STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065399	A. BUILDING _____ B. WING _____	**04/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIO GRANDE INN	**39 CALLE MILLER LA JARA, CO 81140**

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 0610 **Level of harm -** Actual harm **Residents Affected -** Few	**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 ensure one (#1) of two sample residents was protected from abuse and ensure that concerning injuries of unknown origin were thoroughly investigated to prevent recurrence. The facility failed to prevent multiple, repeated injuries to Resident #1, who was non-interviewable and dependent on staff for care. Record review revealed the resident suffered a series of injuries that the facility failed to thoroughly investigate, assess and track, and failed to implement protective measures to prevent, although the injuries indicated rough treatment during care. The resident's injuries documented by the facility were: -On 2/12/2020, bruising to the resident's forehead, bruising to the right foot and a scratch on the right shin; -On 2/16/2020, bruising to the resident's left toe; -On 2/21/2020, bruising to the left upper pubic bone; -On [DATE]20, redness and broken blood vessels to the right eye; -On [DATE], bruising to the pubis and perineal area. According to hospital documentation after the resident was discharged to the hospital on [DATE] for a high fever and condition change, she had multiple bruises of different ages from unknown trauma, including injuries to her pubic area, labia, abdomen, forehead, eye, both legs, left thigh, right foot, and both hands. The facility's failure to investigate and protect the resident from abuse resulted in multiple recurring injuries. Findings include: I. Resident status Resident #1, [AGE], was admitted on [DATE] and discharged to the hospital on [DATE]. According to the February 2020 computerized physician orders [REDACTED]. The 12/29/19 minimum data set (MDS) assessment revealed the resident's cognitive status was not completed due to the resident was rarely/never understood. The resident had severe cognitive impairment. She required extensive two-person assistance with transfers, dressing, toilet use, and personal hygiene. She had other behavior symptoms not directed toward others, occurring one to three days from the past seven, and did not reject care during the assessment period. II. Record review A. Care plans The care plan, dated 9/25/19, identified the resident had the potential for alteration in skin integrity related to incontinence, decreased mobility, and [MEDICAL CONDITION]. Interventions included a skin check to be performed weekly. The care plan, dated 9/2[DATE]9 and revised on 3/30/2020, identified the resident's activity of daily living (ADL) status would be maintained at optimal level with all needs met on a daily basis. Interventions included to monitor skin condition during care and report to the nurse. The care plan did not identify the resident required two-person transfers, as indicated in the MDS assessment. The care plan was revised 30 days after the resident was discharged . The care plan, dated 9/26/19 and revised on 3/30/2020, identified the resident exhibited behaviors such as striking self and crying. Interventions included to monitor for behaviors of striking self and document per shift. The care plan was revised after the resident was discharged . The resident did not have a care plan identifying her at risk for abuse. B. Skin assessments The weekly wound assessment report, dated 2/12/2020, identified on the visual body map three areas: 1. A bruise to the forehead; 2. A bruise to the top of the right foot; 3. A scratch to the right lateral shin. The wound assessment report documented the right lateral shin scratch was caused by an accident, and the bruise on the top of the right foot was also caused by an accident. The facility provided no other skin assessments. The cause of the bruise to the resident's forehead was not documented or investigated. The facility failed to document weekly skin assessments for Resident #1 during February 2020. C. Investigative reports and progress notes 1. Injuries on 2/12/2020 - right foot and right calf The incident report dated 2/12/2020 documented, Certified nurse aide (CNA) came and reported that the resident has a bruise to top of right foot and scratch to back of right calf. Bruise top of right foot size 2 cm X 2 cm. Scratch to back of right calf size 4.5 cm in length. Immediate post incident action was, Remove foot pedals when transferring. Also put on derma leg protectors. Wear slippers to prevent rubbing on top of her foot. The narrative of investigation documented, Interdisciplinary team (IDT) - it is reasonable to conclude this resident was seen by the staff kicking her wheelchair with her right foot which resulted in a bruise on the top of her right foot. The resident is currently out of the facility at this time in the hospital and will be reassessed when she returns. There was no mention in the incident report of the bruise to the resident's forehead (see below). There was no corresponding nursing or behavioral note regarding the resident kicking her own wheelchair. 2. Injury on 2/12/2020 - bruise to forehead The nursing progress note dated 2/13/2020 at 1:54 p.m. documented, Resident had bruise on right side of forehead measuring 2 cm X 3.5 cm. Area is yellow and looks old. There was no evidence of an investigation into the cause of the bruise, and no prior documentation of the bruising other than the 2/12/2020 skin assessment. 3. Injury on 2/16/20 - bruising to left second toe The incident report dated 2/16/2020 documented, CNA came and reported to this nurse that the resident has a bruise to (the) second toe to the left foot. Bruise to second toe to left foot purplish discoloration size 2 cm X 2 cm. Immediate post-incident action was, Ensure resident wearing slippers when transferring. The narrative of investigation documented, IDT- It is reasonable to conclude this resident was seen by the staff kicking at her wheelchair with her feet. It is reasonable to conclude this resident's bruises on her feet were caused by the resident kicking her own wheelchair. The resident is currently out of the facility at this time and will be assessed upon her return from the hospital. There was no corresponding nursing or behavioral note regarding the resident being witnessed kicking her own wheelchair. There was no evidence of an investigation into the resident's new injury. 4. Injuries on 2/21/2020 - left upper pubic bone and right foot The nursing progress note dated 2/21/2020 at 5:53 p.m. noted, While giving care to the resident it was noted that resident had areas of concerns, resident demonstrates no signs or symptoms (s/sx) of fear. The incident report dated 2/21/2020 documented, During changing of brief it was noted that the resident had bruises to the left upper pubic bone. No pain, also has noted bruising to right foot. Bruise to pubic area 4.5 cm X 1 cm, bruise to foot 12.5 cm X 10 cm, and scab measures 2.5 cm X 1.2 cm to the top of mid right foot. Immediate post-incident action was, Re-educated nursing staff on the importance of using two person transfers. The narrative of investigation documented, IDT- investigation: staff interviews - noted bruises this afternoon, slight discoloration this early a.m. Resident denies fear and abuse, no s/sx of abuse or fear noted. Continued interview results, resident did participate on scenic drive in bus on 2/21/2020. Seatbelt matches with place of bruising and size correlates with belt buckle. Resident also noted to be kicking her feet while on drive. Resident does tend to kick her feet and/or swing her hands, hitting herself when agitated - see care plan. Chart review, labs low platelet count noted which can increase bruising. Reasonable to conclude bruising related to seatbelt and kicking her feet. Staff education to ensure proper placement of seat belt and foot pedals-cushion areas if needed. Ensure proper footwear to protect residents feet. There were no corresponding nursing notes in the resident's medical record regarding resident behaviors or staff actions that may have contributed to the resident's new injuries. There was no documentation on the medical record regarding self-injurious behavior. There was no evidence of a thorough investigation into the resident's injuries. 5. Injury on [DATE]20 - right eye The nursing progress note dated [DATE]20 at 2:19 a.m. documented, CNA came and reported that the resident has redness to right eye. This nurse went and checked eye. Noticed resident has a broken blood vessel to right eye. When asked resident if it hurt, the resident stated no. Asked the resident if she had rubbed her eye and she stated yeah. There was no evidence of an investigation of the resident's new injury. The care plan was never updated or reviewed after each of the above injuries to include interventions and assess for effectiveness of the interventions to prevent further injuries. Although staff surmised per

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

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F 0610 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) IDT notes that the resident's injuries were from her striking herself, nursing progress notes, reviewed for the month of February 2020, did not include any documentation of the identified behavior of striking herself. Likewise, behavior tracking documentation during February 2020 revealed no evidence of the resident striking herself. Staff documented asking the resident if she had injured herself but failed to investigate further. Moreover, the resident had severe cognitive impairment and was unable to make herself understood. 6. Injuries on [DATE] - pubis and perineal area The facility investigation from an incident on [DATE] documented, Bruise noted to residents peri-area by a CNA #4, and reported to the charge nurse on [DATE]. Charge nurse (CN) states she had just contacted the power of attorney (POA) regarding transferring resident to a local hospital for evaluation for continued elevated temperature. CN notified nursing staff to get resident ready for transfer at about 3:35 p.m. At 3:50 p.m. CN assessed the resident just prior to transfer, noting dark purple bruise about 5 in X 2 in to pubis. Resident did not express fear or abuse, shaking her head no. Resident was not guarding, flinching, or expressing s/x of fear or abuse. Manager on duty (MOD) contacted the director of nursing (DON) notifying her of the bruising. MOD then transferred resident to emergency department (ED) via facility vehicle. MOD reported to ED staff that the facility was aware of bruising and will be conducting investigation as well. CNA #3 from the night shift on 2/29/2020 was placed on probation on [DATE] until investigation completed. Nursing home administrator (NHA) notified of bruising on [DATE] at 8:30 a.m. The Sheriff's office called, NHA told that case was open on resident and another case number would not be issued. Staff and residents interviewed by NHA and social services director (SSD) from [DATE] and [DATE]. Results of interviews: CNA #3 stated she was giving the resident a bed bath on 2/29/2020 at about 8:30 p.m. Resident was noted to be scratching her peri-area vigorously. CNA #3 states resident was cooperative with bed bath. Licensed practical nurse (LPN) #1 stated he entered residents room about 8:45 p.m. to ask CNA #3 for assistance once she was done. LPN #1 stated resident appeared calm, no signs or symptoms of distress noted. CNA #3 stated the resident was 'very sweaty as her fever broke' about 4:00 a.m. on [DATE]. CNA #3 stated as she transferred the resident to her wheelchair, the resident sat forcefully on the pummel portion of her wheelchair cushion as it was not properly aligned in chair. CNA #3 then states she pushed the resident in her wheelchair to the tub room for a bath. CNA #3 had resident in whirlpool bath when residents 'bottom slid forward.' CNA #3 states she used her forearm forcefully to residents peri-area to keep resident from sliding further into tub as CNA #3 reached for the call light. Certified medication aide (CMA) #1 states she entered tub room and assisted CNA #3 to boost the resident up in the tub. CMA #1 states resident calm and did not appear to be in any distress. CNA #3 then used the call light again about 4:30 a.m., LPN #1 entered tub room and assisted resident to stand as CNA #3 pulled up residents attends and pajama bottoms. LPN #1 states resident was calm and cooperative with care and did not appear to be in any distress. CNA #3 then pushed the resident in a wheelchair back to the room and transferred the resident to bed. On [DATE] CNA #4 states she noticed bruising to the peri-area and reported it to CN after breakfast. CNA #4 stated the resident was cooperative with care, but was feverish and not feeling well overall. Reasonable to conclude that bruising to the lower peri-area was caused by transferring the resident to sit forcefully to pummel portion of wheelchair cushion. Reasonable to conclude that bruising to pubis caused by CNA #3 forcefully using forearm to peri-area to keep the resident from slipping in the tub. Signed by the NHA on [DATE]. Handwritten notes on the bottom of the page included: Chart review-low platelets; two person assist, previous bruising, CNA #3 did not work with Resident #1 on or prior to bruising being noted. Interviews with residents on B and E hall completed on [DATE] by NHA and SSD. No stated concerns. Interviews with residents on A and F halls completed on [DATE] by NHA and SSD. No concerns stated. The incident report from [DATE] was not clear if the resident had the assistance of two people for the transfer and the forceful sit or the forearm to peri-area was done with only one aide present. There was no documentation to show that additional facility staff were interviewed regarding the resident's multiple injuries. The resident's care plan did not identify two-person assistance, and the care plan was not updated. D. Hospital records The arrival nursing progress note dated [DATE] at 3:41 p.m. included, She has a subconjunctival hemorrhage to the right eye that they (the facility) state has been there since last weekend and bruising to the right lower leg and foot of unknown time, and new bruising to the perineal area and the right hand. She has no history of, such as falling out of the chair or falling out of the bed, and the patient has a cognitive delay and is unable to give any history. She also has bruising to the forehead that they (the facility) state has been there since last week. Review of systems on admission noted, Abnormalities: decreased appetite and fever 24 hours and multiple bruises of different ages to her body from unknown trauma. Review of the hospital's photographs of the resident's injuries, dated 3/1 and [DATE], revealed the following: On [DATE]: 1. A dark pink bruise to the posterior of the right hand. 2. A dark purple bruising and swelling to pubic area. 3. An old pink bruise to abdomen. 4. A dark pink bruise to anterior right hand. 5. Dark purple bruising and swelling to labia majora. 6. Pink bruising and old abrasion to lower right anterior leg. 7. A pink bruise and a red scab to the anterior of the lower left leg. 8. A pink bruise to the left upper leg on the back and left posterior thigh. 9. Dark purple bruising and a red scab to inner right foot. 10. A dark purple scab and wound to top of the right foot. On [DATE]: 1. A pink bruise to forehead. 2. Trauma to the right eye (a red sclera). 3. A red scab and red s[REDACTED]e to the right thumb. 4. Dark red s[REDACTED]es and scabs to palm of right hand. 5. A pink scab/bruise to left pinky. III. Interviews CNA #1 was interviewed on [DATE]20 at 9:15 a.m. She said any skin issues found while providing cares were reported to the charge nurse (CN). CNA #2 was interviewed on [DATE]20 at 9:20 a.m. She said all skin issues were reported to the CN and the CN would do an assessment. CNAs #6, #7, and #8 could not be reached for an interview, and did not return messages. RN #1 was interviewed on [DATE]20 at 9:30 a.m. She said when a CNA reported a new skin issue, she would assess the area, complete an investigation, notify the provider, family, DON and NHA. She said she would implement interventions to help prevent further injuries. The DON was interviewed on [DATE]20 at 9:58 a.m. She said she expected the aides to report any new skin issues to the CN. She said the CN would then complete an incident report. She said any new interventions should be added to the care plan. She said the IDT team met to discuss the incident report and review the interventions. She said each resident received a skin assessment weekly. She said she did not know why there were not weekly skin assessments completed for Resident #1. She said labs were reported by the hospital that Resident #1 had a low platelet count and the low platelet count would be responsible for the bruising. The DON was interviewed a second time on 4/7/2020 at 12:18 p.m. She said the behaviors that were tracked in the Medication Administration Record [REDACTED]. She said the tracking of the behavior should have been done in the progress notes, and she acknowledged it was not documented. The DON said the big injuries were investigated and as a result the aide was terminated, and the nurse was written up. As far as the resident's other injuries, she said she was unable to answer why they were not investigated.