STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065100	A. BUILDING _____ B. WING _____	09/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROCK CANYON RESPIRATORY AND REHABILITATION CENTER	2515 PITMAN PL PUEBLO, CO 81004

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide the care and services to prevent the development and worsening of a pressure injury for one (#1) of three residents reviewed out of five sample residents. The facility failed to implement interventions upon admission when the resident was identified as a high risk for skin integrity problems. When the resident was seen by the wound physician, recommendations were not implemented from the wound physician in a timely manner. When the wound had progressed from a moisture associated skin disorder to a pressure ulcer, new interventions were not assessed and implemented to prevent the pressure ulcer from worsening. Furthermore, the dietary department did not implement interventions timely to help promote healing of the pressure ulcer when it was identified as worsening. Due to the facility failures, the resident wound had progressed from moisture associated skin disorder (MASD) on admission of 6/17/2020 to an inhouse acquired Stage 3 pressure ulcer on 7/21/2020, causing the resident pain. She was sent to the hospital on [DATE], while at the hospital the wound was documented as a Stage 4 as of 7/27/2020. Findings include: I. Professional reference According to the National Pressure Inquiry Advisory Panel, retrieved 9/10/2020 from https://npiap.com/page/PressureInjuryStages, pressure injury stages were defined as follows: Stage 1 Pressure Injury: Non-blanchable [DIAGNOSES REDACTED] of intact skin Intact skin with a localized area of non-blanchable [DIAGNOSES REDACTED], which may appear differently in darkly pigmented skin. Presence of blanchable [DIAGNOSES REDACTED] or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated [MEDICAL CONDITION] (IAD), intertriginous [MEDICAL CONDITION] (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without [DIAGNOSES REDACTED] or fluctuance) on the heel or ischemic limb should not be softened or removed. II. Facility policy and procedure The Pressure Ulcer Skin Monitoring and Management policy and procedure, last revised 9/2/2020, provided by the facility on 9/2/2020, included in pertinent part, In order to prevent the development of skin breakdown or prevent existing pressure ulcers from worsening, nursing staff shall implement approaches as appropriate and consistent with the resident's care plan. If moisture associated skin disorder (MASD) is identified upon admission an air mattress should be placed within 48 hours and a referral made to the wound physician. Preventative measures should continue, such as: pressure reduction, continence care, mobility, nutrition and hydration management. Re-evaluate existing treatment regimen in connection with the resident's clinical presentation, to include current interventions and care plan considerations, if any wound is not healing or showing improvement. III. Resident status Resident #1, younger than 65, was admitted to the facility on [DATE] and discharged on [DATE] to the hospital. According to the July 2020 computerized physician orders [REDACTED]. The 6/21/2020 minimum data set (MDS) assessment documented the resident had no cognitive impairment according to the brief interview for mental status (BIMS) score of 15 out of 15. The resident exhibited no behaviors toward others and did not reject care. She required extensive assistance of staff for all activities of daily living (ADL) including transfers, toileting, bed mobility and personal hygiene. The resident was at risk for pressure injuries. IV. Resident interview Resident #1 was interviewed by telephone on 8/5/2020 at 11:10 a.m. She said her pressure injury developed at the facility two weeks after she was admitted . She said that she was left for extended periods of time without being changed or repositioned. She said often when she requested staff change her; staff would tell her they would come back or they were short staffed and she would need to wait. She said, she told the staff, it is not my choice to be like this, it really hurts my pride and I asked for help and you can ' t even help me. V. Record review The 6/17/2020 Initial Admission Record revealed the resident had moisture associated skin disorder (MASD) to her sacrum measuring 4 centimeters (cm) by 4.5 cm. The 6/17/2020 Braden Scale for Predicting Pressure Sore Risk revealed the resident was at a moderate risk with a score of 13. The care plan, initiated 6/18/2020, revealed the resident had actual impairment to her skin integrity, MASD. Interventions included: -Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short; -Encourage good nutrition and hydration in order to promote healthier skin; -Keep skin clean and dry. Use lotion on dry skin; and, -Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface. -The care plan did not include interventions, such as an air mattress, mentioned in the facility's policy for preventing pressure injuries for a resident admitted with MASD (see above). The June 2020 CPO revealed orders upon admission included: -Pressure reducing mattress per facility protocol, ordered 6/18/2020. However, the mattress type was not appropriate for this resident. Furthermore an air mattress was not implemented until 7/16/2020 (see July CPO below) which was not given to the resident for another 48 hours (see director of nursing interview below). The 6/19/2020 Nutritional Summary progress note by the registered dietitian (RD), the resident was malnourished and agreed to a house shake twice a day and prostat (liquid protein) daily to provide 1,440 calories (kcal) and 60 grams (g) of protein. These recommendations were ordered by the physician on 6/21/2020. A 6/23/2020 skin/wound note revealed initial wound rounds were completed with the wound physician. It indicated the resident had MASD to her sacrum, measuring 4 cm by 4.5 cm with 100% [MEDICATION NAME] (healthy) tissue to the wound bed. The recommendation was for the area to be cleansed often and barrier cream applied twice a day, skin was to be kept clean and dry and the resident was to be on a pressure reducing mattress. The 6/23/2020 wound tracker form completed by the wound physician revealed the top portion of the assessment reviewing vitals, causes for delayed healing, preventative measures, falls, procedures was left incomplete. Review of the other body systems, such as cardiovascular, respiratory, musculoskeletal, neurological, abdomen, eyes/nose/throat, and orientation was done. It identified the MASD to the sacrum as measuring 4 x 4.5 x 0.1 with 100% [MEDICATION NAME] tissue, minimal drainage

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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) and healthy periwound. Treatment was barrier cream twice a day. The physician orders [REDACTED]. The 6/24/2020 weekly skin evaluation documented the resident's skin is warm dry and intact other than noted wounds (no other wounds were noted in the document) treatment in place. Review of the record revealed no weekly skin evaluation was completed for the week of 6/26/2020 to 7/4/2020. The 6/30/2020 wound tracker form completed by the wound physician revealed the top portion of the assessment was incomplete including review of the body systems. It identified the MASD to the sacrum as measuring 5.5 cm by 6 cm with an undetermined depth. It indicated the wound bed had 10% granulation (healing) tissue, 40% eschar (dry,dead tissue) and 50% [MEDICATION NAME] tissue with a moderate amount of bloody drainage and a healthy periwound. The progression of the wound was documented worse. Treatment was honey with a foam dressing. -This treatment was not processed as an order. The 7/1/2020 skin/wound note revealed wound rounds were completed with the wound physician and the MASD to the sacrum was worse however the treatment was to cleanse the wound often and apply barrier cream twice a day, keep skin clean and dry and a pressure reducing mattress. -This treatment did not match the treatment recommendation made by the wound physician on 6/30/2020 (see above). A 7/4/2020 nursing progress note revealed the wound to the sacrum needed to be assessed by the wound team. It indicated the area was cleaned and thick barrier cream was applied with a foam dressing and the resident was being repositioned every two hours with a wedge. -This treatment did not match the current physician orders [REDACTED]. The 7/7/2020 wound tracker form completed by the wound physician revealed the top portion of the assessment was incomplete including a review of the body systems. It identified the MASD to the sacrum as measuring 4 cm by 3 cm by 0.1 cm with 10% granulation tissue and 90% slough (dead tissue) in the wound bed with a moderate amount of drainage and the periwound was red. It indicated the subcutaneous tissue (the innermost layer of skin) was debrided (removal of dead tissue). The progression of the wound was not documented. The treatment was honey with alginate and a foam dressing daily. The July 2020 physician orders [REDACTED]. The 7/8/2020 daily skilled note revealed a pressure reducing device for the resident's chair was being used to maintain skin integrity, along with a turning and repositioning program. It indicated the resident was cooperative with the treatment. -These interventions were not added to the resident's care plan. The 7/8/2020 weekly skin evaluation was incomplete. It documented the resident had wounds on the buttocks, sacrum, abdomen. The wounds to her ankles were healed. It indicated the resident tolerated wound care well. It did not provide the specific location of the wounds, the type of wounds, the measurements of the wounds or the stage of the wounds. -This indicated the resident had the ability to heal and the wounds were avoidable. According to 7/8/2020 nursing progress notes, the RD recommended discontinuation of the residents supplements due to the high vitamin D and calcium content since the resident's laboratory results showed an elevated calcium level. -The note did not address the resident's wounds or the need for supplementation to assist with wound healing or an alternate source to promote healing. The 7/9/2020 skin/wound progress note revealed the progression of the wound was stable and added an intervention to reposition often as the resident tolerated. The July 2020 CPO revealed the house shakes and liquid protein were discontinued on 7/8/2020 however no alternative supplements to aid in wound healing were ordered at that time. According to the July 2020 treatment administration record (TAR), the treatment ordered for the MASD to the sacrum was blank on 7/12/2020, indicating it was not done. The 7/13/2020 daily skilled note revealed the resident was having pain originating from the sacral wound, rated 7-10 and described it as a burning ache. It indicated repositioning, pressure relief and rest were non-pharmacological interventions used. The note also identified the wound to the sacrum as a pressure wound and interventions were a pressure relief mattress and cushion and turning every two hours or more for relief. The 7/14/2020 wound tracker form completed by the wound physician revealed the top portion of the form was incomplete including a review of the body systems. It identified a pressure wound to the sacrum measuring 5.2 cm by 6 cm by an undetermined depth with 10% granulation tissue and 90% eschar in the wound bed with minimal drainage and a healthy periwound. It indicated the wound was debrided to the subcutaneous tissue. The progression of the wound was not documented. Treatment was honey and foam daily. The 7/14/2020 skin/wound progress note revealed the etiology of the wound was classified as MASD (even though the wound physician classified it as pressure) and the progression of the wound was worse. The 7/15/2020 weekly skin evaluation was incomplete. It documented the resident had wounds on the buttocks, sacrum, abdomen. The wounds on her ankles were healed. It indicated the resident tolerated wound care well. It did not provide the specific location of the wounds, the type of wounds, the measurements of the wounds or the stage of the wounds. On 7/16/2020, the July 2020 CPO was updated to include the following: -Air mattress for sacral pressure ulcer; -Juven (supplement) mix one packet with eight to ten ounces of water or juice two times a day for wound healing; and, -Nepro (supplement) one carton one time a day for wound healing. -However the air mattress did not specify if it was a standard air mattress or alternating pressure amd/or moisture reducing to help the residents wounds heal and prevent further breakdown. The July 2020 Medication Administration Record [REDACTED]. The 7/15/2020 daily skilled note revealed the resident was having pain originating from the sacral wound, rated 7-10 and described it as a burning ache. It indicated repositioning, pressure relief and rest were non-pharmacological interventions used. According to the July 2020 TAR, the treatment ordered for the MASD to the sacrum was blank on 7/20/2020, indicating it was not done. The 7/21/2020 wound tracker form revealed the top portion of the form was incomplete including a review of the body systems. It identified wound #2 to the sacrum measuring 4.5 cm by 7 cm with a 1.5 cm depth with moderate drainage and a healthy periwound. No description of the wound bed was documented and the etiology (such as pressure or MASD) was not documented. It indicated the wound was debrided to the muscle. The progression of the wound was documented as worse. Treatment was honey, calcium alginate and a foam dressing daily. The 7/21/2020 skin/wound progress note revealed the etiology of the wound was classified as MASD/pressure. The wound bed was described as 10% granulation tissue with 90% eschar with a moderate amount of bloody drainage. It documented the progression of the wound was worse and was debrided. The 7/21/2020 weekly skin evaluation revealed the resident had a stage 3 pressure ulcer to the sacrum that measured 4.5 cm by 7 cm by 1.5 cm. The 7/21/2020 daily skilled note revealed the resident was having pain originating from the sacrum wound rated 7-10 and described as dull aching. It indicated non-pharmacological interventions, such as: the resident being repositioned every two hours or more using wedges, off-loading and rest, were used. The 7/21/2020 nursing progress note revealed wound rounds were completed and the area to the sacrum had progressively gotten worse despite ongoing interventions and being followed by a wound care specialist. It indicated the resident was on two different dietary supplements to help with wound healing and had been placed on an air mattress. The resident was being repositioned as tolerated and placed in her wheelchair multiple times a day as the resident allowed. The 7/23/2020 daily skilled note revealed the resident was having pain originating, in part, from the wounds on her coccyx rated 6-10 and described as sharp pain. It indicated the pain rating decreased after wound care and repositioning as well as medication management. The note also revealed the resident had chills, clammy skin and a low grade fever throughout the shift. The resident's care plan was updated on 7/23/2020 to include a stage 3 pressure ulcer to the sacrum. Interventions included: -Administer medications and treatments as ordered. Monitor/document for side effects and effectiveness; -Assess/record/monitor wound healing. Measure length, width and depth where possible. Assess and document the status of wound perimeter, wound bed and healing progress. Report improvements and declines to the physician; -Call light within reach; -Encourage fluid intake and assist to keep skin hydrated; -Follow facility policies/protocols for the prevention/treatment of [REDACTED]. Document alternative methods. The care plan did not include interventions such as the air mattress to the bed, a pressure reducing device for the chair, a turning and repositioning program for off-loading pressure, a consultation with the registered dietitian for nutritional recommendations or the assessment and recommendations of the wound physician. A 7/24/2020 change of condition was done related to the resident having a fever and altered mental status. The July 2020 CPO was updated on 7/24/2020 with an order to send the resident to the emergency department for evaluation and treatment for [REDACTED]. The 7/27/2020 hospital wound note documented the resident had a Stage 4 pressure ulcer to her sacrum. VI. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 8/5/2020 at 5:11 p.m. She said that she had provided care to Resident #1, however, she had been on vacation for two weeks during the time that her MASD developed into a pressure injury. She said that when she left for vacation, the MASD was small and by the time she returned to work, two weeks later, it was huge. She said that when she was working with the resident, she would reposition her every two hours which was standard. She said she did not know how it could have gotten that bad. The assistant director of nursing (ADON) #1 was interviewed on 8/28/2020 at 3:25 p.m. She said Resident #1 was admitted to the facility with surgical wounds to her right foot and shin, an abdominal wound from the removal of her feeding tube and MASD to her sacrum. She said they were putting barrier cream on the MASD when she first arrived and it was stable. She said she went on vacation and when she returned, it turned into an open wound. She said at that point she got the resident an air mattress and tried to encourage the resident to reposition but she refused frequently. She said the resident was put on supplements as soon as her skin issues arose but they had to be changed related to sodium issues. She said the resident was seen weekly by the wound physician and dietary was involved. Licensed

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) practical nurse (LPN) #1 was interviewed on 9/2/2020 at 3:40 p.m. He said he did wound treatments as ordered on a daily basis. He said physician orders [REDACTED]. He said a physician order [REDACTED]. He said physician orders [REDACTED]. He said the Braden assessment was used to identify a resident's risk for skin breakdown. He said the Braden assessment was done upon admission and quarterly. He said weekly skin assessments were completed in shower days and when a resident was being changed. He said the CNAs would report any changes or abnormalities in the skin they observe while providing care. Registered nurse (RN) #1 was interviewed on 9/2/2020 at 3:51 p.m. He said physician orders [REDACTED]. He said there was no reason an order should be started seven days after it was received. He said it was important to initiate physician orders [REDACTED]. He said the Braden scale assessment was done upon admission and quarterly. He said the Braden scale assessment was used to determine a resident's risk for skin breakdown due to the level of movement, how moist the skin was, and their nutritional status. He said the CNAs report to the nurse any abnormalities observed while providing shower and incontinence care. He said the nurse then conducted a skin assessment to determine if there was an issue. He said CNAs should be repositioning residents every two hours when they do their rounds. He said he saw the CNAs doing their rounds and supervised them. CNA #2 was interviewed on 9/2/2020 at 4:00 p.m. She said any abnormality on the skin observed while providing care to residents was to be reported to the nurse. She said the CNAs looked for redness, skin tears, skin breakdown, and bruises while providing resident care including peri-care. She said a skin assessment was completed upon admission when the resident was put into bed after arrival. She said she repositioned residents every two hours when she completed her rounds. She said wedges and pillows were used to help reposition residents. She said the CNAs could find positioning guidance on the computer and from the nurse. The DON and the clinical resource consultant (CRC) were interviewed on 9/3/2020 at 4:00 p.m. They confirmed the wound physician recommendations made on 6/30/2020 were not put into place until 7/7/2020. They said the expectation was for the staff to change and use the correct order immediately. The CRC said they had identified this as a problem in June 2020 so they started a process of reviewing the orders to ensure they were being changed immediately. The DON said the hole in the TAR for 7/12/2020 was probably because the nurse that was rounding that day did not sign off on the treatment because that was when the physician wound had done rounds. (According to the record, the physician saw the resident on 7/14/2020). The DON said she knew the treatment for 7/20/2020 was done because there was a treatment note in the progress notes. (No treatment note was found or provided for this date). The DON and CRC said the facility continued to offer repositioning and supplements and added boots to prevent her heels from breaking down but the resident was very non-compliant. They said they were not able to get the air mattress until 7/16/2020 (although it was ordered on [DATE]) because there was a delay in getting the mattress from the company due to COVID-19. They said there were therapy interventions as well that they tried, however, they did not provide documentation of these attempted interventions. The DON and CRC said it would have been useful if nursing staff had documented all the times the resident refused repositioning due to the resident's documentation not reflective that she refused repositioning. The DON and CRC confirmed when you reviewed the resident's record it only reflected a few times the resident refused care.