STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065367	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLAGE CARE AND REHABILITATION CENTER, THE	9221 WADSWORTH PKWY WESTMINSTER, CO 80021

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 0600 **Level of harm -** 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 record review, observation and interview, the facility failed to ensure one (#1) of three sample residents was provided care and services according to the nursing standards of practice and remained free from neglect. The facility failures contributed to delayed healing and/or worsening of the resident's wounds, the development of new wounds, and a neglectful lack of necessary resident care and services. Cross-reference F684, failure to provide the highest practicable quality of care; and F609, failure to timely report neglect to the proper authorities. Findings include: I. Facility policies A. The Abuse policy, dated 7/20/18, was provided by the interim nursing home administrator (INHA) on 6/17/2020 at 4:30 p.m. The policy read, It is the policy of the facility that each resident will be free from Abuse. Abuse can include verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion. The resident will also be free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. Additionally, residents will be protected from abuse, neglect, and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection. The facility will strive to educate staff and other applicable individuals in techniques to protect all parties. B. The Abuse Prevention Program, dated 7/20/18, was provided by the INHA on 6/17/2020 at 4:30 p.m. The policy read in pertinent part that it was the policy of the facility to encourage and support all residents, staff, families, visitors, volunteers and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion or misappropriation of resident property. The policy documented, An owner, licensee, Administrator, Licensed Nurse, employee or volunteer of a nursing home shall not physically, mentally or emotionally abuse, mistreat or neglect a resident. The policy defined neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. II. Facility investigation The facility investigation was provided by the IDON on 6/17/2020 at 1:30 p.m. Review of the investigation revealed facility staff first identified Resident #1 had wounds to his left and right heel on 5/23/2020 during interviews 5/27/2020; however, assessment of the wounds to include characteristics of the wounds, causation, notification to physician or family, implementation of interventions and treatment orders were not implemented until four days after the wounds were identified. According to the facility's investigation, started on 5/27/2020, the interviews revealed the resident's nurse was notified on 5/23/2020, by his CNA, that the resident had a blister on his right heel which leaked fluid. The interim director of nursing (IDON) was notified on 5/27/2020 that the resident had wounds to both heels. The resident's heels were assessed on 5/27/2020. The assessment revealed Resident #1 had acquired a DTI to the left heel and a stage II pressure injury to his right heel on 5/27/2020. The failure of the facility nursing staff, on 5/23/2020, to assess Resident #1's heels, document the findings, and failure to notify the physician and family of Resident #1's change of condition (COC), resulted in the resident's heels being unassessed and untreated for [REDACTED].#4 was interviewed by the IDON on 5/27/2020. In her statement she said she reported to registered nurse supervisor RNS #2 that on 5/23/2020 while putting Resident #1 to bed her and another CNA (unknown) noticed he had a blister to his right heel which was leaking, so they put a brief under it so it would not get the bed wet. She stated she did not notice any other issues on the other foot. RNS #2 was interviewed on 5/27/2020. In her statement she said on 5/23/2020 she received in report from the day nurse that Resident #1 had a blister and adjustments made to his medications. She sated Resident had a blister to his left heel that was small (contradictory to the statement above, and later interviews see below). She said at 12:30 a.m. on 5/24/2020 she was notified by the CNA that while transferring the resident to bed they heard a pop and the resident's blister opened and drained; however, the skin was intact and a dressing was not required (this also was contradictory to the statement above and follow-up interviews below). She said there was no deep tissue injury (DTI) to the resident's heels. She also stated at 1:00 a.m. on 5/24/2020 she reported to the on-coming registered nurse (RN) #3 that the area needed to be observed for any changes or new orders and reported the same information to the on-coming RNS #3 at shift change the following morning. The interviews revealed, Nursing reported during shift report that the resident had bilateral heel blisters present on 5/23/2020 and skin prep was applied to affected areas. The resident's medical record was reviewed and revealed, Nurse's notes and weekly skin assessments did not indicate resident had blisters to his heels and the treatment administration records (TAR) showed no evidence of monitoring to blisters on bilateral heels. Although the facility completed an investigation of wound development to Resident #1's bilateral heels and provided the nursing staff education on abuse prevention and wound prevention, the facility did not follow standards of practice timely, and there was a delay in assessment and treatment. The facility failed to monitor and document wound treatments to the resident's bilateral lower extremities on admission as well as failed to monitor newly found wounds to his bilateral heels for four days, which put the resident at risk for delayed healing and at risk for infection. The facility determined the investigation of neglect was unsubstantiated. III. Failure to keep Resident #1 free from neglect. A. Resident status Resident #1, age 87, was admitted on [DATE]. According to the June 2020 computerized physician orders [REDACTED]. The 4/19/2020 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of two out of 15. He exhibited verbal and physical behaviors towards others and at times would resist care. He required extensive two-person assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. He was frequently incontinent of the bowel and bladder. The resident had one or more unhealed pressure ulcers. The number of stage 2 pressure ulcers present was documented as two. The number of these stage 2 pressure ulcers that were present upon admission/entry or reentry was documented as two. The number of venous and arterial ulcers present was documented as two. The resident had a pressure reducing device for chair, pressure ulcer/injury care, application of nonsurgical dressings and application of ointments/medications. The documentation was blank for the turning and repositioning program and pressure reducing device for bed. B. Observation and staff interview On 6/17/2020 at 11:55 a.m., IDON, licensed practical nurse (LPN) #2 unknown certified nurse aide (CNA) #3 were observed providing wound care to Resident #1's BLE and bilateral heels. Resident #1 was observed in bed. He had bilateral Prevalon boots on his feet and his heels were floated with pillows. CNA #3 repositioned Resident #1 and removed his Prevalon boots and was asked to help hold the resident's legs during wound care. The IDON said Resident #1 was admitted with multiple scabs to his bilateral lower extremities and then developed pressure ulcers to his heels. The IDON removed the dressing to Resident #1's right heel. The wound had sanguineous (fresh bleeding) drainage, no signs or symptoms of infection, the surrounding tissue was macerated. The IDON said the wound was a stage 2 which had worsened. She said the reason it worsened was because the resident had [MEDICAL CONDITION] and poor blood flow. The wound bed (mid wound) had 50% necrotic eschar, and 50% pink pale skin surrounding the eschar. It measured 6.0 x 5.0 cm. The right great toe was an intact scabbed area with 100% eschar, it

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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) measured 1.5 x 1.5 cm. There was slight redness to surrounding skin. The IDON said Resident #1 was on the last day of antibiotic treatment for [REDACTED]. The right inner ankle (malleolus) was intact, red and non- blanching. It measured 1.5 x 1.6 cm. The IDON said there was a scab that lifted to the area. The pressure ulcer to the left heel had a black cap, 100% eschar and its wound edges were attached to the wound bed, there was no drainage. It measured 3.3 by 5.3 cm. The IDON said the wound initially was a deep tissue injury but now was unstageable. The IDON said she would have the staff contact the physician for new treatment orders to the right heel, and planned to continue alcohol prep to the left heel. They continued to measure and treat all other scattered scabs to Resident #1's bilateral lower extremities per physician orders. C. Record review 1. Care Plans The resident's comprehensive care plan, dated 4/20/2020, documented the resident was admitted with multiple scabs and bruising to his bilateral lower extremities (BLE). He was at risk for skin breakdown related to incontinence, impaired mobility and presence of comorbid conditions. Staff were to perform complete assessment of skin and areas of redness,, no massage over pressure areas, heelbow protectors. Nursing staff were to check the resident's skin for areas of redness, report any changes to the nurse and perform a complete assessment of skin with areas of redness noted. The care plan was revised on 5/28/2020 following the facility's investigation wound development and treatment. The care plan revealed Resident #1 had facility-acquired wounds to his bilateral heels, SDTI (suspected deep tissue injury) to his left heel and a stage 2 pressure ulcer to his right heel. 2. Assessments a. Review of May 2020 weekly skin assessments documented on the TAR revealed nursing staff documented Resident #1's skin was intact on 5/6/2020 and 5/20/2020. The 5/6/2020 skin assessment did not have additional documentation. The 5/20/2020 skin assessment revealed Resident #1 had scabbed areas to his BUE and BLE, skin prep was applied per physician order. b. The 5/27/2020 wound assessment to the right heel revealed Resident #1 had an open blister, the base color was red with discoloration surrounding the wound, there was a moderate amount of sero-sanguineous (thin, watery, pale red to pink plasma with red blood cells) drainage, and tissue type was granulation tissue. It measured 4.5 x 7.0 x 0 cm. Podus (float) boots and air mattress were ordered. The 5/27/2020 wound assessment to the left heel revealed Resident #1 had a pressure ulcer with necrotic tissue. It was documented as not applicable under the stage. The base color was black, the wound was dry, and the tissue type was necrotic tissue. It measured 6.0 x 4.5 x 0 cm. Podus (float) boots and air mattress were ordered. 3. Physician treatment orders administration The physician treatment from April 2020 and May 2020 revealed nursing staff were to provide the ordered treatments and complete skin assessment monitoring every shift and full body skin assessments were to be done weekly. Treatment orders were provided by the physician on 4/12, 4/14, and 5/27/2020. 4. Treatment administration records (TARs) TAR review revealed Resident #1 refused treatment to his BLE five times in April 2020 and refused treatment to his BLE one time in May 2020. Review of the May 2020 TAR revealed eight different nurses documented they provided the treatment (skin prep) to Resident #1's BLE scabs, abrasions and open areas from 5/23/2020 to 5/27/2020. According to the physician on 6/19/2020 at 8:47 a.m., If the treatment was completed to all scabbed areas including the toes it would be difficult not to assess Resident #1's bilateral heels (see interview below). 5. Progress notes A nurse's note dated 5/23/2020 documented All scabs to BLE skin prepped as ordered. No s/s of infection noted. A nurse's note for 5/28/2020 revealed the treatment to BLE was completed; skin prep applied to scabbed areas. Pressure area with necrotic tissue found on L heel. Two open blisters to the side of L foot. Open blister with discoloration surrounding found on R heel. Head to toe Skin check done findings and measurement with weekly skin assessment. Areas cleaned and dressed. The physician progress notes [REDACTED].#1's wounds. The physician progress notes [REDACTED]. The physician wrote Nurses noticed heel blisters in the past couple of days which have now opened to heel ulcers, unstageable, left heel has large area of eschar and right heel has a large open area, pt. (patient) tends to dig his heels into the mattress when he is laying down, other risk factors include severe dementia and malnutrition. The resident also has unspecified open wound to the right lower leg sequela (resulting from disease injury). IV. Staff interviews LPN #1 was interviewed on 6/16/2020 at 10:20 a.m. The LPN said she was not aware Resident #1 had pressure wounds to his bilateral lower extremities until she was notified by LPN #2 on 5/27/2020. She said the nurses who knew about the wounds before 5/27/2020 should have completed a risk watch and she was notified it was not completed when the wounds were first identified. She said when they assessed Resident #1's wounds on 5/27/2020 the resident had a pressure ulcer to the left heel which was necrotic and the right heel had an open blister with discoloration. She said if the nurse did not complete an assessment of a resident's new wound and notify the physician that would be a form of neglect. CNAs #1 and #2 were interviewed on 6/16/2020 at 4:00 p.m. They said if a resident had a new wound or skin issue they would notify the nurse immediately. RN #3 was interviewed on 6/17/2020 at 3:05 p.m. RN #3 said failing to provide care and services to the resident would be considered a form of neglect. She acknowledged failing to notify the physician and family, assessing a wound or obtaining treatment orders for a new wound would be an example of neglect. She said I'm guilty and failed in that area, I should have notified the Doctor. RNS #3 was interviewed 6/17/2020 at 4:41 p.m. She said the last time she had abuse training was two weekends ago. She said her definition of neglect was not providing resident care needs. She said if a nurse knew about a new wound and failed to treat it that would be considered neglect. V. Administrative interviews The IDON was interviewed on 6/16/2020 at 12:55 p.m. She said she started interviewing the nurses about Resident #1's wound to his BLE and still was in the process of providing 1:1 education to all nurses about wound care. She stated she could not determine who the specific staff was or the exact date the bilateral heel blisters occurred could not be determined. IDON was interviewed a second time on 6/16/2020 at 4:12 p.m. She said at times the facility would use SBAR (situation, background, assessment, and recommendation) for any change of condition. She said they were not documenting or using SBAR consistently. The DON would ultimately follow-up with the nurses to ensure that they were completed for any change in condition. She said she felt that was a standard at all facilities; however, the nurses there just did not have the skill set of knowing the standards of practice. The IDON was interviewed again on 6/17/2020 at 1:45 p.m. She said she was unaware RN #3 came in to relieve RNS #2 from the floor on the morning of 5/24/2020 so she did not get a statement from RN #3 about Resident #1 having a blister to his heel. She said she attempted to call RN #3 to follow up with her; however, she had not returned her call. The INHA and IDON were interviewed on 6/17/2020 at 6:35 p.m. The INHA stated she was not a clinical person but from her understanding the nurses should have reported and documented the new wounds. The INHA said the nurse who identified Resident #1 as having new wounds should have started an investigation. They agreed that was a standard of practice. The IDON stated the neglect allegation was reported late to the state agency. She said she made that mistake and it would never happen again. The INHA and IDON acknowledged the facility's failures constituted neglect. The physician was interviewed on 6/19/2020 at 8:47 a.m. The physician stated it would be hard to argue that the nurse who saw Resident #1's feet every day would have not seen blisters to his bilateral heels. He said he had no explanation for why the wounds to his bilateral heels would not have been seen when the nurse provided treatment. VI. Facility follow-up In-service training and education was provided by the IDON on 6/17/2020 at 1:30 p.m. The training included abuse training to include neglect and appropriate reporting of abuse (25 staff signed acknowledgment), pressure ulcer training to include assessments, weekly skin assessments, implementation of an intervention, notification to physician and family, obtaining appropriate treatment orders and use of stop and watch assessment/tool. They completed a full house skin audit started on 5/27/2020 and completed on 5/29/2020, no new wounds were identified. The IDON also provided documentation of 1:1 education to front line staff which included when the nurse identified any wound or skin condition they should document their assessment to include, what type of wound or skin condition that is present, what it looks like, if it had infection, what type of drainage it had, if it worsened, notification, documentation and follow-up charting after a skin concern was identified. The INHA provided online facility training of all licensed nurses who had complete wound care risk assessment and care plan training completed by 20 licensed nurses in 2019.
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 record review, observation and staff interviews, the facility failed to ensure an investigation of alleged resident neglect for one (#1) of three sample residents was reported to the State Survey Agency timely. Specifically, the facility failed to timely report an allegation of neglect in accordance with State law, including to the State Survey Agency, within 24 hours of the alleged incident. Cross reference F600, failure to prevent neglect and provide care and services according to nursing standards of practice. Findings include: I. Facility policies A. The Abuse Prevention Program, dated 7/20/18, was provided by the interim nursing home administrator (INHA) on 6/17/2020 at 4:30 p.m. The policy read in pertinent part, that it was the policy of the facility to encourage and support all residents, staff, families,

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) visitors, volunteers and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion or misappropriation of resident property. The policy read, An owner, licensee, Administrator, Licensed Nurse, employee or volunteer of a nursing home shall not physically, mentally or emotionally abuse, mistreat or neglect a resident. Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation or misappropriation shall immediately report to the Nursing Home Administrator. The Nursing Home Administrator or designee will report abuse to the state agency per State and Federal requirements. The policy defined neglect as Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. B. The Abuse policy dated 7/20/18, was provided by the interim nursing home administrator (INHA) on 6/17/2020 at 4:30 p.m. The policy read in pertinent part, Residents will be protected from abuse, neglect, and harm while they are residing at the facility. The policy read, if an incident or allegation is considered reportable, the Administrator or designee will make an initial (immediate or within 24 hours) report to the State Agency. A follow up investigation will be submitted to the State Agency within five (5) working days. II. Facility investigation The facility investigation was provided by the IDON on 6/17/2020 at 1:30 p.m. Review of the investigation revealed during interviews on 5/27/2020, facility staff first identified Resident #1 had wounds to his left and to his right heels on 5/23/2020; however, assessment of the wounds to include characteristics of the wounds, causation, notification to physician or family, implementation of interventions and treatment orders were not implemented until four days after the wounds were identified. III. Resident status Resident #1, age 87, was admitted on [DATE]. According to the June 2020 computerized physician orders [REDACTED]. The pressure injuries were not documented on the CPO. The 4/19/2020 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of two out of 15. He exhibited verbal and physical behaviors towards others and at times would resist care. He required extensive two-person assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. He was frequently incontinent of bowel and bladder. The resident had one or more unhealed pressure ulcers. The number of stage 2 pressure ulcers present was documented as two. The number of these stage 2 pressure ulcers that were present upon admission/entry or reentry was documented as two. The number of venous and arterial ulcers present was documented as two. The resident had a pressure reducing device for chair, pressure ulcer/injury care, application of nonsurgical dressings and application of ointments/medications. The documentation was blank for the turning and repositioning program and pressure reducing device for bed. IV. Record review The resident's comprehensive care plan, dated 4/20/2020, documented the resident was admitted with multiple scabs and bruising to extremities, especially bilateral lower extremities (BLE). He had a history of [REDACTED]. He was at risk for skin breakdown related to incontinence, impaired mobility and presence of co-morbid conditions. The care plan documented the resident Rubs and digs heels against bed. Removes dressings and picks at scabs. The interventions included: moisture barrier applied to buttocks, document the resident's incontinent, perform complete assessment of skin and areas of redness, use pads/briefs to manage incontinence, no massage over pressure areas, Equagel to wheelchair (w/c), heelbow protectors, check skin for areas of redness and report any changes to the nurse and perform complete assessment of skin with areas of redness noted. The comprehensive care plan was revised on 5/28/2020 following the facility's investigation into wound development and treatment. The care plan revealed Resident #1 had in-house acquired wounds to his bilateral heels, SDTI (suspected deep tissue injury) to his left heel and a stage 2 pressure ulcer to his right heel. Interventions included a physical therapy (PT) evaluation, Doppler venous/arterial with ankle brachial index ABI, Prevalon boot to bilateral feet at all times, assess and record characteristics of the wound, and alternating air mattress. V. Staff interviews The IDON was interviewed on 6/16/2020 at 12:55 p.m. She said she started working at the facility as interim DON on 5/26/2020. She said Resident #1's wounds were found one day after she started on 5/27/2020. She said she was notified by the staff to look at Resident #1's heels. She said he had a DTI to the left heel, and stage II to the right heel. She said she interviewed staff, they ordered Prevalon boots, an upgraded low air loss mattress, completed a nutritional assessment, and had physical therapy complete an assessment. She said the NP, PA, and physician assessed residents at the facility two to three times a week. She said the facility supervisors would assess the resident's wounds with visits via telehealth (via supervisor phone) and the physician. She said venous studies were completed for Resident #1 which were negative for [MEDICAL CONDITION] or blood clot and the ABI results were pending. She said she started interviewing the nurses about Resident #1's wound to his BLE and still was in the process of providing one-to-one education to all nurses about wound care. The IDON was interviewed a second time on 6/16/2020 at 4:12 p.m. She said on 5/27/2020 when she discovered the wound, she started an investigation. She started interviewing staff about the wounds that were identified on the resident's bilateral heals. She said it was reported to the state agency on 5/29/2020. The INHA and IDON were interviewed on 6/17/2020 at 6:35 p.m. The INHA said the nurse who identified Resident #1 as having new wounds should have started an investigation. They agreed that was a standard of practice. The DON was interviewed on 6/17/2020 at approximately 6:20 p.m. The DON stated, the neglect allegation was reported late. She said she made that mistake and it would never happen again. She agreed the allegation should have been reported within 24 hours of discovery of the resident's heel wounds.
F 0684 **Level of harm** - 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 observation, interviews and record review, the facility failed to provide the highest practicable quality of care for one (#1) of three sample residents. Resident #1, who was severely cognitively impaired, had physical and verbal behaviors, was debilitated from a fall and had multiple comorbidities including cerebral infarction (stroke), metabolic [MEDICAL CONDITION], dementia, protein calorie malnutrition, [MEDICAL CONDITION] infarction, and rhabdomyolysis, and was identified as high risk for wound development. He was admitted to the facility on [DATE]. His admission data assessment revealed he had multiple scabbed areas, wounds and abrasions to his bilateral upper extremities and bilateral lower extremities (BLE). Significant wounds were documented to his BLE. The left lower extremity (LLE) wounds included a 20 x (by) 6.4 cm (centimeter) abrasion and a mid shin 13.5 x 2.5 cm abrasion. The right lower extremity (RLE) included a 10 x 5.7 cm lateral to knee/shin abrasion with various scabs, right mid shin 8.7 x 1.5 cm abrasion. The great toe had 2.0 x 2.0 cm abrasion with a 0.8 x 0.5 cm area of slough and the medial malleolus had a 1.5 x 0.5 cm wound with slough. Resident #1 had pressure injuries which were not monitored to his right dorsal (facing upward while standing) great toe and right medial malleolus which were identified on admission (see above and physician note 4/14/2020). In addition Resident #1 developed a wound to his right heel on 5/23/2020 and a wound to his left heel (date unknown). These wounds were identified by nursing staff (see investigation below); however, administration was not notified until 5/27/2020. During the four days the nursing staff did not assess the wounds for causation, document characteristics of the wound, monitor, notify the physician or family, implement interventions, nor obtain physician orders to treat the resident's bilateral heel wounds until they were brought to the interim director of nursing's (IDON's) attention on 5/27/2020. Although the facility completed an investigation of wound development to Resident #1's bilateral heels and provided staff education on standards of practice including notification to the physician/family, treatments, assessing characteristics and monitoring wounds; the facility did not follow standards of practice timely and there was a delay in assessment and treatment. The facility knowingly failed to monitor and document the healing of the open wounds to the resident's bilateral lower extremities on admission as well as failed to monitor newly found wounds to his bilateral heels for four days which put the resident at risk for delayed healing and at risk of infection. On assessment 5/27/2020 Resident #1's left heel was not staged (see wound assessment) and had necrotic tissue (see staff interview); Resident #1's right heel was documented as a stage 2 blister with a red wound base which later was observed to have 50% necrotic tissue (see wound observation below). The facility failures contributed to delayed healing and/or worsening of the resident's wounds, and the development of new wounds. Cross-reference F600, failure to keep the resident free from neglect. Findings include: I. Facility policy The Wound Care policy, undated, was provided by the interim nursing home administrator (INHA) on 6/17/2020 at 4:30 p.m. It documented in pertinent part, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Verify that there is a physician's order for this procedure. Review the resident's care plan to assess for any special needs of the resident. -The following should be recorded in the resident's medical record: -The type of wound care given. -The date and time the wound care was given. -The position in which the resident was placed. -The name and title of the individual performing the wound care. -Any change in the resident's condition. -All assessment data (i.e., wound bed

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) color, size, drainage, etc.) obtained when inspecting the wound. -How the resident tolerated the procedure. -Any problems or complaints made by the resident related to the procedure. -If the resident refused the treatment and the reason(s) why. -The signature and title of the person recording the data. -Notify the supervisor if the resident refuses the wound care. -Report other information in accordance with facility policy and professional standards of practice. II. Resident #1's status Resident #1, age 87, was admitted on [DATE]. According to the June 2020 computerized physician orders (CPO), [DIAGNOSES REDACTED]. Pressure ulcers were not documented on the June 2020 CPO. The 4/19/2020 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of two out of 15. He exhibited verbal and physical behaviors towards others and at times would resist care. He required extensive two-person assistance with bed mobility, transfers, toilet use and personal hygiene. The resident had one or more unhealed pressure ulcers. The number of stage 2 pressure ulcers present was documented as two. The number of these stage 2 pressure ulcers that were present upon admission/entry or reentry was documented as two. The number of venous and arterial ulcers present was documented as two. The resident had a pressure reducing device for his chair, pressure ulcer/injury care, application of nonsurgical dressings and application of ointments/medications. The documentation was blank for a turning and repositioning program and a pressure reducing device for bed. The resident received antipsychotics for seven out of seven days and antianxiety medication for two out of seven days, and antipsychotics were received on a routine basis only. III. Failure to assess wounds appropriately on admission and failure to assess the development of new wounds. A. Observation and interviews On 6/17/2020 at 11:55 a.m., the IDON, licensed practical nurse (LPN) #2 and certified nurse aide (CNA) #3 were observed providing wound care to Resident #1's BLE to include bilateral heels. Resident #1 was observed in bed. He had bilateral Prevalon boots on his feet and his heels were floated with pillows. A bedside table was observed with a clean field and treatment supplies. All three staff washed their hands and CNA #3 and the IDON donned gloves. LPN #2 was the scribe and CNA #3 repositioned Resident #1 and removed his Prevalon boots and was asked to help hold the resident's legs during wound care. The IDON said Resident #1 was admitted with multiple scabs to his bilateral lower extremities and then developed pressure ulcers to his heels. LPN #2 said treatment orders to the right heel was to clean the right heel with normal saline (NS), apply xeroform to the wound base (the healthy tissue) and not the area with eschar, and wrap with kerlix. The IDON removed the dressing to Resident #1's right heel. The wound had sanguineous (fresh bleeding) drainage, no signs/symptoms (s/s) of infection, the surrounding tissue was macerated. The IDON said the wound was a stage 2 which had worsened. She said the reason it worsened was because the resident had [MEDICAL CONDITION] and poor blood flow which was diagnosed with [REDACTED]. The wound bed (mid wound) had 50% necrotic eschar, and 50% pink pale skin surrounding the eschar. It measured 6.0 x 5.0 cm. The right great toe was an intact scabbed area with 100% eschar, it measured 1.5 x 1.5 cm. There was slight redness to the surrounding skin. The IDON said Resident #1 was on the last day of antibiotic treatment for [REDACTED]. The right inner ankle (malleolus) was intact, red and non blanching. It measured 1.5 x 1.6 cm. The IDON said there was a scab that lifted to the area. The pressure ulcer to the left heel had a black cap, 100% eschar and its wound edges were attached to the wound bed; there was no drainage. It measured 3.3 by 5.3 cm. The IDON said the wound initially was a deep tissue injury but now was unstageable. LPN #2 said the treatment for [REDACTED]. The IDON said she would have the staff contact the physician for new treatment orders to the right heel, and planned to continue alcohol prep to the left heel. They continued to measure and treat all other scattered scabs to Resident #1's bilateral lower extremities per physician orders. B. Record review 1. Care plans The 4/12/2020 individual resident care plan (developed within 48 hours of admission), documented Resident #1 had wounds and documentation was left blank under wound locations. Interventions included repositioning every two hours and barrier cream. Documentation was left blank: under special mattress, heel protectors/elevate heels and wheelchair cushion. The 4/20/2020 care plan report, revised 5/28/2020, revealed Resident #1 acquired wounds to his bilateral heels, SDTI (suspected deep tissue injury) to his left heel, and a stage 2 pressure ulcer to his right heel. Interventions implemented were a physical therapy (PT) evaluation, Doppler venous/arterial with ankle brachial index ABI, Prevalon boot to bilateral feet at all times, assess and record characteristics of the wound, and alternating air mattress. In addition on the care plan Resident #1 rubbed and dug his heels into the bed and would often remove his dressings. -There was no intervention listed for this behavior or no implementation of offloading devices utilized, preventative measures or alternate treatments until the wounds were discovered on 5/23/2020 and not documented (see interviews below). 2. Admission Data Collection and Documentation form The 4/12/2020 Admission Data Collection and Documentation revealed Resident #1 was admitted with multiple scabs and abrasions to his bilateral upper extremities (BUE) and BLE. Although there were orders to apply skin prep to the scabbed areas, there was no documentation to include monitoring healing of larger abrasions, the pressure points as identified by the physician (see below) or the open areas listed on the Admission Data Collection and Documentation form. Also documented on this form was a Braden Scale for predicting pressure ulcers. It revealed Resident #1 was at high risk for developing pressure ulcers with a score of 11 out of 18 (a score of 15-18=At risk, 13-14=Moderate risk, 10-12=High risk, and 6-9=Very high risk). Resident #1's substantial wounds documented to his BLE were as follows: -LLE 20 x 6.4 cm abrasion and mid shin with 13.5 x 2.5 cm abrasion. -RLE 10 x 5.7 cm lateral to knee/shin abrasion with various scabs, right mid shin 8.7 x 1.5 cm abrasion, great toe had 2.0 x 2.0 cm abrasion with a 0.8 x 0.5 cm area of slough and at medial malleolus had 1.5 x 0.5 cm wound with slough. 3. Treatment orders The April 2020 treatment administration record (TAR) revealed Resident #1 had orders as follows: -Starting 4/14/2020 apply skin prep to all scabs and abrasions to BUE and BLE every shift. -Starting 4/14/2020 cleanse all open venous ulcers with normal saline (NS), pat dry, cover with xeroform ([MEDICATION NAME]) gauze and cover with non-adherent [MEDICATION NAME] dressing secure with kerlix. -Starting 4/14/2020 monitor all abrasions and scabs for signs and symptoms of infection every shift. The May 2020 TAR revealed Resident #1 had orders as follows: -Starting 4/14/2020 apply skin prep to all scabs and abrasions to BUE and BLE every shift. -Starting 4/14/2020 monitor all abrasions and scabs for signs and symptoms of infection every shift. -Starting 4/29/2020 cleanse all open venous ulcers with NS, pat dry, apply skin prep, and monitor for signs and symptoms of infection every shift. -Starting 5/27/2020 ensure soft boot is in place to the left foot while in bed. Document in nursing notes any noncompliance every shift. -Starting 5/27/2020 ensure heels are floated while in bed, document in nursing notes any noncompliance. -Starting 5/27/2020 left heel DTI, apply [MEDICATION NAME] to discolored areas, let dry and leave open to air. Monitor for signs and symptoms of infection every shift and document changes in nursing notes. -Starting 5/27/2020 right heel open blister, cleanse with NS, pat dry, apply xeroform gauze to open area, cover with adhesive foam dressing and change daily. Monitor for signs and symptoms of infection and document changes in the nursing notes. According to the April and May 2020 TARs, Resident #1 refused treatment to his BLE five times in April 2020 and refused treatment to his BLE one time in May 2020, on night shift on 5/22/2020. Review of the May 2020 TAR revealed eight different nurses documented they provided the treatment (skin prep) to Resident #1's BLE scabs, abrasions and open areas from 5/23/2020 to 5/27/2020. Interview with the physician revealed if the treatment was completed to all scabbed areas including the toes it would be difficult not to assess Resident #1's bilateral heels (see below). 4. Nursing notes Review of nursing notes from 5/23/2020 to 5/27/2020 revealed one nurse documented completing treatment to Resident #1's BLE. This was documented on 5/23/2020 at 3:05 p.m. There were no other nursing notes documenting he had skin prep applied to his BLE. 5. physician progress notes [REDACTED].#1 had multiple wounds to his BLE. Some were on pressure points such as the right medial malleolus and first metatarsophalangeal (right great toe). It further documented some of the wounds had punched out areas suggestive of arterial ulcers. The physician progress notes [REDACTED].#1's wound to the right medial malleolar region was still large with surrounding [DIAGNOSES REDACTED] (redness). The right great toe and right second toe wounds were closing over well. The physician progress notes [REDACTED].#1's wound to his right medial malleolus had slough and the resident would not keep his dressings on. The physician progress notes [REDACTED].#1's wound to his right medial malleolus was the largest wound, which was becoming more shallow and was covered with a scab. The physician progress notes [REDACTED].#1's wounds. The physician progress notes [REDACTED].#1 had bilateral heel ulcers for the past couple of days. The physician progress notes [REDACTED].#1's pressure ulcers to his bilateral heels were unavoidable due to his abnormal ABI and vascular compromise and the resident was being treated with antibiotics for [MEDICAL CONDITION] to his right great and right second toes. 6. Skin assessments Review of May 2020 skin assessments documented on the TAR revealed nursing staff documented Resident #1's skin was intact on 5/6/2020 and 5/20/2020. The 5/6/2020 skin assessment did not have additional documentation. The 5/20/2020 skin assessment revealed Resident #1 had scabbed areas to his BUE and BLE, and skin prep was applied per physician order. The 5/13/2020 skin assessment documented Resident #1 refused to have his skin assessment completed, however treatment (skin prep) was applied to the resident's BLE per nursing notes and TAR. The 5/27/2020 skin assessment documented bilateral pressure ulcers (see wound assessment below). 7. Facility investigation of Resident #1's bilateral heel wounds The facility investigation was provided by the IDON on

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	065367	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLAGE CARE AND REHABILITATION CENTER, THE	9221 WADSWORTH PKWY WESTMINSTER, CO 80021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) 6/17/2020 at 1:30 p.m. Review of the investigation revealed facility staff first identified Resident #1 had wounds to his left and right heels on 5/23/2020 during interviews on 5/27/2020. However, assessment of the wounds to include characteristics of the wounds, causation, notification to physician or family, implementation of interventions and treatment orders, were not implemented until four days after the wounds were identified. CNA #4 was interviewed on 5/27/2020. In her statement she said she reported to registered nurse supervisor (RNS) #2 that on 5/23/2020 while putting Resident #1 to bed, she and another CNA (unknown) noticed he had a blister to his right heel which was leaking, so they put a brief under it so it would not get the bed wet. She stated she did not notice any other issues on the other foot. RNS #2 was interviewed on 5/27/2020. In her statement she said on 5/23/2020 she received in report from the day nurse that Resident #1 had a blister and adjustments were made to his medications. She stated the resident had a blister to his left heel that was small (contradictory to the statement above, and later interviews below). She said at 12:30 a.m. on 5/24/2020 she was notified by the CNA that while transferring the resident to bed they heard a pop and the resident's blister opened and drained. However, the skin was intact and a dressing was not required (this also was contradictory to the statement above and follow-up interviews below). She said there was no deep tissue injury (DTI) to the resident's heels. She also stated at 1:00 a.m. on 5/24/2020 she reported to the on-coming registered nurse (RN) #3 that the area needed to be observed for any changes or new orders and reported the same information to the on-coming RNS #3 at shift change the following morning. The 5/27/2020 wound assessment to the right heel revealed Resident #1 had an open blister, the base color was red with discoloration surrounding the wound, there was a moderate amount of sero-sanguineous (thin, watery, pale red to pink plasma with red blood cells) drainage, and tissue type was granulation tissue. It measured 4.5 x 7.0 x 0 cm. Podus (float) boots and air mattress were ordered. The 5/27/2020 wound assessment to the left heel revealed Resident #1 had a pressure ulcer with necrotic tissue. It was documented as not applicable under the stage. The base color was black, the wound was dry, and the tissue type was necrotic tissue. It measured 6.0 x 4.5 x 0 cm. Podus (float) boots and air mattress were ordered. See below for follow-up to the identification of the facility acquired pressure ulcers. IV. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 6/16/2020 at 10:20 a.m. She said she had worked at the facility for four years and always worked on the skilled unit, which was the 600 hallway. She said none of her residents had any wounds on her unit. She said she did not believe she received any wound care training other than wound vac (negative pressure, vacuum assisted healing) training which she received one year ago by the MDS coordinator. She said they would monitor all wounds such as pressure wounds, surgical wounds and diabetic wounds. She said if a resident developed wounds they would complete a risk watch (internal change in condition form), which included an assessment of the wound, interventions and notification to the physician for treatment orders. RNS #1 was interviewed on 6/16/2020 at 10:30 a.m. She said she had worked at the facility for [AGE] years. She said the MDS coordinator had completed wound rounds. She said she had not received any training related to wound care in the past year. She said she did not remember the last time a resident had a wound in the facility and it had been a long time since a resident had a pressure wound at the facility. She said Resident #1's wounds were likely venous or arterial wounds in nature because Resident #1 had ultrasound and ABI studies completed which showed he had poor blood flow to his bilateral lower extremities. She said if a resident had a new wound that was identified, the nursing staff would complete a risk watch which included measurements, notification, when it was found, the description of the wound, and she would get treatment orders for the wound. She said she was not aware Resident #1 had pressure wounds to his bilateral lower extremities until she was notified by LPN #2 on 5/27/2020. She said the nurses who knew about the wounds before 5/27/2020 should have completed a risk watch and she was notified it was not completed when the wounds were first identified. She said when they assessed Resident #1's wounds on 5/27/2020 the resident had a pressure ulcer to the left heel which was necrotic and the right heel had an open blister with discoloration. She said if the nurse did not complete an assessment of a resident's new wound and notify the physician that would be a form of neglect. RN #1 was interviewed on 6/16/2020 at 11:30 a.m. She said she had worked at the facility for [AGE] years. She said there were no residents with wounds on her unit which was the 500 hallway. She said she had received wound care training through the facility's online training about six months ago. She said she was taking care of Resident #1 on 5/23/2020, the day in which two night nurses reported he had wounds to his heels. She said she worked the day shift that day and she checked Resident #1's skin and he did not have any wounds on his bilateral heels. She said she did not pass along in report the resident had wounds, and if he did she would have followed up as a standard of practice, and would have completed a risk watch form. RN #2 was interviewed on 6/16/2020 at 3:10 p.m. She said she was working on the 400 hallway and there were no residents who had wounds on her unit. She said Resident #1 had wounds but they were not pressure ulcers that required monitoring and were considered venous/arterial wounds in nature. She said if a resident developed wounds they would complete a risk watch assessment. She said she did not know who completed wound rounds. CNAs #1 and #2 were interviewed on 6/16/2020 at 4:00 p.m. They said they regularly worked with Resident #1. They said, When he first admitted he was very violent, he was combative, he kicked, pinched, scratched and spit on us. They said he would fall a lot, he was restless and hard to keep calm and was up and down and would try to stand up alone. CNA #1 said he sun-downed (state of confusion starting late afternoon and spanning into the night). She said he needed one to two-person assistance with all his cares. She said he used to be able to walk before he developed wounds, then he used a mechanical lift for a short while and since he received specialty shoes, and now he was able to bear weight and transfer. They said he wore Prevalon boots while in bed; however, he would remove them. They said they used to float his heels with pillows before the Prevalon boots were added, but he would remove the pillows. They said he had one-to-one care for about five weeks because of his behaviors and multiple falls. They said recently in the past few weeks his behaviors had improved and he was less combative, calm and cooperative. They said while the resident was on quarantine the resident had bed baths, but when he was off quarantine he would take a shower and never refused. They said if a resident had a new wound or skin issue they would notify the nurse immediately. RNS #2 was interviewed on 6/17/2020 at 1:24 p.m. She said on 5/23/2020 she received in report from the day nurse (she was not sure who the nurse was) that Resident #1 had a dime size blister to his left heel and the treatment was skin prep. She said around 12:30 a.m. or 12:45 a.m. on 5/24/2020 the CNAs (CNA #4 was the primary CNA working who notified her and she was not sure who was the other CNA working was) notified her they heard a pop when they put Resident #1 to bed and his blister had ruptured. She said, I initially looked at it and it was a ruptured intact blister and within 10 minutes I gave (RN #3) report and at that time I delegated the observation to her. She said RN #3 did not say she would follow-up, but she said okay. She said she did not follow-up with RN #3 later in the shift to ensure she assessed the resident's heel, but she reported it to on-coming RNS #3 to follow-up. She said she did not return to work at the facility until 5/27/2020 and that was the first day she was aware of the wound to Resident #1's right heel which was a DTI. RN #3 was interviewed on 6/17/2020 at 3:05 p.m. She said she had worked at the facility PRN (as needed) for three years. She said she usually worked two days per week. She said on 5/24/2020 RNS #2 reported to her that the resident had a blister to his left heel. She said she did not know how long it had been there or if it was brand new. She said CNA #4 told her that she told RNS #2 about the ruptured blister. She said she checked the area to Resident #1's left heel and she applied the skin prep to it. She said the left heel blister was intact, deflated and not leaking. She said she told RNS #3 the following day, along with the on-coming nurse about the intact blister. She said she did not notify the physician to obtain treatment orders and she assumed RNS #3 would contact the physician to obtain orders. She said she assumed RNS #3 would implement an intervention. She said she received wound care training when she first started working through an online computer training at the facility. She said she had received abuse/neglect training in the last six months. She said failing to provide care and services to a resident would be considered a form of neglect. She acknowledged failing to notify the physician and family, assess a wound or obtain treatment orders for a new wound would be an example of neglect. She said I'm guilty and failed in that area, I should have notified the doctor. CNA #4 was interviewed on 6/17/2020 at 4:07 p.m. She said she worked full time on the night shift. She said she had taken care of Resident #1 frequently. She said on 5/23/2020 she and another CNA were getting Resident #1 to bed around 8:00 p.m., and they noticed the sheets were wet at the end of the bed, so she removed the resident's right sock which was wet and she noticed the resident had a blister that popped. She said she notified RNS #2 right after and RNS #2 told her she knew the resident had a blister on his heel. She said she asked DNS #2 if she would go and take a look at it because it had popped. She said RNS #2 just told her to put a pillow under it, so she did and also placed a chuck underneath it. She said Resident #1 had non-skid socks on when they put him to bed. She said, I removed his sock to the right foot only and did not think to check his other foot. She said she did not know for sure if RN #3 ever went in to check the resident's heel because she had to finish caring for other residents, and she could not remember the CNA's name who was helping her that night. She said RN #3 came in to work around 12:00 a.m. or 1:00 a.m. to work on that particular unit, but she could not remember if she told her about Resident #1's blister. RNS #3 was

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VILLAGE CARE AND REHABILITATION CENTER, THE	**9221 WADSWORTH PKWY WESTMINSTER, CO 80021**

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 5) interviewed 6/17/2020 at 4:41 p.m. She said she was an RN supervisor that worked Friday, Saturday, and Sunday. She said she worked on 5/24/2020 and did not remember receiving report from RNS #2 that Resident #1 had a blister to his right or left heel. She said she did not remember RN #3 telling her Resident #1 had a blister to his right or left heel. She said, Obviously, if they said they told me about it, then maybe they did but I just don't remember. She said if a resident had a newly acquired wound she would notify the director of nursing (DON). She said she would assess the wound, contact the physician for treatment orders, notify the family, and obtain measurements once a week to ensure the wound was healing. She said they would make sure to check the wound daily. She said the nurses on the floor would complete wound rounds and the physician would monitor via their telehealth visit, and the nurse practitioner (NP) or physician assistant (PA) would follow-up if the wound was getting worse. She said the MDS coordinator would give them information on wounds because she was wound care certified. She said the last time she had abuse/neglect training was two weekends ago. She said her definition of neglect was not providing resident care needs. She said if a nurse knew about a new wound and failed to treat it, that would be considered neglect. V. Administrative interviews The IDON was interviewed on 6/16/2020 at 12:55 p.m. She said she started working at the facility as interim DON on 5/26/2020. She said Resident #1's wounds were found one day after she started on 5/27/2020. She said she was notified by the staff and asked to look at Resident #1's heels. She said he had a DTI to the left heel, and a stage II to the right heel. She said she interviewed staff, they ordered Prevalon boots, an upgraded low air loss mattress, completed a nutritional assessment, and had physical therapy complete an assessment. She said the NP, PA, and physician assessed residents at the facility two to three times a week. She said the facility supervisors would assess the resident's wounds with visits via telehealth (via supervisor phone) and the physician. She said venous studies were completed for Resident #1, which were negative for [MEDICAL CONDITION] or blood clot, and the ABI results were pending. She said she started interviewing the nurses about Resident #1's wound to his BLE and still was in the process of providing one-to-one education to all nurses about wound care. She said weekly skin assessments were being completed; however, the follow-up to any skin conditions such as bruising and scabs were not implemented. Since then, they completed 100% skin audits, and had been completing random skin assessments. The IDON was interviewed a second time on 6/16/2020 at 4:12 p.m. She said at times the facility would use SBAR (situation, background, assessment, and recommendation) for any change of condition. She said they were not documenting or using SBAR consistently. She said the DON would ultimately follow-up with the nurses to ensure that they were completed for any change in condition. She said she felt that was a standard at all facilities; however, the nurses there just did not have the skill set of knowing the standards of practice. The IDON was interviewed again on 6/17/2020 at 1:45 p.m. She said she was unaware RN #3 came in to relieve RNS #2 from the floor on the morning of 5/24/2020 so she did not get a statement from RN #3 about Resident #1 having a blister to his heel. She said she attempted to call RN #3 to follow up with her; however, she had not returned her call. The INHA and IDON were interviewed on 6/17/2020 at 6:35 p.m. The IDON said she was not sure why it was documented on the MDS that Resident #1 had two pressure ulcers and two venous/arterial ulcers upon admission and they were not monitored. She said the MDS coordinator was not available for an interview. The INHA said the nurse who identified Resident #1 as having new wounds should have started an investigation. They agreed that was a standard of practice. The INHA said they felt they had reviewed the resident's care multiple times in stand-up frequently and provided many approaches. The PA was interviewed on 6/18/2020 at 4:35 p.m. She said she visualized the Resident #1's wounds periodically and not with each visit. She said the physician would also visualize the resident's wounds via telehealth visits. She said the resident did have wounds on admission that were suggestive of pressure. She said the physician, nurse practitioner (NP), or physician assistant did not complete measurements of the resident's wounds. She said caring for the resident's wounds was a team effort and the nurses would provide wound care and the physician would give wound orders, but would not necessarily document all the details about the wounds to include measurements and the description and type of wound it was. She said if the physician assessed any of Resident #1's wounds visually he would document it in his report. She said typically he did not write it down if he did not look at it. She said the resident's Doppler reports and ABI were abnormal, indicating poor blood flow and delayed healing process, but not necessarily would have been the reason he developed his bilateral heel pressure ulcers. The physician was interviewed on 6/19/2020 at 8:47 a.m. He said Resident #1 had multiple falls and multiple behaviors. He said Resident #1 did not sustain any injuries from his falls. He said the facility had provided one-to-one care for Resident #1, and he often required multiple