STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065405	A. BUILDING _____ B. WING _____	03/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUITES PARKER, THE	9398 CROWN CREST BLVD PARKER, CO 80138

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** - Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility failed to ensure two (#11 and #12) of three out of 12 sample residents received care consistent with professional standards of practice to promote healing of pressure injuries. Specifically, the facility failed to: -Ensure a qualified staff comprehensively assessed the development of Resident #12's wounds to the tops of his toes as pressure ulcers including causation; -Provide adequate tracking and monitoring with implementation of appropriate interventions for Resident #12's pressure ulcers timely (weekly wound measurements with description of the wound) to promote wound healing; and, -Ensure Resident #11's wound treatments were completed and documented consistently. Findings include: I. Facility policy and procedure The Wound Care policy, dated 2018, was provided by the director of nursing (DON) on 3/30/2020 at 10:18 a.m. It read, in pertinent part, to verify there was a physician order [REDACTED]., wound bed color, size, drainage, etc.) obtained when inspecting the wound. Notify the supervisor if the resident refused wound care and report other information in accordance with facility policy and professional standards of practice. II. Resident #12 A. Resident status Resident #12, age 74, was admitted on [DATE] and readmitted on [DATE]. According to the March 2020 computerized physician orders [REDACTED]. The 3/30/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out 15. He required extensive two-person assistance with bed mobility, transfers, dressing and toileting. He had an indwelling catheter and was incontinent of bowel. He was at risk for pressure ulcer development and had an assessment tool completed. He had pressure injury care, pressure injury treatment, pressure injury devices to the bed and wheelchair, and he received nutrition/hydration and was repositioned and turned. It was documented the resident had two unstageable wounds present. B. Wound observation and interviews On 3/25/2020 at 12:15 p.m. unit manager (UM) #1 was observed providing wound care to Resident #12's left lower lateral calf area and the top of the toes on his left foot. The areas were scabbed over, black, intact, with no drainage, and the surrounding skin was intact without signs of infection. He had bilateral lower extremity (BLE) [MEDICAL CONDITION], two to three plus (pitting) [MEDICAL CONDITION] to the left lower extremity. UM #1 said she believed the resident ' s wounds reopened and thought his wounds to his toes were new and he was admitted with them from the hospital. She said his [MEDICAL CONDITION] to his lower extremities had improved. She said the resident was being followed by the wound physician and the hospital had called the areas to his left lower extremity pressure injuries. She said the unit managers on each floor rounded with the wound physician during weekly wound rounds. She said current treatment orders included cleansing the area with a wound cleanser, applying skin prep the scabs twice a day and to weave a 4x4 in-between the toes. Resident #12 said staff had been repositioning him, floating his heels and completing his treatments routinely. C. Record review The care plan, initiated 3/13/17, revised 12/28/19 revealed the resident had a history of [REDACTED]. Interventions included to reposition the resident every two hours as the resident allowed, float heels, and to check air mattress for functioning. The weekly Head to Toe Skin Check dated 2/8/2020 revealed Resident #12 had scabbed areas to the tops of each toe on the left foot and the left lateral calf had a black scabbed area with redness that measured 10 cm (centimeters) x (by) 3-4 (three to four) cm. He had dry calloused heels. It also documented the wound nurse was notified. The Skin and Wound Evaluation dated 2/17/2020 revealed Resident #12's left lateral calf was assessed as an arterial wound which was scabbed and measured 2.5 cm x 1.3 cm. It also documented the left outer shin reopened. The February 2020 treatment administration record (TAR) revealed the resident had orders for [MEDICATION NAME] ([MEDICATION NAME] used to treat dry skin) to BLE once every other day; however, there was no specific orders to the black scabbed areas to left lateral calf until 2/22/2020 and the top of the residents left toes until 2/27/2020. The February 2020 TAR documented an order dated 2/22/2020 which read to cleanse the left outer shin scabbing with wound cleanser, apply skin prep daily and as needed; and an order dated 2/27/2020 to cleanse toe wound on left foot with normal saline, apply barrier cream to surrounding skin and paint the toes with iodine swab daily. The resident had a brief hospitalized from [DATE] to 2/26/2020. There was no documentation in the clinical record of review of Resident #12's wounds to the top of his toes to include causation and no review of effective treatment for [REDACTED]. D. Staff interview The DON and UM #1 were interviewed on 3/25/2020 at 6:38 p.m. The DON said she was aware Resident #12 complained of burning pain to his coccyx, and was found to have a stage one pressure ulcer which quickly resolved. The DON said she was not aware the resident had wounds to the top of his toes in early February 2020. UM #2 said she was unaware of the resident's new wounds and staff did not inform her to add him to weekly wound rounds on 2/8/2020, she said she was only aware of the scabbed area to the left lateral calf. They acknowledged there was a delay in treatment to the resident's wounds which was 14 days later and there was no assessment of causation of Resident #12's toe wounds. The DON said the process for identifying a new wound was the floor nurse needed to complete a progress note, call the physician for a treatment and notify the wound nurse so that the resident could be followed weekly by the physician. III. Resident #11 A. Resident status Resident #11, age 89, was admitted on [DATE] and readmitted on [DATE]. According to the March 2020 CPO [DIAGNOSES REDACTED]. The 3/23/2020 MDS revealed the resident was severely impaired with a BIMS score two out of 10. She required two-person extensive assistance with bed mobility, dressing, transfers and toileting. She had an indwelling catheter and was incontinent of bowel. She had one stage 4 pressure injury. She had pressure injury care, pressure injury treatment, pressure injury devices to the bed and wheelchair, and she received nutrition/hydration and was repositioned and turned. She was on hospice services. B. Record review The care plan, initiated 11/6/19, revised 12/6/19 revealed Resident #11 had a Wound Vac (vacuum-assisted closure of a wound) to her right ischium related to immobility and poor circulation. Interventions included to inspect and monitor the area, notify the surgeon as needed, air mattress, float boots, wound nurse and reinforce repositioning. Review of Resident #11's TARs revealed incomplete documentation of treatments provided or refusal of care. The January 2020 TAR revealed Resident #11 refused to have her Wound Vac changed to her coccyx/sacrum on 1/9/2020 and 1/16/2020, and the TAR was blank (not documented as completed) on 1/7/2020 and 1/23/2020. The February 2020 TAR revealed Resident #11 refused her wound vac change to her coccyx/sacrum on 2/5/2020 and the TAR was blank (not documented as completed) on 2/27/2020 and 2/28/2020. The March 2020 TAR revealed Resident #11 refused her dressing change to her coccyx/sacrum on 3/3/2020 and the TAR was blank (not documented as completed) on 3/16, 3/19, and 3/21/2020. Additionally, the TAR was blank (not documented as completed) for Resident #11's treatment to her left heel on 3/7, 3/19, and 3/21/2020 and treatment to her right heel on 3/19, 3/20, and 3/21/2020. Review of Resident #11's progress notes revealed the interdisciplinary team (IDT) reviewed the resident's care on 3/13/2020 and 3/20/2020 and had no further recommendations. There was no documentation in the record for incomplete documentation or refusal of care. C. Staff interviews The DON was interviewed on 3/25/2020 at 5:40 p.m. She said she was reviewing nursing documentation as to why Resident #11 had missed documentation on the TAR for treatments. -At 6:02 p.m. she stated that she could not find any documentation of why the treatment was not documented as completed. She acknowledged her staff had not completed documentation consistently. She said she had started an education with all the floor nurses and would start a daily audit of resident treatments. -At 7:42 p.m., via email the DON clarified the wound care process, she said their process was for the nurse to document and implement an intervention and or treatment to prevent further injury,

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 -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) and to document any change in condition on the 24 hour report. This was to include any new wounds. The nursing home administrator and DON were interviewed on 3/26/2020 at 10:20 a.m. They acknowledged systemic issues with a particular nurse not following facility procedure with Resident #12's care. The DON said they had started the education and monitoring process as there was a delay in treatment and monitoring. They acknowledged Resident #11's treatments were not documented as completed, but felt they did not have any problems with treatments being completed. They had no response as to the process of treatments being completed and documented in the clinical record other than the documentation provided in the progress notes and TAR. IV. Follow-up A final copy of the education and auditing tool was provided by the DON on 3/25/2020 at 7:10 p.m. The education provided to eight licensed nurses read, when a wound was observed, a wound alert sheet must be filled out and interventions implemented. The wound nurse must be notified. The audit included the resident name, wound site, documentation on TAR, nursing note, nurse responsible, and comments to include education was provided.