STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065147	A. BUILDING _____ B. WING _____	08/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHEYENNE MOUNTAIN CENTER	835 TENDERFOOT HILL RD COLORADO SPRINGS, CO 80906

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 observations, record review and staff interviews, the facility failed to ensure one (#1) out of three residents received necessary care and services to prevent the development of pressure injuries to his left lower extremity (calf and heel). Specifically: The resident was at known risk for pressure injury due to his compromised medical condition. (Cross-reference F692). He developed deep tissue injuries (DTI) which progressed to unstageable, necrotic wounds, contributing to pain and infection. Interviews revealed that at the family's request, the facility had been using a non-formulary device to relieve pressure on the resident's left lower extremity for six months to a year. The device was a doughnut-type personal pillow with a hole in the middle, similar to a cervical collar used for the neck. The facility was aware the doughnut-type device was inappropriate for pressure relief. However, it failed to take steps to minimize the risk it posed for pressure injuries development. Specifically, although use of the device was mentioned on the Kardex and care plan, there was no evidence the device had been evaluated by therapy until after the resident's wound developed and neither the Kardex nor the care planned instructed staff how to properly place the device under the resident's left lower extremity. None of the staff interviewed stated they had received training on how to place the device to prevent complications. Further, there was no documentation the resident and/or family was educated regarding the use of a non-formulary positioning device and the risks versus benefits of its use. Findings include: I. Policy and procedures The Skin Integrity Management policy, last revised 1/31/2020, was provided by the director of nursing (DON) on 8/26/2020 at 2:30 p.m. The policy read in part, The implementation of an individual patient's skin integrity management occurs within the care delivery process. Staff continually observe and monitor patients for changes and implement revisions to the plan of care as needed. Notify Medical Director, Center Nurse Executive (CNE), and Center Executive Director (CED) if deviation from protocol is requested by physician/advanced practice provider (APP), managed care company, or others. II. Professional reference The National Pressure Ulcer Advisory Panel, NPUAP Pressure Injury Stages 2016, http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (July, 2017) accessed on 8/30/2020, reveals the following pertinent information: Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. III. Resident #1 A. Resident status - known risk for developing pressure injuries and use of a doughnut-type device to relieve pressure at family request that the facility did not recommend. 1. Record review Resident #1, age greater than 65, admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The minimum data set (MDS) assessment dated [DATE], revealed the resident had moderate cognitive impairment with a brief interview of mental status (BIMS) of ten out of 15. He required extensive assistance with bed mobility and was total dependence with toileting. He was at high risk for pressure ulcers with no unhealed pressure ulcers during the assessment period. He had moisture. He had a pressure-reducing device in place. He had associated skin damage (MASD) and received ointments and medications other than to the feet. The Kardex (a flow sheet to direct resident care) created 10/18 and current as of 8/17/2020, documented in pertinent part under the section titled Other Devices, off load/float heels while in bed with doughnut ring provided by family. A care plan, created on 2/17/19, and revised on 7/13/2020, identified the resident at risk for skin breakdown related [MEDICAL CONDITION], decreased mobility, preference to stay in bed and family providing positioning devices that the facility does not recommend. The goal was the resident's wound/skin impairment will heal as evidenced by decrease in size, absence of [DIAGNOSES REDACTED] and drainage and/or presence of granulation x 30 days (revised 7/13/2020). Interventions included in part, off load/float heels while in bed with the doughnut ring provided by family (initiated 2/17/19; revised 7/14/2020), and provide wound treatment as ordered. 2. Observations and interview of doughnut-type device (pillow) to relieve pressure On 8/20/2020 at 2:05 p.m. and 2:20 p.m., observations with the director of therapy (DOT) revealed a doughnut-type pillow in Resident #1's room. Per the DOT, the pillow appeared to be a device used for immobilizing the neck and he called it a cervical collar. He stated the family wanted the resident to use this device for his left lower extremity (LLE); however, it was non-formulary and he said it was not the appropriate device for positioning/elevating feet. Review of Resident #1's record failed to disclose evidence, other than the Kardex and care plan dates above, when the facility began using the doughnut-type pillow provided by the family. The DOT, interviewed again on 8/20/2020 at 3:15 p.m., said he did not have any documentation in the therapy notes that the resident had the doughnut pillow provided by the family for positioning. He said they had recommended a different device which was part of their formulary and he did not know the staff were not using the recommended therapy device. B. Resident decline - development of pressure injuries 1. Family and hospice nurse interview A family member, interviewed on 8/17/2020 at 1:00 p.m., said she had recently had a [MEDICATION NAME] visit with the resident. She said she could see his left foot showing from underneath the blanket and she asked a staff member to lift up the blanket. She said she asked them to remove his bandage on his left leg and saw he had a very bad looking, black wound. A hospice nurse said that since she began seeing the resident, he had not had any wounds on his left lower extremity (LLE), only some excoriation to his sacral area. However, said when she saw him again on 7/21/2020, he had a soft blue colored boot on his LLE for a deep tissue injury (DTI). She said licensed practical nurse (LPN) #1 told her she believed the doughnut-type pillow the family provided caused the DTI. She said the resident had been stable for quite some time, up until the wounds appeared and then he began to decline. She said she never saw a pressure-relieving device on his foot before 7/21/2020, and only saw his feet elevated on pillows. 2. Observation and interview revealed a black, necrotic wound on the resident left foot (calf and heel) that caused the resident pain. On 8/20/2020 at 1:30 p.m., a wound care observation was conducted with unit manager (UM) #1. She said the resident had been medicated with [MEDICATION NAME] 10 milligrams 20 minutes ago; however, Resident #1 said the pain medication was not working on the pain in his foot. UM #1 lifted the blankets off his lower legs and revealed he had a blue, soft boot over his left lower extremity. His feet were exposed which revealed the toes on his left foot were black and necrotic. The resident winced with pain when his left leg was touched and slightly repositioned. The UM said she was going to contact hospice to see if there was anything else that could be given to him for pain before she attempted to do the dressing change. On 8/20/2020 at 4:40 p.m., wound care observations were conducted with UM #1 and certified nurse aide (CNA) #8. The UM said the resident was pre-medicated with [MEDICATION NAME] sulfate 10 milligrams 25 minutes earlier. She asked the resident how his pain was and he said it was no good. As the UM began to position his left leg to remove the old bandage, the resident winced with pain. After removing the dressing, dated 8/19/2020, the left ankle and calf area was exposed. The skin was black and necrotic extending from the ankle and three quarters of the way up his calf, just below the back of the knee. The resident winced and grimaced. The UM confirmed there was no drainage and that the tissue was non-viable. She said the left toes were gangrenous. After cleansing the wound, she applied [MEDICATION NAME] to the area, let it dry and then wrapped it with a clean gauze dressing. She then

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) reapplied the protective soft boot and placed his leg in a comfortable position. 3. Record review and interview confirmed Resident #1 developed new pressure injuries mid-July 2020. a. Interview The director of nursing (DON), interviewed on 8/17/2020 at 4:50 p.m., said Resident #1 was admitted to skilled care with post-surgical wounds to the LLE. He had vascular issues and had a stroke. She said he was mostly bed bound and would get up for showers or to be weighed. She said the wounds on the LLE from admission had healed up until he acquired the new wounds. b. Record review confirmed new pressure injuries developed mid-July, associated with pain and infection. June 2020: -A 6/24/2020 skin note documented in pertinent part that a skin check was performed and there were no skin injuries or wounds noted. July 2020: -A skin check dated 7/13/2020 documented a new skin injury, DTI (deep tissue injury), to the left posterior ankle. The wound type was described as pressure. -An IDT (interdisciplinary) wound round note dated 7/13/2020 by the wound nurse documented a left distal posterior calf/ankle DTI wound measuring 7cm(centimeters) by 8.5cm (centimeter) x UTD (unable to determine). The wound was 100 percent dark purple and the skin was intact. The wound was treated with sure prep and was offloaded. -A wound care progress note dated 7/20/2020 written by the wound doctor, documented in part, the following information regarding new wounds: Context three DTI's -Wound #6 left, distal posterior calf/ankle is a DTI persistent non-blanchable deep red, maroon or purple discoloration pressure ulcer and has received a status of not healed. Initial wound encounter measurements are 5.2cm(centimeters)x5.5cm(centimeters) with no measurable depth with an area of 28.6 sq (square) cm (centimeters). Wound bed had 100 percent [MEDICATION NAME]. -Wound #7 left heel is a DTI persistent non-blanchable deep red, maroon or purple discoloration pressure ulcer and has received a status of not healed. Initial wound encounter measurements are 4cm(centimeters)x2.5cm(centimeters) with no measurable depth with an area of 10 sq(square) cm(centimeters). Wound bed has 100 percent [MEDICATION NAME]. A wound care progress note dated 7/27/2020 by the wound doctor documented the following: -Wound #6 left distal posterior calf/ankle, unstageable obscured full-thickness skin and tissue loss. Measurements: 8cm(centimeters)x6.7cm(centimeters), no measurable depth, 56.6 sq(square) cm(centimeters) moderate amount of drainage noted. Wound bed 80 percent eschar, 20 percent granulation. -Wound #7 left heel unstageable obscured full-thickness skin and tissue loss. Measurements: 5cmx6cm, no measurable depth, 30 sq cm. Wound bed has 100 percent eschar. August 2020: - An IDT wound round note dated 8/3/2020 by the wound nurse documented in part, left distal posterior calf/ankle, unstageable. 9.7cm x10cmxUTD (unable to determine) depth. Left heel, unstageable. Measurements: 6cm x3.3cm xUTD (unable to determine) depth. -A 8/3/2020 wound doctor progress note documented the resident's measurements as follows: Wound #6, left distal posterior calf/ankle-8cmx6.7cm no measurable depth Wound #7, left heel-6cmx3.3cm no measurable depth -An 8/7/2020 hospice nurse note documented in part the facility called for the hospice nurse to assess the resident. The resident reported pain to his lower left extremity saying It hurts a lot. The resident was noted to have increased necrotic areas and green drainage to his left outer shin. The shin area measured 13cm(centimeters)x8.7cm(centimeters). The left heel wound was measured at 6cm x7cm. The resident was placed on an antibiotic for ten days. -An IDT wound round note dated 8/17/2020 documented in part, left distal posterior calf/ankle, unstageable. Measurements: 17cm x10cmxUTD (unable to determine) depth. Wound appears 100 percent eschar. Treatment recommended with [MEDICATION NAME] and kerlix (gauze wrap) dressing daily and as needed. Left heel, unstageable. Measurements: 5.5cm(centimeters)x6cm(centimeters)xUTD (unable to determine). Wound appears 100 percent eschar(dead tissue). Treated with [MEDICATION NAME] and kerlix and off loading of foot. Left toes, DTI/arterial. Measurements: 7cm(centimeters)x10cm(centimeters), (circumference of toes) xUTD (unable to determine. Wound appears 100 percent eschar(dead tissue). C. Failure to take steps to prevent the development of the resident's LLE unstageable, necrotic pressure injuries. Record review and interviews revealed the facility responded to Resident #1's pressure injuries above beginning on 7/13/2020, with a physical therapy evaluation, orders for a soft boot, protein supplement, wound consultants, wound rounds, and revised treatments. However, the facility failed to take steps to prevent the development of the unstageable, necrotic pressure injuries despite knowledge that the doughnut-type device was inappropriate and belief the device contributed to the resident's pressure injuries. Specifically: Record review and interview revealed the facility was aware the resident was using a doughnut-type device prior to the development of his pressure injuries and considered its use inappropriate. See Kardex (created 10/2018 and current as of 8/17/2020) above, which read, off load/float heels while in bed with doughnut ring provided by family. See care plan (created 2/17/2019 and revised 7/13/2020) above which read, family providing positioning devices that the facility does not recommend. Interventions included in part, off load/float heels while in bed with the doughnut ring provided by the family. Interview revealed the facility believed the doughnut-type device contributed to the resident's pressure injuries. -The DOT, interviewed on 8/20/2020 at 2:05 p.m. and 2:20 p.m., said that depending on how the cervical collar pillow was being placed/positioned on the resident's LLE/ankle, if placed inappropriately, it could cause pressure on the ankle. He said if staff were placing the pillow around the ankle and then securing the Velcro, the ankle would sit on top of the cushion and the heel would dangle in the middle, touching the mattress. -The nursing home administrator (NHA), interviewed on 8/17/ :40 p.m., said the resident's calf wound was caused by the positioning device (doughnut pillow) that the family had brought in and insisted the facility use. She said the left heel wound was due to the way the cushion was positioned under the resident's left ankle and the heel dropped through the hole in the middle causing the left heel to rub against the sheet. Yet, the facility failed to take steps to minimize the risk the doughnut-type device posed for pressure injury development. Specifically: 1. Although use of the device was mentioned on the Kardex and care plan, there was no evidence the device had been evaluated by therapy until 7/15/2020, after the resident's pressure injuries developed. -Record review revealed an order for [REDACTED]. And a PT clarification : Evaluation only, pressure relief interventions updated and revised 7/15/2020. -A PT evaluation dated 7/15/2020 documented the resident was referred due to impaired skin integrity to the left posterior distal calf/ankle DTI. The outcome of the evaluation was the resident had a heel pressure device in place and it was replaced with the resident's prior soft boot. 2. Although the use of the doughnut-type device was mentioned on the Kardex and care plan, neither the Kardex nor the care planned instructed staff how to properly place the device under the resident's left lower extremity. Staff interviews revealed none had received training on how to properly place the doughnut-type device. The DOT, in his interview on 8/20/2020 at 2:05 p.m., said he did not know if staff were educated on the proper placement of the cervical collar pillow. CNA #1, interviewed on 8/20/2020 at 1:58 p.m., said the resident did not have wounds on his left leg up until a month ago or so and now all of a sudden he did and they were pretty bad. She said she usually elevates the resident's feet with regular pillows. She said she had not received any training on how to use any positioning device for Resident #1. Licensed practical nurse (LPN) #1, interviewed on 8/20/2020 at 4:10 p.m., said the resident did not have any leg wounds until a month ago. She said the family wanted them to use the doughnut pillow they brought in about six months ago for the left leg. She said the resident did not like the boot that therapy provided. She said she believed it was the pillow that caused the wound due to not being placed around the leg properly. She said she did not receive any training on how to place the pillow properly on his LLE. UM #1, interviewed on 8/20/2020 at 5:00 p.m., said the family brought the doughnut pillow in a while back, maybe longer than a year ago. She said the family wanted the pillow used instead of the one we recommended. She said she did not receive any training on how to use the personal pillow properly. CNA #8, interviewed on 8/20/2020 at 5:00 p.m., she said that she had been taking care of Resident #1 for the past couple of months. She said she usually props resident's feet up on several pillows to help avoid pressure. She said she had used the pillow provided by the family on the LLE but did not receive any instructions on how to properly place it. The DON, interviewed a second time on 8/20/2020 at 5:15 p.m., she said they were using the doughnut pillow per the family's request. She said she did not know how long the pillow was in use and did not know if staff had been instructed on how to properly place the pillow. She said she would look for documentation on both issues. The wound nurse (WN), interviewed on 8/24/2020 at 5:00 p.m., said the resident did not have any unhealed wounds to the LLE until she was notified to look at the newly acquired wounds. She said when she first saw the wound behind the ankle/calf area it was purple and the skin was intact. She said she did not know if the facility had care planned the use of the pillow before using it. She said the resident DTI was caused by the improper use and application of the doughnut pillow, stating one of the CNAs placing the device provided by the family incorrectly. The shape of the DTI wound on the back of the ankle/calf area was the shape of the doughnut pillow, round. She said the wound kept getting worse and unfortunately was not going to heal due to his already compromised state. She said she did not personally provide any education to the staff about the use of the doughnut pillow. 3. There was no documentation to show the resident and/or family had been educated regarding the use of a non-formulary positioning device and the risks versus benefits of its use. The DON, in an interview on 8/17/2020 at 4:50 p.m. and in another interview on 8/20/20 at 5:15 p.m. said the facility had recommended a soft protective boot for Resident #1 and his heels were always elevated. She said the family had brought a pillow from home and wanted it used instead of the boot for offloading his LLE. She said staff had tried to educate the family about using the soft boot instead of the one

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) they brought from home. She further said they had tried educating the family many times but did not know if there was any documentation to support that. The NHA, interviewed on 8/17/2020 at 4:50 p.m. with the DON said Resident #1's family insisted the facility use the doughnut pillow (see above). She said the facility documented in the resident's record the risk of using the cervical collar pillow and the wound nurse had spoken to the spouse about the risks. The WN, interviewed on 8/24 at 5:00 p.m., confirmed she talked to the family to let them know the pillow could cause issues and recommended that a facility soft boot be used. However, there was no documentation in Resident #1's record to show the resident or his family was thoroughly educated on the use of the doughnut-type pillow and the risk for harm versus benefits of its use. (See care plan above) D. Physician interviews The primary care physician (PCP) for the resident, interviewed on 8/25/2020 at 2:29 p.m., said that it had been difficult to get in to see the resident due to the COVID-19 restrictions. He said there was a care conference held with the hospice team, the family and the facility representatives. He said they discussed many concerns including the wounds caused by pressure. He said the resident had very serious vascular disease (circulation) and had a dry gangrene on his left toes due to poor circulation. He said the resident had underlying ischemia (insufficient blood flow) which predisposed him to skin breakdown. He said he was not aware the resident had been using a non-formulary positioning device. The wound doctor (WD), interviewed on 8/27/2020 at 1:49 p.m., said the resident had sustained a DTI from pressure. He said wounds could be caused by immobility, lack of sensation or improper placement of a positioning device. He said he did not remember what type of a device was used to elevate the resident's LLE. He said that doughnut cushions are not good to use for elevating an extremity because it puts pressure on one area and did not spread the pressure out evenly. He said if a resident had predisposing complications, proper care and interventions should be put into place; otherwise, if things are not being done correctly, problems could arise and then become worse. He said the resident's wounds started out as DTIs and then worsened. He said he had not seen the resident in about two weeks and did not know the status of the wounds at this time.
F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to ensure one (#1) of three residents reviewed for nutrition out of three sample residents received the necessary care and services to maintain acceptable parameters of nutritional status. Specifically, the facility failed to ensure: -A formal nutritional assessment was completed following a significant weight loss for Resident #1; -Monitoring of nutritional interventions and intakes was adequate and completed; and, -Additional measures and interventions were considered and put into place to ensure adequate meal intake and prevent further weight loss. The facility failures contributed to the resident experiencing a significant weight loss. Findings include: I. Facility policy The director of nursing (DON) provided the facility's Nutrition/Hydration Management policy, revised 1/31/2020, on 8/25/2020 at 12:35 p.m. The policy documented in part, The implementation of an individual patient's nutrition/hydration management occurs within the care delivery process. Staff will consistently observe and monitor patients for changes and implement revisions to the plan of care as needed. The purpose was to provide safe and effective care to manage patients ' nutrition and hydration needs. -Address any changes in condition that affect or potentially affect the patient's nutritional status with Dietician when indicated; -Observe oral intake of meals, supplements and snacks and complete the meal monitor data collection sheet when ordered or indicated; -Monitor patient's weight as ordered; -Review Dietitian's progress notes to identify ongoing progress and recommendations; -Revise patient's care plan as needed; -Document: percentage of food/fluid intake, administration of oral supplements, enteral feedings, or total [MEDICATION NAME] feedings; -Intake and output as ordered/indicated. II. Resident #1 Resident #1, age greater than 65, admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. (Cross-reference F686) On 8/17/2020 at 1:00 p.m., a family member stated she had recently visited the resident. She said it had been awhile since she had seen Resident #1 and he looked much thinner and weak since the last time. She was concerned staff were not assisting him to eat. On 8/20/2020 at 1:15 p.m. the resident was lying in bed and slightly turned to his right side facing the over the bed table. He was trying to reposition his upper body using the bed cane. The resident appeared thin and frail. The cheeks of his face were sunken in. His upper body and arms appeared thin and bony. He had an opened bottle of water on his bedside table. He said he did not like the facility food brought to him. He said he had not had much of an appetite lately and missed his family coming in to see him. A. Resident status The minimum data set (MDS) assessment dated [DATE] revealed the resident had moderate cognitive impairment with a brief interview of mental status (BIMS) of ten out of 15. He required extensive assistance with eating of one person. His height was 64 inches and weight of 163 pounds and had no or unknown weight loss or gain during the review period. He was not assessed to have a swallowing disorder. A care plan initiated 11/8/18 with a target date of 9/20/2020 identified the resident required assistance at times for eating related to paralysis/weakness affecting the left upper extremity. (LUE). Interventions included to provide set-up, supervision assistance for utilizing suitable utensils needed for eating. A care plan initiated 12/17/19 and revised on 1/9/2020 revealed the resident had a strong preference for Hispanic foods, often did not eat facility meals but would eat food brought in by family members. The goal was the resident would have intake of food and fluids as desired for comfort and pleasure x90 days. Interventions included to warm up food provided by family as needed, honor food preferences within meal plan, weight per facility protocol and monitor for changes in nutritional status (changes in intake, ability to feed self, unplanned weight loss/gain, abnormal labs) and report to food and nutrition to physician as indicated. A nutritional assessment dated [DATE] documented there were no concerns identified. The resident's weight was 165 pounds on 3/5/2020. His BMI (Body Mass Index) was 28.3. He was on a regular liberalized diet and had a strong preference for Mexican food. He was considered overweight by BMI standards, however; appropriate for age. He had selective food preferences and primarily liked sweets, baked goods and Mexican foods. He had generally poor intake of facility foods. The family typically brought in food and supplements, however; they were currently unable to visit. The note further read that the importance of eating facility foods was discussed with the resident. His average intake was 60 percent and breakfast was usually his best. The resident was not assessed to have a significant weight loss or gain. The summary documented the resident remained on Hospice services with the goal of nutrition being comfort oriented while attempting to minimize preventable weight loss and skin breakdown as able. As needed interventions included fortified pudding twice a day with meals, fortified oatmeal, two bowls with banana and use of a scoop plate with meals and assistance with meals. A nutritional assessment dated [DATE] also documented in pertinent part there were no concerns identified. The resident's weight was 162.6 on 6/3/2020 and his BMI was 27.9. He remained on the same regular, liberalized diet. The resident ate in his room per infection control protocol and needed set up assistance at minimum and additional assistance as needed. He received a scoop plate to encourage independent eating. He continued to exhibit poor intake of facility foods and did well with the fortified oatmeal at breakfast. The family had provided food and snacks that were kept in the resident's room. Under the section entitled skin integrity, the resident did not have any skin injuries per skin check of 6/3/2020. The RD attempted to contact the resident's power of attorney (POA) and left a voicemail. (There was no further documentation the RD attempted to follow up with the POA.) The plan was to continue current interventions (see above). B. Record review revealed weight loss in July 2020, followed by further, significant weight loss in August 2020, as well as poor intake. 1. The weight record over the last six months revealed the following: 3/5/2020 -165.0 pounds 5/3/2020 - 163.8 pounds 7/2/2020 - 155.8 pounds 8/6/2020- 140.8 pounds The weight record revealed a 14.67 percent weight loss from 3/5/2020 to 8/6/2020; a 14.05 percent weight loss from 5/3/2020 to 8/6/2020; and a 9.40 percent weight loss from 7/2/2020 to 8/6/2020. 2. Intake A 30-day (7/27/2020 to 8/25/2020) look-back record of the resident's daily meal intakes revealed he consumed between 25 to 50 percent. There were 20 days out of 30 with only two meals recorded for the day and two out of 30 days where only one meal was recorded for the day. There was zero percent consumed recorded on: 7/31/2020 (breakfast, lunch, dinner); 8/3/2020 (breakfast, lunch dinner); 8/15/2020 (breakfast and dinner); 8/16/2020 (breakfast and dinner); 8/17/2020 (breakfast, lunch, dinner); 8/19/2020 (breakfast, lunch, dinner); 8/20/2020 (breakfast, lunch, dinner); 8/22/2020 (breakfast, lunch, dinner). Five refusals were recorded on 7/27/2020 (lunch), 8/11/2020 (breakfast), 8/12/2020 (breakfast), 8/15/2020 (lunch) and 8/16/2020 (lunch). C. Facility response to Resident #1's poor intake, weight loss 7/2/2020 and significant weight loss 8/6/2020 - failures in facility response. 1. Facility response A 7/14/2020 nutrition note documented the resident had wounds and a protein supplement was recommended to promote wound healing (Proheal 30 milliliters every day).Other interventions included cheddar omelet and fortified oatmeal at breakfast, fortified pudding at lunch and dinner and food and supplements brought in by family. A care plan meeting note dated 7/29/2020 documented the resident's diet was reviewed and noted that he refused facility foods and Ensure supplement was provided. The daughter requested that someone assist him with meals to ensure he was eating properly. The resident's Kardex (a flow sheet to direct resident care) created 10/18 and current as of 8/17/2020, similar to the resident's care

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F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) plan, read to encourage resident to consume all fluids of choice during meals, please warm up food provided by family for resident as needed, provide fortified foods per RD (registered dietitian) recommendations, provide Mexican foods within facility's ability as resident requests and provide set-up assist at meals, additional assistance as needed. A progress note by the nurse practitioner, dated 8/3/2020, documented the resident was seen for a change of condition related to left foot necrosis. The note revealed the resident had abnormal weight loss, appeared chronically ill, his cheeks were sunken and he had temporal wasting. In addition, the note revealed the resident appeared to have lost more weight with more temporal wasting. There were no recommendations made during the visit to address the additional weight loss. A nutrition note dated 8/19/2020 documented the RD recommended increasing supplement to three times a day due to weight loss and the 8/2020 CPO documented the following order in pertinent part: -Regular, liberalized diet, regular texture. Start date 11/4/19. -Protein liquid 30ml (milliliters) two times a day. Start date 7/29/2020 -Ensure three times a day. Start date 8/18/2020 -Multi Vitamin/Minerals. Start date 7/29/2020 -[MEDICATION NAME] (appetite stimulant) 7.5mg (milligrams). Start date 7/23/2020. Finally, progress notes reviewed for the past 45 days revealed staff encouraged the resident to eat and offered supplemental shakes with little to no success. 2. Failures in facility response Record review revealed no evidence found in the clinical record the RD calculated Resident #1's caloric (Kcal), fluids or protein needs to sustain and maintain optimal nutritional health and wound healing based on his age, height, weight and medical condition following his significant weight loss 8/6/2020. (Cross-reference F686; the resident currently has an acquired, unstageable, necrotic wound to his left lower extremity.) Record review revealed a new MDS assessment was not completed following the resident's significant weight loss of 15 pounds in one month. Record review revealed there were no additional interventions implemented or care planned when the significant weight loss was identified. Record review of the 7/14/20 nutrition note (see above) documented the family was bringing food and supplements but the note did not specify how often to offer the food items or the supplements to the resident or how this should be monitored. Moreover, the DON, interviewed on 8/24 at 6:20 p.m., was asked to provide any documentation to show that the monitoring was occurring. The DON did not provide any additional documentation. Record review of intake records revealed no documentation the facility reapproached the resident to offer nourishment when he refused his meals or had zero intake (see above) . Finally, while review of progress notes for the past 45 days revealed staff encouraged the resident to eat and offered supplemental shakes with little to no success, there was no documentation found staff attempted additional interventions such as calling the family to discuss other suggestions or to talk to the resident to encourage him to eat. D. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 8/20/2020 at 1:55 p.m. She said she had been taking care of the resident for the past three months. She said he was declining and had lost weight. She said he often refuses to eat. She said his family would send in Mexican food and he really liked tamales; however, he was not always eating the food the family brought in. She said she offered to feed him but he wanted to do it himself. The director of nursing (DON) was interviewed on 8/24/2020 at 6:20 p.m. She said the interdisciplinary team (IDT) had at risk meetings on Tuesdays and weight loss was addressed. She said the RD was involved in the meetings and gave updates and input. If there was a significant change in weight then a change of condition was documented. She said the family had been bringing food for the resident that he liked and the daughter would call to check and see if he received the food. She said that nursing was told to document in the clinical record when food from the family was offered. She said they had a designated IDT person assigned to check in with the resident to encourage him to eat. The RD was interviewed on 8/25/2020 at 10:50 a.m. He said he had started working at the facility in June 2020. -He said he completed a nutritional assessment on residents quarterly with the MDS schedule. He said if a resident triggered for weight loss, he would take a look at them. He said if a resident has a weight loss, they try to provide items that the residents prefer to prevent any further weight loss. He said nursing was responsible for updating the physician regarding weight loss issues. He said if the nurse practitioner was in the building he would speak to them. He said the IDT met every morning and they would discuss any residents that had nutritional concerns and they also have at risk meetings. He said they discuss as a team what would be beneficial to the resident. He said he was responsible for updating the nutrition care plan. He said if there was weight loss identified with a resident, he would try and follow up with a note, otherwise, he would capture it in the next quarterly MDS assessment. He said he tried to provide oversight to residents with weight loss concerns to observe at least one meal, however; he could not make it to every resident. He said he reviewed meal intake records and talked with staff regarding concerns. -He said Resident #1 did have a significant weight loss and they offer him the food the family brings in and offer liquid supplements. He said the resident did not like the facility food but seemed to do well with breakfast items such as oatmeal. He said he tried calling the resident's wife and left a message but did not hear back from her. He said he did not attempt to reach back out to her. -He said that collaboration with hospice was done through care conferences. He said that when a resident was on hospice care it was about comfort and that food and fluids were provided for comfort and for pleasure. He said Resident #1 also recently started on an appetite stimulant. He said the family used to come in frequently before the COVID-19 pandemic visitor restrictions were put into place. He said the impact of this, having wounds (cross-reference F686) and not having his family around, could potentially be a factor in his significant weight loss. The primary care physician (PCP) was interviewed on 8/25/2020 at 2:30 p.m. He said the resident was thin with poor intake. He said that his [DIAGNOSES REDACTED]. He said the impact of not being able to see his family on a regular basis may also be a contributing factor to his weight loss.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of Coronavirus (COVID-19) and infection for two of four units. Specifically the facility failed to follow Centers for Disease Prevention and Control (CDC) recommendations to: -Ensure residents were offered opportunity to perform hand hygiene before eating meals; -Ensure residents were encouraged and reminded to wear masks when out of their rooms; and, -Ensure staff were wearing personal protective equipment properly. I. Findings include: A. Facility policy and procedures The COVID-19, Infection Control Policies and Procedures, revised 6/3/2020, was provided by the director of nursing (DON) on 8/18/2020 at 11:00 a.m., it read in pertinent part: In addition to standard precautions, contact and airborne precautions will be implemented for patients suspected or confirmed to have COVID-19 based on the CDC guidance. - Implement universal use of facemasks/respirator and eye protection while in the Center. - Staff will perform hand hygiene per CDC guidelines and assist patients to complete hand hygiene, as needed. -Patients must wear a facemask when exiting their rooms. -Patients who cannot tolerate a cloth/ facemask will be instructed to cover their mouth and nose with a tissue. The Contact Precautions, Infection Control Policies and Procedures, revised 6/15/19, was provided by the DON on 8/18/2020 at 11:00 a.m., it read in pertinent part: Staff must use barrier precautions when entering the room. Wear a gown and gloves. Wear eye protection if splashing of infectious material is likely. -Before exiting room, remove and bag gown and gloves and wash hands upon exiting room. The Droplet Precautions and Respiratory Hygiene/Cough Etiquette, Infection Control Policies and Procedures, revised 6/15/19, was provided by the DON on 8/18/2020 at 11:00 a.m., it read in pertinent part: Before exiting room, remove and bag PPE and wash hands. The facility did not have a policy on resident hand hygiene. B. Professional standard According to CDC guidance, Responding to Coronavirus (COVID-19) in Nursing Homes Considerations for the Public Health Response to COVID-19 in Nursing Homes, updated 4/30/2020; retrieved 8/28/2020 from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. -All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and gown. According to CDC guidance, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 7/15/2020; retrieved 8/28/2020 from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html When caring for a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection: Personnel entering the room should use PPE as described. -Respirator or facemask: Put on an N95 respirator (or equivalent or higher-level respirator) or facemask (if a respirator is not available) before entry into the patient room or care area. -Eye protection: Put on eye protection upon entry to the patient room or care area. -Gloves: Put on clean, non-sterile gloves upon entry into the patient room or care area. -Gowns: Put on a clean isolation gown upon entry into the patient room or area. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. According to CDC guidance, How to Protect Yourself and Others, updated 7/31/2020; retrieved 8/28/ from: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html Everyone should wash your hands often,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065147	A. BUILDING _____ B. WING _____	08/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHEYENNE MOUNTAIN CENTER	835 TENDERFOOT HILL RD COLORADO SPRINGS, CO 80906

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) especially after you have been in a public place, or after blowing your nose, coughing, or sneezing. It is especially important to wash: Before eating or preparing food. Before touching your face. After using the restroom. After leaving a public place. After blowing your nose, coughing, or sneezing. After handling your mask. According to the CDC guidance, Hand Hygiene in Healthcare Settings for Patients, last reviewed 3/15/16, retrieved 8/28/2020 from https://www.cdc.gov/handhygiene/patients/index.html Clean Hands Count for Patients. Patients should clean their hands: Before preparing or eating food According to CDC guidance, Considerations for Memory Care Units in Long-term Care Facilities, updated May 12, 2020, retrieved 8/28/2020 from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html Routines are very important for residents with dementia. Try to keep their environment and routines as consistent as possible while still reminding and assisting with frequent hand hygiene. According to CDC guidance, Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, updated 5/7/2020, retrieved 8/28/2020 from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their room. C. Observations On 8/20/2020 at 12:04 p.m., lunch service was observed on the Cheyenne unit. Several certified nurse aides (CNA) delivered room trays to each of the residents on the unit. - CNA #7 was observed delivering room trays to both residents in room [ROOM NUMBER], one resident in room [ROOM NUMBER], and one resident in room [ROOM NUMBER]. CNA #7 did not offer, remind, encourage or assist any of the residents a method of performing hand hygiene before they ate their meal. -CNA #2 was observed delivering room trays to a resident in room [ROOM NUMBER] and then to a resident in room [ROOM NUMBER] CNA #2 did not offer, remind, encourage or assist either of the residents a method of performing hand hygiene before they ate their meal. -CNA #4 was observed delivering room trays to a resident in room [ROOM NUMBER] and then to a resident in room [ROOM NUMBER]. CNA #4 did not offer, remind, encourage or assist either of the residents a method of performing hand hygiene before they ate their meal. On 8/20/2020 at 12:26 p.m., a male resident in room [ROOM NUMBER] was observed eating finger foods. This was the same resident who CNA #2 had delivered a room tray, and had not been offered a method of hand hygiene prior to starting to eat his meal. On 8/20/2020 at 1:30 p.m., licensed practical nurse (LPN) #1 was observed wearing her mask positioned under her chin, exposing her mouth and nose. There were a couple of residents and CNAs in the hall as she passed. None of the staff said anything to her about the way she was wearing her mask. On 8/20/2020 at 1:48 p.m., CNA #10, an agency staff sitter, was observed in the hallway wearing a facemask positioned below her nose and no eye protection. CNA #10 said she had been trained by her agency and followed the protocols of the facility. She said she was informed by the facility that staff were required to wear goggles and a mask covering their nose and mouth while in care areas in the facility. On 8/20/2020 at 4:00 p.m., LPN #1 was observed sitting at the nurse's station with her mask positioned below her nose. On 8/20/2020 at 5:02 p.m., dinner service was observed on the Columbine unit. Several CNAs delivered room trays to residents on the unit. -CNA # 6 was observed delivering a room tray to a resident in room [ROOM NUMBER]. CNA #6 did not offer, remind, encourage or assist the resident a method of performing hand hygiene before the resident started eating the meal. -CNA #3 was observed delivering room trays to residents in room [ROOM NUMBER] and room [ROOM NUMBER]. CNA #3 did not offer, remind, encourage or assist either of the residents a method of performing hand hygiene before they ate their meal. -CNA #5 was observed delivering room trays to residents in room [ROOM NUMBER] and room [ROOM NUMBER]. CNA #5 did not offer, remind, encourage or assist either of the residents a method of performing hand hygiene before they ate their meal. -CNA #12 was observed delivering drinks to residents on the Columbine unit in halls 500, 700, and 1200. CNA #12 did not offer, remind, encourage or assist any of the residents a method of performing hand hygiene as she went from room to room delivering drinks for the diner meal. CNA #12 was interviewed on 8/20/20 at 5:15 p.m. CNA #12 said she was assigned to serve the resident drinks and the staff delivering the room trays would help the residents perform hand hygiene if they needed assistance. On 8/20/2020 at 5:50 p.m. LPN #1 was observed wearing her mask positioned below her nose. The LPNs whole nose was exposed. LPN #1 was at the medication cart talking with two male residents who were not wearing any type of mask or facial covering. One male resident had been seated directly beside the medication cart in a dining room type chair and the other resident approached in his wheelchair. LPN #3 made no attempts to adjust her mask as she talked with the two residents nor did she offer or encourage either resident to put on a mask or facial covering. On 8/20/2020 at 5:55 p.m., CNA #5 was observed picking up a room tray from room [ROOM NUMBER]. The resident in that room was on droplet and contact precautions. CNA #5 put on full PPE and entered the room. The CNA exited the room without removing any PPE and without performing any hand hygiene. The CNAs mask was positioned below his nose, exposing his full nose while providing care. When he was done assisting the resident he exited the room still wearing his used gloves and gown. He walked with the resident's meal tray down the hall to place it on the tray cart. The CNA returned to the resident's room standing in the doorway to remove his gloves and gown. He struggled to remove his gown and dropped his face protection glasses on the floor. After removing his gown he picked up the safety glasses and went back inside of the resident's room without putting on any PPE, to wash his hands and glasses in the residents sink. He exited the room with his safety glasses on but he had not adjusted his mask so that it covered his mouth and nose fully. CNA #5 was interviewed on 8/20/2020 at 6:01 p.m. CNA #5 said he was trying to find another staff person to hand the room tray to but was unable to find someone, so he had to take the tray out on his own. CNA #5 said staff are trained to remove their PPE including gloves, and gown and wash hands after completing resident care before exiting the resident's room. He said he was not trained that he had to wear an N95 mask when care for residents under observation and on droplet precautions. He said the reason he went back into the resident room after removing his PPE was to wash his hands, sometimes we can contaminate our hand when removing the gown and other PPE. He said there was antibacterial hand rub just inside the door and in the hall but believed that washing with soap and water was better. Facility training records were reviewed on 8/20/2020, CNA#5 participated in regular training for hand hygiene and proper use of PPE to prevent the spread of infection. D. Additional staff interviews The DON was interviewed on 8/24/2020 and 6:21 p.m. The DON said they were focusing hand hygiene efforts mainly on the secured unit ensuring residents received frequent assistance with hand hygiene but it was expected that staff would assist and offer hand hygiene reminders to all residents so they could perform hand hygiene before and after meals. She was aware that a couple of facility staff were not in compliance with wearing their masks and they were wearing the mask positioned below their noses. The facility had been working with staff to gain compliance with proper mask use. She said they continued to work on the issue. The recent changes in CDC guidance prompted the facility to purchase 200 goggles. The goggles were distributed to staff and they have extras; staff were expected to wear goggles along with their masks, continuously, when working in the facility. E. Status of COVID-19 in the facility The NHA was interviewed on 8/17/2020 at 1:45 p.m. The DON said the resident census was 133 and there were no COVID-19 positive residents in the facility. She said residents were placed on isolation precautions for 14 days when newly admitted and if they were readmitted from the hospital or, went out of the facility for a medical appointment. Quarantine designated unit with eight reside new or readmit on observation for 14 day.