STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065052	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulder Post Acute	2121 Mesa Dr Boulder, CO 80304

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 0684 Level of Harm - Minimal harm or potential for 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** 41172 Based on observations, record review and interviews, the facility failed to ensure one (#3) of three residents received treatment and care in accordance with professional standards of practice out of 15 sample residents. Specifically, the facility failed to: -Investigate, treat, and implement interventions to prevent wounds to the resident's knees; and, -Complete routine weekly skin assessments. Findings include: I. Facility policy and procedure The policies for skin management and accidents and injuries were requested from the director of nursing (DON) on 5/21/24 at 12:00 p.m. and were not received by the end of the survey (on 5/21/24). II. Resident #3 A. Resident status Resident #3, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included Huntington's disease (progressive breakdown of nerve cells in the brain leading to inability to control movement and cognitive changes), anxiety and a history of falls. The 2/14/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. He was dependent on staff for personal hygiene, toileting and dressing. He required moderate to partial assistance with transferring and bed mobility. B. Observation and interview (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/24 at 11:13 a.m. Resident #3 was observed with certified nurse aide (CNA) #2. Resident #3 was sitting in his recliner. CNA #2 said the resident had a history of falls and she was concerned about his knees. She said he slid out of his recliner continuously and got up to walk without assistance frequently. CNA #2 rolled up the resident's sweat pants to reveal Resident #3's knees. The resident's right knee had a redness discoloration with three round scabbed areas approximately 1 cm (centimeter) in size around the knee cap. The outer right knee had a new appearing abraded area which was red and approximately 2 cm in size. The resident's left anterior knee had three scattered, round scabbed areas approximately 1 cm in size. CNA #2 said she had seen the resident bang his legs on the dining room table. She said she did not know what the plan was to prevent the skin injuries. CNA #2 went to her computer to check the kardex for a plan to prevent injuries to the resident's knees. She said there was no plan to prevent the injuries. CNA #2 said the nurse was aware of the injuries. Unit manager (UM) #1 was interviewed on 5/20/24 at 11:30 a.m. UM #1 said she was aware of the injuries on Resident #3's knees. She said she was unsure how the injuries occurred. She said the resident could be impulsive with uncontrolled movements. C. Record review Resident #3's skin assessments were reviewed for May 2024. -The 5/9/24 skin assessment was incomplete and did not document whether the skin was intact or there were injuries. -There was no skin assessment for the week of 5/16/24. -The resident's progress notes and evaluations were reviewed. There was no record of the skin injuries to the resident's knees. -There was no documentation to indicate the physician, resident, or medical durable power of attorney (MDPOA) were notified of the injuries to the resident's knees. The skin care plan, initiated 8/19/20, was reviewed. The care plan documented the resident was at risk of pressure injuries and abrasions and bruising due to uncontrolled movement and poor safety awareness. Interventions included educating the resident, family and caregivers as to causes of skin breakdown including transfers, positioning requirements, importance of taking care during ambulation and mobility, good nutrition and frequent repositioning,iInforming the resident, family, caregivers of any new area of skin breakdown, providing a pressure relieving mattress, monitoring nutritional status, monitoring and documenting any changes to the skin status, Obtaining laboratory or diagnostic work as ordered and performing weekly skin checks by a licensed nurse. -However, the change in the resident's skin status was not documented, the resident, family and provider were not notified of the injuries and the weekly skin assessments were not completed as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. DON interview The DON was interviewed on 5/20/24 at 12:01 p.m. The DON said Resident #3 was impulsive and she was aware of his knee injuries. She said the resident was supposed to wear knee pads to prevent injuries to his knees but he refused the knee pads. -However, The DON said she had reviewed the resident's progress notes and there was no documentation knee pads had been offered and refused. The DON said the nurses should have completed a risk management form and notified the provider and family of the skin injuries to the resident's knees. She said she was not aware that had not been completed. The DON said she had reviewed Resident #3's orders and care plan and there were no orders and no care plan for the knee pads. The DON said there was no skin assessment done for the week of 5/16/24. She said she thought the problem was with the electronic medical record system. She said she had audited the skin assessments today (5/20/24), when it was brought to her attention, and there were four residents who had missed skin assessments. IV. Facility follow up On 5/21/24 at 11:44 a.m. the DON provided a performance improvement plan (PIP) titled Nursing Weekly Skin Summaries, dated 5/21/24 (during the survey). The PIP documented education was to be completed for all nursing staff by 5/24/24. Nursing management was to audit 5 (five) times per week for 30 days and would review in upcoming QAPI (Quality Assurance Performance improvement) meetings. After 30 days, nursing management would review weekly and continue to report findings in QAPI until substantial compliance had been met. Skin assessments would be done every week on each resident by a licensed nurse in the facility. Education would be provided to nursing staff to put any injury/scab into risk management and the content of skin assessment. Daily monitoring orders would be put in the treatment administration record (TAR) until healed. The DON and the unit managers would meet with all nursing staff to provide education regarding the weekly skin summaries and the nursing teams obligation to complete them when they were scheduled. Nursing managers were to have a list of residents and when the residents' skin assessments were due. Nursing management was to audit the skin assessments everyday before the end of their shift to ensure that they had been completed. After 30 days, an audit would be conducted weekly until compliance had been met. The facility would continue to discuss the findings in QAPI meetings. -The PIP did not address investigating the cause of skin injuries.