. According to the March 2020 computerized physician orders [REDACTED]. The 1/20/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BI[CONDITION]) score of 15 out of 15. She required extensive assistance from one person for bed mobility, dressing and personal hygiene. She required extensive assistance from two people for transfers and toileting. The resident was at risk for developing pressure ulcers but did not have any identified ulcers, wounds or skin problems during the assessment period. B. Record review The care plan, initiated 8/27/18 and last revised on 2/22/19, revealed the resident had the potential for alteration in skin integrity related to limited mobility and pain. The goal was to maintain intact skin with no skin breakdown. Interventions include a weekly skin check. The care plan did not include any interventions to prevent skin breakdown, identify current skin integrity issues, treatment or interventions for the resident's skin integrity issues at the time of the survey. (Cross reference F657) The 11/29/19 nursing progress note revealed the resident had a new blister in between her right great toe and the second toe. It indicated the root cause was from the way the resident's toes overlapped and caused friction. The resident did not complain of any pain or discomfort to the blister. The note did not reveal whether the blister was blood or fluid filled and did not include measurements for the blister. The November 2019 CPO included an order to cleanse between the second and third toe with wound cleanser and pat dry. Apply [MEDICATION NAME] and leave open to air or cover with a dressing if the resident wishes, order date 11/29/19. The 11/30/19 nursing progress note clarified the location of the blister on the right foot was located between the second and third toes. The 12/5/19 weekly skin integrity data collection documented the resident's skin was not intact. No other description was given. The 12/8/19 nursing progress note revealed the area between the second and third toe of the right foot appeared as an open area with no drainage. The 12/9/19 nurse practitioner (NP) progress note revealed the resident had fungal debris between her toes with slight swelling of the toes. It indicated the resident's toe alignment made the toes fit very tightly together. There was a small five millimeter (mm) wound due to a cracking of the skin between the second and third digits of the right foot. The plan was to apply [MEDICATION NAME] to the wound and cover with a foam dressing after applying an athlete's foot cream to the foot and in between the toes twice daily for ten days. The [DATE] weekly skin integrity data collection revealed the resident's skin was not intact. It indicated the resident had a right toe fungal rash. A [DATE] nursing progress note revealed the fungal area between the second and third toe on the right foot continued to worsen. The area was described red with no drainage however note also revealed the resident reported a large amount of drainage to the nurse. The December 2019 medication administration record (MAR) revealed the resident allowed treatment only once per day, not twice as ordered, between 12/20/19-12/2[DATE]9. The resident's medical record was reviewed on [DATE]20 at 1:30 p.m. The record did not include additional documentation of the area between the resident's second and third toe on the right foot again until [DATE]. The physician's orders [REDACTED]. The order for the [MEDICATION NAME] and foam dressing was discontinued on 12/2[DATE]9. It did not indicate why the dressing was discontinued. The [DATE] nursing progress note revealed the resident had a blister/fungal infection in between her second and third toes again. The area was noted to have resolved but had returned. It indicated she did have a treatment ordered before for [MEDICATION NAME] and a dressing but she refused the treatment. The [DATE] nursing progress note revealed the resident was complaining of pain to her right foot. The area between her second and third toe on her right foot had redness, swelling and appeared blistered. The area was hot to touch. The resident was sent to the emergency room (ER) for further evaluation and treatment of [REDACTED]. The resident was diagnosed and treated for [REDACTED]. She was discharged back to the facility on [DATE] with wound care orders, antibiotic orders to continue for two weeks and a follow up appointment with the wound clinic on 1/ 0. The [DATE]20 readmission collection tool revealed the right foot, great toe, second toe, and third toes each had one by one centimeter (cm) reddened open areas. It indicated a 0.5 cm by 0.5 cm scab to the left foot, outer great toe. (This area is not mentioned again until a wound clinic progress note on 2/11/2020, see below). According to the January 2020 CPO, readmission orders [REDACTED]. The [DATE] NP progress note revealed the resident had right foot [MEDICAL CONDITION] that presumably started in the small wound between her second and third toe. The right foot had two wounds with scant drainage. One wound was between the second and third toes and the other was on the top of the great toe. The toes had some swelling and the foot had some discoloration but no warmth. It indicated the resident frequently refused treatments, wound care and an exam prior to hospitalization and the resident returned to the facility on an antibiotic and dressing changes were to be done daily with [MEDICATION NAME] and [MED] ([MEDICATION NAME] non-adherent dressing). The resident was encouraged to allow the dressing changes daily approximately thirty minutes after her pain medication was administered for maximum pain relief. According to the January 2020 CPOs, the physician orders [REDACTED]. Dry the foot and between toes. Apply [MEDICATION NAME] to wound beds, cover with [MED], wrap with gauze and ace wrap. Change daily. The [DATE] wound clinic progress notes revealed the resident was seen for a skin ulcer to the right foot with fat layer exposed. Wound care instructions included to clean with saline, apply [MEDICATION NAME] to the right great toe and second web space, cover with [MED], wrap with gauze and ace wrap daily; apply A&D ointment (moisturizing, skin protectant) to dry intact skin. The resident had a follow up appointment with the wound clinic on 2/11/2020. A review of the resident's medical record revealed [REDACTED]. The 2/5/2020 NP progress note revealed the previous [MEDICAL CONDITION] was now resolved. It indicated a small area remained with only some pink discoloration on the skin. The NP ordered to discontinue the current dressing and only a dry dressing was to be applied. It indicated the dry dressing was not necessary, but ordered because the resident was nervous about keeping it open to air. The NP ordered for facility staff to clean between the toes every 24 hours. A review of the resident's medical record revealed [REDACTED]. The [DATE]20 weekly skin integrity data collection revealed the right foot was healing and the [MEDICAL CONDITION] was resolved but the resident still wanted it wrapped. No other skin integrity

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	065356	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF COLORADO SPRINGS	2490 INTERNATIONAL CIR COLORADO SPRINGS, CO 80910

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) issues were identified. The 2/11/2020 wound clinic progress note revealed the ulcer at the base of the first and second toes of the right foot were well-healed. It indicated the resident had large medial bunions (bony bump that develops on the inside of the foot at the big toe joint) on both feet with small shallow ulcers noted. The resident also had a left great ingrown toenail. The ulcers on her bunions were debrided (removal of damaged tissue), cleansed with saline and dressed with absorbent foam dressings. The left great toenail was partially removed, cleansed with saline, treated with antibiotic ointment and gauze. The instructions given to the facility included: -Clean the left great toe with saline daily, apply [MEDICATION NAME] and cover with a band aid for one week; -Apply small foam dressing on the two medical bunions and change two times a week; -A&D ointment to dry, intact skin on both feet; -Start [MEDICATION NAME] (an antibiotic) 500 milligrams (mg) one tablet by mouth three times daily for 10 days; and -Follow up in three weeks. Review of the record on [DATE] revealed the instructions given to the facility by the wound clinic on 2/11/2020 were added to the residents MAR. The treatment to the left great toe and treatment to both feet was signed off as being provided on 2/12/2020 but were not signed off as being provided on 2/13/2020 and were discontinued on 2/13/2020. The other orders continued. The 2/13/2020 NP progress note revealed the left great toe had an open area with an approximate one cm by four mm scab present, scant purulent drainage from underneath the scab was seeping. There was redness and swelling to the great toe with tenderness limited to the area of the wound. The plan was to cleanse the wound with [MEDICATION NAME], apply [MEDICATION NAME] and then cover with [MED] and wrap with gauze. There was no mention of the ulcers to the bunions on both of her feet or treatment put into place. The order for this treatment was not transcribed onto the February 2020 MAR or TAR and was not documented as being completed. The 2/15/2020 weekly skin integrity data collection revealed the right foot had a scab to the outside great toe, (this area was documented as healed by the NP on 2/5/2020 and the wound clinic on 2/11/29) and skin was not intact to the left foot great toe nail removal site. No description of these areas was given. According to the 2/25/2020 wound clinic progress notes, treatment orders for the resident's feet were the same as the previous visit on 2/11/2020. The treatment orders were not transcribed onto the February 2020 MAR or TAR and were not documented as being completed. The [DATE] wound clinic progress notes revealed the resident continued to have skin impairment to her left great toe and bilateral bunions. Treatment orders included: -Clean feet with saline daily. Apply [MEDICATION NAME] to the left great toe and cover with a band aide daily for one week; -Cover small wounds on bunions on bilateral feet with a small foam border dressing two times a week; and -Apply A&D ointment to dry, intact skin on both feet. The March 2020 MAR revealed the order for the left great toe was transcribed and treatment started on [DATE]. The order to cover the small wounds on the bilateral bunions was not transcribed onto the March 2020 MAR or TAR as ordered by the wound clinic and were not documented as being completed. C. Staff interviews The DON was interviewed on 3/11/2020 at 9:35 a.m. She said the facility did not monitor wounds that were not a Stage 3 or 4 pressure wounds, stasis or diabetic ulcer. She said they did not investigate or monitor blisters. Unit manager (UM) #1 was interviewed on 3/11/2020 at 12:20 p.m. She said the skin issues Resident #2 had with her feet were not wounds that would be monitored by the facility except on the weekly skin checks done by the nurses. She said the orders received from the wound clinic had to be verified and approved by the facility practitioner. She said the NP did not always agree with the orders so she would change them. She said the nurse who entered the orders for treatment to the resident's feet did not schedule them to be done on the MAR or TAR and therefore there was no documentation of the treatments being done unless the nurse entered it in a progress note. She said all of the resident's skin issues should have been care planned along with interventions to prevent further skin breakdown. UM #2 was interviewed on 3/11/2020 at 1:37 p.m. She said all skin integrity issues should be documented weekly on the weekly skin integrity data collection that included measurements and a description of the wound. She said the designated UM and the assistant director of nursing (ADON) monitored stage 3 and 4 pressure ulcers, venous or stasis ulcers, and diabetic ulcers weekly and documented it in the resident's record. The DON was interviewed again on 3/11/2020 at 3:30 p.m. She said Resident #2 had a fungal infection and [MEDICAL CONDITION] to her feet. She said those skin conditions were not something the facility monitored extensively, like a pressure ulcer or other wound.
F 0686 **Level of harm** - Minimal harm or potential for 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** Based on record review and interviews, the facility failed to provide care and services to prevent pressure ulcer development for one (#2) of three residents reviewed for pressure injury out of nine sample residents. Specifically, the facility failed to: - Initiate interventions to prevent the worsening of a pressure injury for Resident #2, including dietary involvement; - Accurately and consistently document Resident #2's wound on her bottom; - Ensure Resident #2's wound care was provided consistently and according to physician orders; and - Update the resident's care plan with newly identified skin integrity issues and interventions. Cross reference F657, care plan timing and revision. Findings include: I. Facility policy and procedure The Documentation and Assessment of Wounds Policy and Procedure, effective 10/3/19, was provided by the director of nursing (DON) on 3/11/2020 at 10:31 a.m. The policy read in pertinent part: - A thorough wound assessment should consist of objective criteria and measurements that promote accurate, consistent comparisons to determine the extent of the wound the effectiveness of wound healing. - Comparison of assessment results to previous findings helps to monitor, communicate, treat, and document wound healing progression or complications. - Observe the general condition of the wound. Note the wound's shape and anatomic location as well as the presence of necrotic tissue and odor. Assess the color of the wound. Measure the wound size. Assess the surrounding area of skin for [DIAGNOSES REDACTED]tous (red) but intact skin, indurated (hard) skin, boggy (soft) tissue or macerated (white) skin . - If appropriate, identify the cause of the wound to ensure proper wound treatment. Apply the appropriate wound care treatments and dressing, as indicated and ordered. II. Resident #2 A. Resident status Resident #2, [AGE], admitted [DATE], discharged to the hospital [DATE] and readmitted [DATE] then discharged to the hospital again on [DATE] and readmitted [DATE]. According to the March 2020 computerized physician orders [REDACTED]. The 1/20/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BI[CONDITION]) score of 15 out of 15. She required extensive assistance from one person for bed mobility, dressing and personal hygiene. She required extensive assistance from two people for transfers and toileting. The resident was at risk for developing pressure ulcers but wounds were not present during the assessment period. She had a pressure relieving device for her bed and chair. B. Resident interview Resident #2 was interviewed on 3/13/2020 at 1:52 p.m. She was seated in her wheelchair in front of her lunch tray on the over-the-bed table in her room. She had a cushion in the wheelchair and an air mattress was observed on the bed. The resident said she returned from the hospital the day before. She said she had a sore on her bottom that they had been taking care of. She said it only painful when they did wound care or when she was lying on her back in bed. The resident said it was difficult to get comfortable when lying in bed. She said she needed assistance from the staff to reposition herself in the bed or chair. She said they did not come in and do it unless she called for them. The resident said she was told she got the sore on her bottom when she was at the wound clinic because they used a board to move her from her wheelchair to their chair when she was getting treatment for [REDACTED]. C. Record review The care plan, initiated 8/27/18 and last revised on 2/22/19, revealed the resident had a potential for alteration in skin integrity related to limited mobility and pain. The goal was to maintain intact skin with no skin breakdown. Interventions include a weekly skin check and a pressure reducing mattress. The care plan did not include any interventions to prevent skin breakdown, current skin integrity issues, treatment or interventions for the resident's current skin integrity issues. (Cross reference F657) The [DATE] nurse practitioner (NP) note revealed the resident reported new soreness to the buttock area. It indicated there was a blood blister to the right buttock near the proximal end of gluteal fold and the etiology (cause) was unknown, the resident and staff were not aware of any known injury. The plan was to monitor for breakdown. According to [DATE] nurses' notes, the resident had a new complaint of pain to her buttocks. The assessment revealed a 1.5 centimeter (cm) by 1.5 cm dark purple area that appeared as a blood blister with redness and induration (hardening of the tissue) surrounding it. It indicated the resident stated the staff at the wound clinic transferred her from her wheelchair to a hard plastic chair. The area had been assessed by the NP and the director of nursing (DON) earlier in the shift. The resident's medical record was reviewed on [DATE] at 1:30 p.m. and revealed the following: - The wound clinic appointment was on 2/11/2020; - There was no documentation the resident had any issues with the skin integrity to her buttocks during routine care from 2/11/2020 to [DATE] when the wound was first identified; and - No interventions were initiated or care planned to prevent further breakdown of the area. The 2/15/2020 weekly skin integrity data collection did not document the blood blister to the right buttock. The [DATE] nursing progress note revealed the right buttock was assessed for a blood blister obtained from the wound clinic when they used a slide board to transfer the resident. It indicated the area was 3.5 cm by 2.25 cm, dark purple and hard, with a small open area and no drainage. The surrounding tissue was red and warm. It indicated the nurse

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 8) was going to notify the DON and have the NP assess. It indicated a significant increase in size since being first identified on [DATE]. The [DATE] NP progress note revealed the blood blister had evolved and it was not completely clear if it burst or absorbed but the area of concern was larger than previous being approximately 1 cm by 2.5 cm. (These measurements did not match the documentation in the nursing progress note). The area was darker than the surrounding tissue with no clear open area. The area was depressed approximately 1 to 2 millimeters (mm). There was redness and induration on the proximal end of the darkened area. It indicated the etiology was unknown, however the resident did mention to the provider that the wound clinic moved her with a slide board. The NP ordered the resident to lay down at least one hour after each meal to give the buttock area rest from the wheelchair. The wheelchair cushion was evaluated by therapy and reported as an excellent pressure relieving cushion. The resident was asked to not sit on a towel which was her common habit. (These interventions were not care planned) According to the February 2020 CPOs, the physician orders [REDACTED]. Apply [MEDICATION NAME] (antibacterial and antimicrobial skin cleanser) to the wound and cover with bordered gauze. - Change daily in the afternoon. - Continue treatment until [MED] (a specialized wound dressing) dressing was available. According to the 2/20/2020 NP progress note, the wound team ordered a special antimicrobial dressing for her buttocks with changes every other day. It indicated that until the dressing arrived [MEDICATION NAME] was to be done with daily changes. It indicated the wound team was uncertain exactly how to classify the wound. The 2/20/2020 nursing progress note revealed the resident refused to lay down in bed in between meals and when she did lay down, it was on her back. The 2/21/2020 NP progress note revealed there was an approximate 1 to 2 mm depth to the wound to the right gluteal fold. There was a thick darkened base with a small amount of foul smelling drainage. There was induration with redness to the proximal portion of the base with some increase in size. It indicated the provider recommended an MRI (magnetic resonance imaging) for further evaluation and the resident was considering it. The 2/21/2020 nursing progress note revealed the resident had a 3 cm by 2 cm (These measurements did not match the documentation in the NP note) open wound to her right buttock. The wound bed was beefy red in color and the edges of the wound were brown with red areas that were hot to touch. It indicated there was a moderate amount of brownish red drainage coming from the site. The 2/22/2020 weekly skin integrity data collection revealed a blood blister area to the left buttock instead of the right buttock. No measurements or description was given. The [DATE]20 nursing progress note revealed the right upper buttock was cleansed with wound cleanser, skin prep was applied to the surrounding wound bed and an [MED] dressing was placed with a transparent adhesive dressing. It indicated the site had a small amount of yellowish, foul smelling drainage. It indicated the right buttock had been assessed by the NP. The [DATE]20 NP progress note revealed the area to the right buttock had developed an eschar with redness and induration surrounding the entire eschar. It indicated the resident reported no pain with palpation of the area, but pain when she laid down in bed, which she had been doing intermittently. It indicated the [MED] dressing was being used over the area. It indicated the resident agreed to an MRI for evaluation for [CONDITION] and had an appointment with the wound clinic for evaluation on 2/25/2020. The February 2020 MAR revealed the treatment with the [MEDICATION NAME] and border gauze was provided daily from 2/20/2020 through 2/25/2020 then was discontinued. It indicated the [MED] was to be started on [DATE]20 but was discontinued on [DATE]20 after new orders were received from the wound clinic on 2/25/2020. The [MED] was not documented as being used on the MAR on the days it was documented as being used in the progress notes. The 2/25/2020 wound clinic progress note revealed the resident was referred to the wound clinic for evaluation of pressure injury wounds on her right buttock and sacral region. It indicated there was an ulcer on the right medial buttock and two smaller ulcers in the fold of the buttock which were smaller but deeper with some slough in the distal ulcer. The ulcer to the right buttock measured 3.9 cm length by 2.4 cm width by 0.1 cm depth and was covered in yellow eschar. It had a large amount of serosanguinous (consisting of both blood and serous fluid) drainage. It indicated the right buttock ulcer was debrided (removal of damaged tissue). Recommendations from the wound clinic included: -Obtain a low air loss mattress and minimize time spent on her back; -Obtain a 2-view x-ray of her sacrum for screening purposes; -Obtain laboratory work consisting of a complete blood count (CBC), c-reactive protein (CRP) and erythrocyte sedimentation rate (ESR)- used to determine inflammation and infection; -Remove the dressing to the coccyx/buttock and rinse with saline. Apply a nickel thick amount of [MED] (an enzymatic [MEDICATION NAME] ointment), cover with gauze, an absorbent dressing and secure with tape daily; and -Follow up in one week on [DATE]. The [DIAGNOSES REDACTED]. According to the February 2020 CPO, physician orders [REDACTED]. Review of the resident's record revealed the wound care orders were entered on [DATE]20 but not scheduled to start until [DATE]20. The resident did not receive any type of wound care to her bottom on [DATE]20. The [DATE]20 nursing progress note revealed the wound to the right inner buttock had a moderate amount of foul smelling serosanguinous drainage. The wound bed was 80% covered with creamy slough and measured 4 cm by 3.5 cm. The surrounding skin was firm and hard with normal color and temperature. The [DATE] nursing progress notes revealed the resident complained of pain to the wound on her right inner buttock. It indicated the wound had a very foul odor emanating from in and was draining a moderate amount of foul smelling brown drainage. It indicated the resident stated the air mattress was uncomfortable and she did not like it and was afraid to fall asleep on it. The 2/29/2020 nursing progress note revealed wound care had to be provided because the old dressing was saturated with foul smelling brown drainage and falling off. The peri-wound was red and hard by the sacrum. It indicated the wound bed had 80% white slough and the edges of the wound were rolled inward. It indicated the resident stated the wound hurt her so bad and the alternating pressure mattress hurt her and was uncomfortable, making it very hard to position the resident and get her comfortable in bed. The 2/29/2020 weekly skin integrity data collection revealed the resident had a right buttock wound. No description or measurements were documented. The [DATE] nursing progress note revealed the resident needed a new treatment order because the dressing ordered was not holding the drainage and would come right off. It indicated the wound had moderate to large amounts of foul smelling brown drainage. The [DATE] wound clinic progress note revealed the left buttock and sacral ulcers were connected with an overlying skin bridge with significant undermining and yellow, firmly adherent slough. The right buttock wound measured 4.2 cm by 1.9 cm by 1.4 cm with undermining from 7 o'clock to 1 o'clock with a depth of 2.2 cm. There was 50% granulation tissue and 50% slough. The coccyx wound measured 1.1 cm by 0.4 cm by 0.1 cm with 100% slough. It indicated a limited debridement was performed due to the resident's complaint of pain but the overlying skin bridge needed to be excised to ensure complete access to the area for appropriate debridement. Recommendations from the wound clinic included: -Wound care to sacrum/buttock: remove dressing and rinse with saline. Apply a nickel thick amount of [MED], and plain calcium alginate with no silver, cover with an absorbent dressing and secure with tape daily; -Obtain [MEDICATION NAME] and [MEDICATION NAME] levels; -Use low air loss mattress and minimize time spent on back; and -Follow up in two weeks. The [DATE] NP progress note revealed the ulcer to the buttock had progressed in an unexpected way and quickly. It indicated the initial injury appeared to be a blood blister or deep tissue injury (DTI), considering there was induration, it may have been an abscess under the skin that absorbed and caused tissue damage. The area had a depth of 2.5 cm that had progressed rapidly. The wound bed had minimal slough but the wound now tunneled from the right buttock to underneath the gluteal fold towards the sacrum. It indicated an MRI of the sacrum and pelvis was pending. The [DATE] nursing progress note revealed the resident's dressing was saturated with a large amount of foul smelling brown drainage. It indicated the resident was crying out in pain with the dressing change. According to the March 2020 CPO, an order was received on [DATE] for [MEDICATION NAME]-[MEDICATION NAME] (a local anesthetic) cream 2.5-2.5% to be applied to the peri wound topically 30 minutes prior to dressing changes. The [DATE] nutrition progress note by the registered dietician revealed an addition of a supplement Prosource Plus 30 milliliters (ml) for 30 days for her increased protein needs related to an increased expenditure due to wound healing on her right buttock. The [DATE] NP progress note revealed the resident had a fever of 101.3 Fahrenheit (F) with a suspicion for [CONDITION] and required a surgical intervention of the wound for optimal healing. It indicated the resident requested hospitalization to expedite the workup and treatment since her MRI was not scheduled until [DATE]20. The [DATE] nursing progress note revealed the resident was sent to the hospital emergency room via ambulance. The 3/6-3/11/2020 hospital physician progress notes [REDACTED]. They were approximately 1 cm deep and probed directly to the bone. There was a 4.5 cm tunnel at 12:00 o'clock and it also tracked under the skin to the right buttock open wound, which also ulcerated and was approximately 1 cm deep as well. It indicated the MRI was negative for [CONDITION] but did reveal there was a 1.8 cm by 1.3 cm fluid collection that appeared significantly higher than the location of the wound. Surgical intervention was not recommended at that time but twice daily wet-to-dry dressings packed appropriately to the wound to allow for debridement of the wound. It indicated the resident was discharged back to the facility on [DATE] with the [DIAGNOSES REDACTED]. The resident's medical record was reviewed on [DATE]20 at 1:30 p.m. and revealed the following: -The air mattress ordered 2/25/2020 was documented being in place on [DATE]20; -The resident was not seen by the dietician until [DATE] with recommendation for wound healing; -No other interventions were put into place to prevent further skin breakdown and promote healing; and -The resident's care

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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 -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 9) plan was not updated with the resident's current skin integrity issues or interventions to prevent further skin breakdown or promote wound healing. D. Staff interviews The NP was interviewed on 3/11/2020 at 10:52 a.m. She said the area on the resident's bottom first presented as a hard blood blister but could have possibly have been an abscess. She said, I believe I ordered a padded dressing as an intervention. She said the resident was being seen by the wound clinic and the facility was following their recommendations. She said the resident was not always compliant with lying down to remove pressure when the wound first developed but has been more compliant recently. Unit manager (UM) #1 was interviewed on 3/11/2020 at 12:20 p.m. She said the area on Resident #2's bottom was considered trauma and not a pressure area because she received it when transferring with a slide board at the wound clinic. She said it started out as a blood blister and then opened up. She said it deteriorated quickly. She said the resident was not compliant with lying down in between meals even with education. She said the NP was monitoring it and had ordered a special dressing (the [MED]) when it started to have an odor but they had to wait for it to be delivered so they were doing wet to dry dressings in the meantime. She said when they did receive and started using the [MED], it should have been documented on the MAR or TAR. She said all of the resident's skin issues should have been care planned along with interventions to prevent further skin breakdown. She said this could have been done by any of the nursing staff. UM #2 was interviewed on 3/11/2020 at 1:37 p.m. She said interventions that could have been put into place immediately after the resident was identified as having a skin issue included placement of a pressure relieving mattress to the bed and cushion to the chair, placing the resident on a turn and reposition schedule, and getting dietary involved to add supplements and protein to promote wound healing. The DON was interviewed on 3/11/2020 at 3:30 p.m. She said Resident #2's wound on her bottom was not pressure related but was caused by trauma. She said the wound clinic did not have the complete picture of the injury prior to classifying it as a pressure injury. She said the wound was being closely monitored by the NP and the UM. She said the air mattress was put into place right after the wound became worse and she already had an appropriate cushion for her wheelchair. She said the resident was non-compliant with lying down after meals and they could not make her lie down if she did not want to.