STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065244	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenwood Springs Healthcare	2305 Blake Ave Glenwood Springs, CO 81601

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 Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observations, record review and interviews, the facility failed to provide the necessary treatment and services to treat and prevent pressure injuries for one (#1) of three residents reviewed for pressure ulcers out of 39 sample residents. Resident #1, who was known to be at risk for pressure injuries, was admitted on [DATE] and readmitted on [DATE]. The resident had diagnoses of multiple sclerosis (disabling disease of brain and spinal cord), neurogenic bladder and metabolic encephalopathy (brain disorder caused by chemical imbalance of the blood). Hospital documentation recommended treatment for the wounds which were present to the Resident #1's sacrum, right lower extremity and left lower extremity upon the resident's readmission to the facility on [DATE]. The recommendations further indicated the resident was to follow up with outpatient wound care. However, the facility failed to initiate a care plan and interventions to prevent the development of pressure injuries until 5/11/24. On 5/6/24, Resident #1 developed a stage 2 pressure injury to the right heel which worsened to a stage 4 pressure injury on 6/28/24. The resident developed a second stage 2 pressure injury to the right lateral (outside) heel on 5/17/24 which worsened to a stage 4 pressure injury on 7/2/24. Resident #1's pressure injury care plan was not updated until 7/2/24, despite the resident having developed a second stage 2 pressure injury to her right lateral heel. Review of the resident's electronic medical record (EMR) did not reveal documentation to indicate the physician was notified when the resident's two stage 2 pressure injuries worsened to stage 4 pressure injuries. Additionally, the facility failed to assess Resident #1's wounds weekly between 5/6/24 to 5/17/24 and again between 6/19/24 to 6/28/24. Due to the facility's failure to implement timely interventions to prevent the development of pressure injuries and the facility's failure to implement additional interventions following pressure injury development, Resident #1 developed two facility-acquired stage 2 pressure injuries, which worsened to stage 4 pressure injuries. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065244	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Glenwood Springs Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2305 Blake Ave Glenwood Springs, CO 81601	

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 Note: The nursing home is disputing this citation.	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 on 8/5/24 from https://www.internationalguideline.com/guideline, 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). 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 (continued on next page)

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F 0686

Level of Harm - Actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

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.

II. Facility policy and procedure

The Skin Management policy and procedure, dated June 2022, was provided by the nursing home administrator (NHA) on 7/30/24 at 1:43 p.m. It read in the pertinent part,

Individuals at risk for skin compromise are identified, assessed, and provided treatment to promote healing, prevent infection, and prevent new pressure injuries from developing.

In accordance with CMS guidelines, 'unavoidable' means that 'the resident developed a pressure injury even though the center had evaluated the resident's clinical condition and pressure injury risk factors; defined and implemented interventions that are consistent with resident needs, goals and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.' All of this must be clearly defined in the resident's medical record.

Upon admission or readmission, residents are assessed for skin integrity by completing a head-to-toe physical assessment of skin condition and completing the Braden scale for predicting pressure sore risk under defined assessment (UDA) in conjunction with the new admission nursing data collection set (UDA).

Following admission, the braden scale for predicting pressure sore risk will be completed weekly for 3 (three) additional weeks (for a total of 4 (four) weeks, including admission), quarterly, annually, and with a significant change of status to determine the risk for development of pressure injuries.

Appropriate preventative surfaces (beds, wheelchairs) will be implemented for residents identified at risk. Interventions are documented on the care plan.

Residents admitted with skin impairment will have interventions to promote healing.

A care plan is developed upon admission, and reviewed upon readmission, identifying the contributing risks for breakdown, including history of skin impairment or the actual impairment, and the interventions implemented to promote healing and prevent further breakdown.

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F 0686

Level of Harm - Actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

III. Resident #1

A. Resident status

Resident #1, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included multiple sclerosis and neurogenic bladder.

The 7/12/24 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The assessment documented the resident was dependent on staff for dressing, toileting hygiene, personal hygiene, bathing, and putting on/taking off footwear. The assessment documented the resident required maximal assistance with turning side to side in bed.

The assessment indicated the resident was at risk for pressure ulcers and had stage 2 and stage 4 pressure ulcers that were not present on admission/readmission.

The assessment indicated the resident did not reject care.

B. Resident observations

On 7/30/24 at 10:38 a.m. Resident #1 was lying in her bed. Resident #1 had a wrapped dressing on her right foot. She did not have compression stockings or shoes on her feet.

On 7/30/24 at 2:37 p.m. Resident #1's wound care was observed with the director of nursing (DON), the assistant director of nursing (ADON) and certified nurse aide (CNA) #1. The resident's right heel had an open wound with visible white bone measuring 2.8 cm (centimeters) long, 2.0 cm wide and 1.0 cm deep. The resident had a second wound visible on the bottom of the foot which was not open. The second wound on the bottom of the foot was dark purple in color and was nonblanchable on assessment. The second wound on the bottom of the foot measured 1.2 cm long and 1.0 cm wide. Resident #1 was not observed to exhibit verbal or nonverbal signs of pain or discomfort during the wound dressing change.

C. Resident Interview

Resident #1 was interviewed on 7/30/24 at 10:41 a.m Resident #1 said she had developed two pressure ulcers at the facility that she felt were avoidable. Resident #1 said she did not always receive weekly skin assessments and the facility did not provide her with the specialty shoes she was promised by nursing staff. Resident #1 said a few months ago she was walking and able to perform several complex self care activities. Resident #1 said she developed the first pressure ulcer on her right heel a few months ago (May 2024) and lost the ability to stand and perform her self-care activities in April 2024. Resident #1 said she felt very angry that she had lost so much of her independence in such a short period of time.

Resident #1 was interviewed again on 7/30/24 at 3:58 p.m. Resident #1 said she did not feel pain or discomfort during the wound dressing change earlier today (7/30/24). Resident #1 said she did not normally need pain medication during her foot wound dressing changes because she could not always feel pain in her feet. Resident #1 said she did not reject care.

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #1 said she did not refuse to exit her wheelchair but had fallen asleep in her wheelchair frequently with her shoes on in the past few months because she could not stand with her heel pressure wounds and staff did not always wake her up to assist her in transferring back into her bed. Resident #1 said she wished staff had tried to wake her up and assisted her with removing her shoes. Resident #1 said this had not been a problem for the last month or so because she did not currently have any shoes to wear for any situation. Resident #1 said she had been bed and wheelchair bound for the last month (July 2024). Resident #1 said she required assistance from staff and a mechanical lift to get in and out of bed. Resident #1 said she had not refused to remove her compression stockings because it was important for her to wear them to help her legs with swelling. Resident #1 said the swelling in her legs is what created leg wounds for her and it had been identified by a doctor in the hospital in March 2024 as a way to prevent pressure sores from occurring. D. Record review Hospital documentation, dated 3/12/24, revealed Resident #1 had wounds on her sacrum, left lower extremity, and right lower extremity. The documentation recommended cleansing sacral wounds daily and as needed for soiling and covering the wound with an optifoam sacral dressing. The documentation recommended wearing tubigrip compression wrappings daily for the left lower extremity wound. The documentation recommended silvasorb covered with a foam dressing over partially open wounds and tubigrip compression wrappings to the right lower leg. The documentation further recommended that Resident #1 elevate her lower extremities with pillows, turn frequently to offload pressure from her sacrum, and follow up with outpatient wound care. -Review of Resident #1's EMR did not reveal documentation to indicate the resident had been scheduled to follow up with outpatient wound care per the physician's recommendations. -Review of the resident's EMR further revealed there was no head to toe skin assessment conducted on 3/17/24 upon the resident's readmission to the facility. A head to toe skin assessment, dated 3/24/24, documented Resident #1 had intact skin. -However, according to hospital documentation prior to the resident's readmission on 3/17/24, Resident #1 had wounds on her sacrum, right lower extremity and left lower extremity (see hospital documentation above). A head to toe skin assessment, dated 3/31/24, documented the resident had intact skin. It documented the resident had blanchable redness to the coccyx and a treatment was in place to an area on Resident #1's right leg. -The assessment failed to document the skin condition on Resident #1's right leg. -The facility failed to implement a pressure ulcer prevention plan of care after identifying an area of redness on the resident's coccyx (see care plan below). (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #1's pressure ulcer care plan, initiated on 5/11/24 (after the resident developed the first stage 2 pressure wound on 5/6/24) and updated on 7/18/24, documented the resident had a pressure ulcer related to edema and the resident was refusing to remove her shoes and compression stockings. The identified interventions included adding an air mattress to the resident's bed, compression stockings for edema management, providing the resident with a DARCO boot (specialized footwear designed to promote foot wound healing), educating the resident about proper skin care to prevent skin breakdown, providing education on the importance of elevating extremities, encouraging the resident to elevate legs for edema management, encouraging the resident to avoid lying on her back and rolling side to side as tolerated, evaluating ulcer characteristics, monitoring ulcer characteristics for signs of progression or declination, notifying the provider if no signs of improvement on current wound regimen, offloading shoes as needed, providing wound care per treatment orders, referring the resident to a specialized practitioner for wound management, using enhanced barrier precautions and using a temporary wheelchair with elevating foot pedals. -However, the resident did not receive the DARCO boot (see resident observation and interview above and ADON interview below). A Braden Scale for predicting pressure sore risk assessment was completed on 4/12/24, 6/17/24, and 7/25/24. All three assessments documented the resident was at risk for developing pressure ulcers. All three assessments documented the resident had no sensory deficit which would limit her ability to feel pain or voice discomfort. -However, the resident was diagnosed with multiple sclerosis and metabolic encephalopathy which the facility said could impact the resident's sensation (see interview below) and the resident said she did not normally feel pain in her feet (see resident interview above. Resident #1's progress notes were reviewed for documented rejections of care between 5/6/24 and 7/21/24. The resident was documented to refuse returning to bed on five occasions, refusing to elevate her legs on 14 occasions and refusing to remove her shoes or compression stockings on three occasions. -There was no documentation to indicate the facility had reoffered care to the resident on the occasions she refused care or that education was provided to the resident regarding the potential outcomes to skin integrity related to refusing care. -Additionally, the facility failed to update the resident's pressure ulcer care plan to reflect the reason the resident occasionally refused care or document the reasons the resident refused the care. A skin pressure injury note, dated 5/6/24, documented the resident had a stage 2 pressure ulcer to the right heel measuring 1.5 cm long, 4.0 cm wide and 0.3 cm deep. The note documented interventions included a pressure reducing mattress and a pressure reducing cushion. -However, the facility failed to implement a pressure injury care plan until 5/11/24, five days after the pressure injury was identified. -Additionally, the facility did not implement a pressure-reducing mattress for Resident #1 until 7/9/24 when a performance improvement plan (PIP) for wounds was implemented (see interviews below). (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	-There was no documentation to indicate the resident's physician or the facility's medical director were notified of the new pressure injury. A weekly skin pressure injury note, dated 5/17/24, documented the resident had a stage 2 pressure ulcer to the right heel measuring 1.5 cm long, 3.0 cm wide and 0.3 cm deep. The assessment further documented a second pressure wound on the resident's right lateral foot measuring 0.5 cm long, 0.5 cm wide and 0.2 cm deep. The note documented interventions included a pressure reducing mattress and a pressure reducing cushion. -The facility did not conduct the weekly skin assessment until 11 days after the previous assessment on 5/6/24. -The facility did not implement a pressure-reducing mattress for Resident #1 until 7/9/24 when a PIP for wounds was implemented (see interviews below) -There was no documentation to indicate the resident's physician or the facility's medical director were notified of the new pressure injury. -The assessment failed to identify new interventions to prevent the deterioration of current skin conditions identified by nursing staff. A weekly skin pressure injury note, dated 5/23/24, documented the resident had a stage 2 pressure ulcer to the right heel that had not improved or worsened. The assessment documented the second pressure wound on the right lateral foot had deteriorated and now measured 0.6 cm long, 0.6 cm wide and 0.2 cm deep. -The assessment failed to identify new interventions to prevent the stagnation or deterioration of current skin conditions identified by nursing staff. -There was no documentation to indicate the resident's physician or the facility's medical director were notified of the worsening pressure injury. -The facility did not implement a pressure-reducing mattress for Resident #1 until 7/9/24. A weekly skin pressure injury note, dated 5/30/24, documented the resident had a stage 2 pressure ulcer to the right heel that had deteriorated and now measured 1.6 cm long, 3 cm wide and 0.3 cm deep. The assessment documented the second pressure wound on the right lateral foot had deteriorated and was now an unstageable wound measuring 1.0 cm long, 1.3 cm wide and had an unknown depth. The assessment documented the wound on the right lateral foot had approximately 50% eschar. (dead skin tissue) -The assessment failed to identify new interventions to prevent the stagnation or deterioration of current skin conditions identified by nursing staff. -There was no documentation to indicate the resident's physician or the facility's medical director were notified of the worsening pressure injury. -The facility did not implement a pressure-reducing mattress for Resident #1 until 7/9/24. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A weekly skin pressure injury note, dated 6/6/24, documented the resident had a stage 2 pressure ulcer to the right heel that had improved and now measured 1.5 cm long, 2.1 cm wide and 0.3 cm deep. The assessment documented the second pressure wound on the right lateral foot had deteriorated and was now a stage 3 pressure wound measuring 1.5 cm long, 2.8 cm wide and was 0.3 cm deep. The assessment documented Resident #1 would supinate (to face a part of the body upwards) her feet which contributed to the deterioration of the wounds. The assessment documented Resident #1 would sleep in her wheelchair all day and all night, would refuse to elevate her legs, and would refuse to remove her shoes or compression stockings. The assessment documented the resident would often refuse to bathe which resulted in poor skin health. -However, Resident #1 was only documented to refuse to return to bed on five separate occasions between 5/6/24 and 7/21/24 and refusing to remove her shoes on three occasions between 5/6/24 and 7/21/24. -The facility failed to identify new interventions to prevent the stagnation or deterioration of current skin conditions identified by nursing staff. -There was no documentation to indicate the resident's physician or the facility's medical director were notified of the worsening pressure injury. A weekly skin pressure injury note, dated 6/15/24, documented the resident had a stage 2 pressure ulcer to the right heel that had deteriorated and now measured 1.5 cm long, 3 cm wide and 0.3 cm deep. The assessment documented the second pressure wound on the right lateral foot had improved and was a stage 3 pressure wound measuring 1.5 cm long, 1.0 cm wide and was 0.2 cm deep. The assessment documented Resident #1 would sleep in her wheelchair all day and all night, would refuse to elevate her legs, and would refuse to remove her shoes or compression stockings. The assessment documented the resident would often refuse to bathe which resulted in poor skin health. -However, Resident #1 was only documented to refuse to return to bed on five separate occasions between 5/6/24 and 7/21/24 and refusing to remove her shoes on three occasions between 5/6/24 and 7/21/24. -The facility performed the weekly assessment nine days after the previous weekly assessment on 6/6/24. -The facility failed to identify new interventions to prevent the stagnation or deterioration of current skin conditions identified by nursing staff. -There was no documentation to indicate the resident's physician or the facility's medical director were notified of the worsening pressure injury. A weekly skin pressure injury note, dated 6/19/24, documented the resident had a stage 2 pressure ulcer to the right heel that had deteriorated and now measured 2.3 cm long, 3.4 cm wide and 0.5 cm deep. The assessment documented the second pressure wound on the right lateral foot had deteriorated and was a stage 3 pressure wound measuring 1.2 cm long, 1.2 cm wide and was 0.3 cm deep. -The assessment failed to identify new interventions to prevent the stagnation or deterioration of current skin conditions identified by nursing staff. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	-There was no documentation to indicate the resident's physician or the facility's medical director were notified of the worsening pressure injuries. A weekly skin pressure injury note, dated 6/28/24, documented the resident had a wound on the right heel that had deteriorated and was now a stage 4 pressure ulcer measuring 4.5 cm long, 4.0 cm wide and 0.7 cm deep. The assessment documented the wound bed was eschar and bone. The assessment documented the second pressure wound on the right lateral foot had deteriorated and was a stage 3 pressure wound measuring 0.7 cm long, 1.5 cm wide and was 0.5 cm deep. -The assessment failed to identify new interventions to prevent the stagnation or deterioration of current skin conditions identified by nursing staff. -The facility performed the weekly skin assessment nine days after the previous assessment on 6/19/24. -There was no documentation to indicate the resident's physician or the facility's medical director were notified of the pressure injury deteriorating to a stage 4 pressure injury A weekly skin pressure injury note, dated 7/2/24, documented the resident had a stage 4 pressure ulcer on the right heel that measured 3 cm long, 3.7 cm wide and 1 cm deep. The assessment documented the second pressure wound on the right lateral foot had deteriorated and was a stage 4 pressure wound measuring 1.2 cm long, 1.2 cm wide and was 0.9 cm deep. -The assessment failed to identify new interventions to prevent the stagnation or deterioration of current skin conditions identified by nursing staff. -There was no documentation to indicate the resident's physician or the facility's medical director were notified Resident #1 now had two stage 4 pressure injuries. A telehealth (virtual) physician's visit note, dated 7/2/24, documented Resident #1 had a stage 4 pressure wound on her right heel and had another wound on the lateral middle part of the foot that was a stage 2 pressure injury. The assessment documented the resident had been in her bed since yesterday (7/1/24) and would not get out of bed. The assessment documented the resident was to receive new shoes and an offloading boot. The assessment further documented the resident was receiving daily dressing changes to the heels and compression stockings were being changed every couple of weeks when the resident would allow a shower. The assessment documented the resident had lower extremity edema (swelling) and required compression with tubigrips and compression wraps. The assessment documented the resident was wheelchair bound but could transfer herself. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A weekly skin pressure injury documentation, dated 7/9/24, documented the resident had a stage 4 pressure ulcer on the right heel that deteriorated and measured 2.8 cm long, 4.0 cm wide and 0.5 cm deep. The assessment documented the second pressure wound on the right lateral foot had improved and was a stage two pressure wound measuring 1 cm long, 1 cm wide, and was 0.2 cm deep. The assessment identified new interventions to include nutritional supplements, and a plan of care discussion that included Resident #1, the nursing home administrator (NHA), the MDS resource nurse, and the corporate consultant (CC). The discussion included education to Resident #1 that her compression stockings were causing increased pressure to her heels, the importance of turning side to side in bed, and the importance of accepting showers. -The facility failed to document weekly skin pressure injury documentation between 7/10/24 and 7/30/24. A telehealth physician visit note, dated 7/10/24, documented a referral for Resident #1 to see wound care to assist with wound debridement (removal of damaged tissue from the wound). -However, there was no documentation to indicate Resident #1 was seen by a wound care physician for wound debridement between 7/10/24 and 7/30/24. A Performance Improvement Plan (PIP) for wounds, dated 7/10/24, was provided by the DON on 7/31/24 at 8:46 a.m. The PIP documented the facility had an opportunity to improve several areas of wound care management in the facility, including the accuracy and timeliness of pressure ulcer assessment, appropriately identifying pressure ulcer wounds, appropriately changing treatment orders, implementing interventions as needed, and holding care conferences with a resident's decision maker as needed. The PIP documented the facility experienced communication breakdown in shift-to-shift report, nursing management assessments and follow-up was inadequate, and a lack of communication with outside resources such as wound clinic specialists. The PIP documented the facility would intervene with several new interventions on 7/10/24. The PIP documented all residents in the facility would have an accurate and in depth skin assessment completed within 24 hours, and all residents would have a head-to-toe skin assessment that was accurate, on time, and thorough. The PIP documented all nursing staff members would receive education on pressure injury prevention, the Braden scale and reporting requirements of skin conditions. -The facility failed to identify when the PIP would be re-evaluated for effectiveness. E. Staff interviews The DON was interviewed on 7/30/24 at 12:10 p.m. The DON said she was previously the facility's NHA and transitioned into the role of DON on 7/29/24. The NHA was interviewed on 7/30/24 at 1:34 p.m. The NHA said the facility did not have documentation indicating the facility notifying a physician when either of Resident #1's wounds progressed to stage 4 (see documentation above). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065244	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenwood Springs Healthcare	2305 Blake Ave Glenwood Springs, CO 81601

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 Note: The nursing home is disputing this citation.	LPN #1 was interviewed on 7/30/24 at 3:58 p.m. LPN #1 said Resident #1 sometimes did not want to shower. LPN #1 said she did not personally have this issue because she and Resident #1 had a good relationship and Resident #1 did not refuse showers for her. LPN #1 said Resident #1 did not often refuse cares for her as long as she took her time with Resident #1 and made the care enticing by explaining that the resident would feel better afterwards. The DON was interviewed again on 7/30/24 at 4:23 p.m. The DON said Resident #1 had a stage 4 pressure wound on her right heel and an unstageable pressure wound on the resident's right lateral foot. The DON said both wounds were currently improving. The DON said the facility's previous DON no longer worked at the facility. The DON said the facility's previous DON had been solely responsible for wound care in the facility, but she had been on vacation since late June 2024 and had not worked in the building in July 2024 at all before she left the facility. The DON said the facility had identified concerns with resident wound care in July 2024 and implemented a PIP to address these concerns. The DON said the facility did not implement new interventions for Resident #1's plan of care after wound deterioration was documented on 5/30/24, 6/6/24, 6/15/24, 6/19/24, or 6/28/24. The DON said she was not aware that the facility did not implement new interventions because she was in the NHA role at the time. The DON said the facility should have implemented new interventions to prevent deterioration of Resident #1's foot wounds. The DON said the facility should perform weekly wound skin assessments every seven days consistently. The DON said the facility failed to consistently assess Resident #1's wounds weekly. The DON said she did not have documentation of weekly wound assessments being completed between 7/10/24 and 7/30/24. The medical director (MD) was interviewed on 7/30/24 at 4:58 p.m. The MD said Resident #1's wounds were facility-acquired and avoidable. The MD reviewed documentation regarding the resident's wounds and said he could not tell if or when any physician was told about Resident #1's stage 4 pressure wounds. The MD said that his physician's office performed assessments of Resident #1's wounds on 7/2/24 and 7/10/24 and issued recommendations only on those occasions. The MD said the first time he assessed the wounds they were already stage 4 pressure wounds. He said a physician should be alerted that a resident had a wound before the wound reached the status of a stage 4 pressure wound. The MD said if he had been notified earlier he would have reassessed the resident's medications and treatments to further prevent the development of the facility-acquired pressure ulcers. The MD said he was unsure if sufficient education was provided to Resident #1 early enough to help prevent pressure injuries. The MD said the facility had one discussion with Resident #1 in July 2024 regarding care plan adherence and since that time Resident #1 had not had rejections of care. The MD said he had evaluated Resident #1's compression stockings and was unsure if they contributed to any specific pressure development for the resident. The MD said it was important for Resident #1 to wear compression stockings to prevent the development of wounds due to swelling. The MD said the facility failed to identify Resident #1's skin concerns in a timely manner. The MD sa[TRUNCATED]