STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065191	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heights Post Acute, The	3131 S Federal Blvd Denver, CO 80236

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** 50853 Based on observations, record review and interviews, the facility failed to provide the necessary treatment and services to prevent pressure injuries from occurring and worsening for one (#9) of three residents out of 14 sample residents. Resident #9 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease and type II diabetes mellitus with diabetic chronic kidney disease. On 2/29/24, Resident #9 was identified to have developed a stage 3 pressure ulcer to his left heel. Record review and interviews revealed the facility failed to identify the skin breakdown on the comprehensive care plan and identify and implement person-centered interventions to prevent the worsening of the pressure injury to the left heel. Additionally, the facility failed to implement interventions ordered by the wound care physician (WCP). Due to the facility's failures to implement interventions recommended by the WCP, Resident #9's stage 3 pressure wound to the left heel worsened. Findings include: I. Professional reference According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA: 2019, retrieved from https://www.internationalguideline.com/guideline on 5/16/24, Pressure ulcer classification is as follows: Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage) Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk). (continued on next page)

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.

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Category/Stage 2: Partial Thickness Skin Loss Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Category/Stage 3: Full Thickness Skin Loss Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/ Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable. Category/Stage 4: Full Thickness Tissue Loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage 4 ulcers can extend into muscle and/ or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed. Suspected Deep Tissue Injury: Depth Unknown Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	For individuals with a Category/Stage III or greater heel pressure injury, elevate the heels using a device specifically designed for heel suspension, offloading the heel completely in such a way as to distribute the weight of the leg along the calf without placing pressure on the Achilles tendon and the popliteal vein. Once a pressure injury develops, pressure relief on the heel is needed to promote perfusion and healing. Pressure on Category/Stage III, IV, and unstageable heel pressure injuries and deep tissue pressure injuries of the heel should be completely offloaded as much as possible. II. Facility policy and procedure The Prevention of Pressure Ulcers policy and procedure, dated 2001, was provided by the director of nursing (DON) on 5/16/24 at 11:54 am. It read in pertinent part, The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Review the interventions and strategies for effectiveness on an ongoing basis. III. Resident #9 A. Resident status Resident #9, age 77, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included alcohol dependence with alcohol-induced persisting dementia, chronic obstructive pulmonary disease (COPD) and type II diabetes mellitus with diabetic chronic kidney disease. The 4/1/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. He was independent with transfers, walking and bed mobility. The assessment indicated the resident was at risk for developing pressure ulcers and had actual skin breakdown of one stage three pressure ulcer not present upon admission. The assessment indicated the resident did not refuse care within the review period. B. Observations On 5/13/24 at 1:26 p.m., Resident #9 was laying in bed on his back. He had non-skid socks on his feet. His heels were not floated. The resident's left heel was observed lying directly on the mattress. At 2:24 p.m., the resident continued laying in bed on his back and was covered with a blanket. He asked if his food was ready and said he was going to get up because he was hungry. He kicked off the blanket revealing his feet were directly on the mattress. His heels were not floated or off loaded. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	At 3:40 p.m. Resident #9 was sitting in the dining room at a table. He said he was waiting for his plate. His heels were observed directly touching the floor. He was wearing non-skid socks and his feet were not elevated or off-loaded. At 4:33 p.m. the resident continued to sit in the dining room at the table. His heels were directly on the floor, not elevated. On 5/14/24 at 10:31 a.m. Resident #9 was lying in bed on his left side. His heels were lying directly on the mattress and were not being floated. At 11:30 a.m. the resident was sitting at a table in the dining room. The balls of his feet were resting on the legs of the table and his heels were pressed directly against the floor. He was wearing non-skid socks. -Resident #9 declined to allow his wound to be observed during the survey. C. Record review The skin integrity care plan, initiated on 4/18/14 and revised on 1/27/15, documented Resident #9 was at risk for skin breakdown related to incontinence of bowel and bladder and had a diagnosis of diabetes. It indicated Resident #9 refused full skin assessments at times. The interventions included administering medication for benign prostatic hyperplasia (BPH) as ordered and monitoring for side effects, administering vitamins as ordered, assisting or giving reminders to the resident for repositioning as needed, providing labs and x-rays as ordered and reporting the results to the physician, monitoring and recording weekly skin checks, monitoring the resident's skin for changes in integrity with routine care and offer fluids with medication pass, meals, activities and at bedside. -Resident #9's comprehensive care plan did not address the resident's actual skin breakdown nor did it provide person-centered interventions to prevent the development and worsening of pressure injuries. The weekly nursing summary, dated 2/26/24, revealed the resident's skin was intact. The resident did not have any open areas or wounds. The 2/29/24 e-interact change of condition communication form documented the resident had an open wound on the left heel. The February 2024 CPO revealed the following physician's order, dated 2/29/24, for wound care to the left heel: Clean with wound cleanser; apply Medihoney and foam dressing two times per day. The WCP's progress note, dated 3/6/24, documented Resident #9 developed a stage 3 pressure injury to the left heel. The wound measurements documented were 3.4 centimeter (cm) length by 3.5 cm width by 0.4 cm depth with 100% granulation. The physician recommended to offload the pressure injury, elevate the resident's legs and float his heels in bed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The facility failed to ensure these recommendations were transcribed into the resident's comprehensive care plan and made part of his plan of care. The WCP's progress note dated 3/13/24 indicated wound measurements of 3.0 cm length by 2.8 cm width by 0.3 cm depth with 100% granulation. The WCP's progress note dated 3/27/24 indicated that the stage 3 pressure ulcer to the resident's left heel had worsened. The wound measurements were 3.0 cm length by 3.2 cm width by 0.3 cm depth with 50% granulation, 30% slough and 20% eschar. The physician continued to recommend the resident's legs be elevated and to float his heels. -The facility continued to fail to ensure the interventions and recommendations made by the WCP were documented in the physician's orders or implemented on the resident's plan of care. The skin evaluation dated 4/3/24 indicated improvement in the wound with measurements of 2.2 cm length by 2.6 cm width by 0.1 cm depth and 100% granulation. The 4/24/24 WCP progress note documented that Resident #9's stage 3 pressure injury to the left heel had worsened. The wound measurements were 2.4 cm length by 2.8 cm width by 0.1 cm depth with 50% granulation, 30% slough and 20% eschar. The interventions recommended by the WCP documented that the resident's heels should be offloaded, elevate the resident's legs and float the resident's heels. The 5/1/24 WCP progress note documented that the stage 3 pressure ulcer to the left heel was stable. The wound measurements were 2.4 cm length by 2.5 cm width by 0.1 cm depth and 100% granulation. The WP continued to recommend offloading/floating of the heels and elevating the resident's legs. The WCP's treatment order, dated 5/10/24, read: Left heel: cleanse with wound cleanser; apply Medihoney (wound treatment) to the wound bed and cover with bordered gauze and Kerlix (gauze dressing) daily and as needed (PRN). -The facility failed to implement the WCP's consistent recommendations to prevent the worsening of Resident #9's stage 3 pressure injury to the left heel. D. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 5/14/24 at 1:55 p.m. CNA #1 said Resident #9 did not require a lot of assistance with personal care. She said she provided reminders to the resident when to come out of his room for meals. She said she did not know if Resident #9 had any pressure injuries. She said wound interventions should be documented in the electronic medical record (EMR). Licensed practical nurse (LPN) #1 was interviewed on 5/14/24 at 2:12 pm. LPN #1 said wound interventions should be documented on the treatment administration record (TAR). She said Resident #9 received treatment for the stage 3 pressure injury to his left heel daily. She said he had a foam dressing on the left heel to protect the wound. She said the resident was not compliant with floating his heels. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-However, the resident's medical record did not reveal any documentation that the resident refused or was non-compliant with the WCP recommendation and did not document the intervention to prevent the worsening of the wound. The DON was interviewed on 5/14/24 at 3:12 p.m. The DON said upon the identification of a new wound, a skin assessment and new treatment orders should be documented in the residents' medical record. She said the wound nurse would evaluate the wound and address the treatment orders if needed. The DON said the resident would be added to the WCP's caseload. The DON said the wound nurse was responsible to review the WCP's progress notes and document any new treatment orders in the resident's medical record. She said every wound should be addressed in the comprehensive care plan with person-centered interventions. She said the interventions should be documented on the kardex (tool utilized by staff to provide person-centered care) for the CNAs. The DON said Resident #9's stage 3 pressure wound to the left heel was not addressed in his comprehensive care plan prior to 5/13/24 and the recommendations from the provider to offload the wound, elevate feet and float heels were not documented in the interventions of his plan of care. The WCP was interviewed on 5/16/24 at 4:35 p.m. The WCP said the origin of the wound on Resident #9's left heel was from pressure. He said during his visits with Resident #9, he stressed to the resident and the nurse caring for him the importance of offloading the pressure on the left heel and elevating his feet. The WCP said the resident could be difficult to work with and some weeks did not allow him to examine his wound. The WCP said he recommended floating the heels on multiple occasions to prevent the worsening of the stage 3 pressure injury. He said he was disappointed that the interventions he had recommended multiple times were not in place. IV. Additional information The updated skin integrity care plan, (updated 5/13/24 at 6:00 p.m., during the survey) documented Resident #9 had a stage 3 pressure ulcer to his left heel and was at risk for further breakdown. The updated interventions (dated 5/13/24) included administering medications as ordered, administering treatments as ordered, nutritional or hydration interventions to manage the resident's skin problems and the WCP to follow. -The care plan interventions, updated 5/13/24, still did not include the treatments of offload wound, elevate feet and float heels, as ordered by the wound care physician.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on record review, observations and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (#8) of three out of 14 sample residents. Specifically, the facility failed to follow infection control practices while providing wound care to Resident #8. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2022), Elsevier, St. Louis Missouri, page 1265, retrieved on 5/23/24 Clean away from the wound. Never use the same piece of gauze to clean across an incision or wound twice. II. Resident #8 status Resident #8, age less than 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included multiple sclerosis (disease affecting the central nervous system), stage 4 pressure ulcer of right hip, stage 4 pressure ulcer of left buttock, stage 4 pressure ulcer of right buttock and chronic obstructive pulmonary disease (COPD). The 5/1/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He required total assistance with bed mobility and transfers. A. Record review According to the May 2024 CPOs, wound care orders were as follows: -Right buttock: cleanse with wound cleanser, apply Calcium Alginate Silver (wound dressing), cover with Island dressing (wound dressing) daily and as needed (PRN); -Right hip: cleanse with wound cleanser, apply Calcium Alginate with Silver, cover with Island dressing; and, -Left buttock: cleanse with wound cleanser, apply Calcium Alginate Silver, cover with Island dressing. B. Observations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 at 9:00 a.m the wound care nurse (WCN) entered the room of Resident #8 to perform treatments to the pressure injuries to the right hip and right buttocks. The WCN had the treatment supplies in a plastic bag upon entering the resident's room and donned (put on) a gown and gloves. The WCN removed the old dressings from both of the resident's wounds (right hip and right buttocks), threw them in the trash, removed her gloves, sanitized her hands and donned a clean pair of gloves. She cleaned the right hip wound with gauze and wound cleanser. Using the same gauze, the WCN folded the gauze in half and cleaned the wound to the right buttocks. She did not change gloves and sanitize her hands between wounds. The WCN changed gloves and cleaned both wounds again, using the same gauze for both wounds and wearing the same gloves. The WCN doffed (took off) her gloves, washed her hands and donned new gloves. She applied Calcium Alginate Silver, per orders, to each wound using the same gloved finger. She covered each wound with Island dressings. She dated each dressing prior to the application. III. Interviews The WCN was interviewed on 5/15/24 at 9:45 a.m. The WCN said she used the same gauze for both wounds to Resident #8's right hip and right buttocks. She said she did not change gloves in between wounds. She said she usually brings a lot of gauze when performing treatments, but tried not to be wasteful. The WCN said she did not understand that each wound should be treated separately, completing one dressing change before moving on to the other wound, to avoid cross contamination. The DON was interviewed on 5/15/24 at 9:46 a.m. She said the WCN should have treated each of Resident #8's wounds separately. She said the WCN should have cleaned the wounds with different pieces of clean gauze. She said the WCN should have sanitized her hands and changed her gloves in between treatments for each wound to prevent potential cross contamination between the wounds.