| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 065249 | A. Building<br>B. Wing | 04/16/2025 |

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| Willow Tree Care Center | 2050 S Main St<br>Delta, CO 81416 |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467<br><br>Based on observations, record review and interviews, the facility failed to ensure one (#1) of three residents out of three sample residents received treatment and care for optimal skin condition of a pressure wound, in accordance with professional standards.<br><br>Specifically, the facility failed to:<br><br>-Develop and implement a care plan for Resident #1's pressure ulcers; and,<br><br>-Ensure interventions were implemented timely to prevent the development and worsening of a pressure injury for Resident #1.<br><br>Findings include:<br><br>I. Professional reference<br><br>According to the All [NAME] Tissue Viability Nurse Forum, Best Practice Statement on the Prevention and Management of Moisture Lesions, September 2023, retrieved online 4/4/25 from:chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.wwic.[NAME]/uploads/files/documents/Professionals/Clinical%20Partners/AWTVNF/All_Wales-Moisture_Lesions_final_final.pdf<br><br>Individuals with incontinence may also have problems with mobility and, as a result, be at risk of developing pressure ulcers as well as moisture lesions. Consequently, when inspecting an individual's skin, it may be difficult to tell if the damage to the skin is caused by moisture alone or moisture in combination with pressure. If the skin is subjected to moisture and pressure, then the treatment strategy will have to overcome both of these insults to the skin. Therefore, along with guidance on how to prevent and manage moisture on the skin, pressure relief will be an important part of care for the individual. Repositioning together with the use of pressure-relieving equipment are the main methods of preventing pressure damage caused by extended periods of localized pressure on the skin. The use of repositioning should be considered in all at-risk individuals as a prevention strategy and should be undertaken to reduce the duration and magnitude of pressure over vulnerable areas of the body. The repositioning schedule should take into account the daily activities of the individual, their ability to tolerate pressure when in the seated and lying positions and the support surfaces in use. If a moisture lesion does not respond to interventions to minimize the effects of moisture alone, then the clinician should consider whether pressure is contributing to the damage and introduce repositioning and pressure relief into the individual's care.<br><br>(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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | II. Resident #1<br><br>A. Resident status<br><br>Resident #1, age greater than age 65, was admitted on [DATE] and discharged on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included acute kidney failure, malignant neoplasm of the prostate (prostate cancer), cognitive communication deficit, weakness and need for personal care.<br><br>The 2/25/25 minimum data set (MDS) assessment indicated Resident #1 had severe cognitive impairments with a staff assessment for mental status. The resident required staff assistance for most of his activities of daily living (ADLs) and used a wheelchair for mobility.<br><br>B. Record review<br><br>The pressure ulcer care plan, initiated 11/2/24, documented Resident #1 had the potential for a pressure ulcer/injury to his coccyx or potential for pressure ulcer development related to dehydration, and immobility. The care directed staff to document the resident's treatment weekly. According to the care plan, the documentation should include the measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate.<br><br>-The pressure ulcer care plan did not identify interventions to prevent the development of a pressure ulcer to his coccyx were identified on his care plan.<br><br>The skin impairment care plan, initiated 12/20/24, documented Resident #1 had the potential impairment to his skin integrity due to his fragile skin. The care plan indicated the resident had a stage 2 and stage 3 pressure ulcer/injury.<br><br>According to the care plan, the resident was anticipated to have a decline in his skin condition and would have interventions to help maintain his comfort.<br><br>The following interventions were put in place after Resident #1 developed pressure injuries: specialty bed air mattress, initiated 12/20/24; pressure relieving bed mattress, initiated 12/27/24; avoid scratching and keep his hands and body parts away from excessive moisture and keep his fingernails short, initiated 12/27/24; and, encourage good nutrition and hydration in order to promote healthier skin, initiated 12/27/24.<br><br>The 10/22/24 admission data collection assessment did not identify Resident #1 had any issues or indications of a pressure injury on his admission to the facility. According to the assessment, the resident had no history of skin issues.<br><br>The October 2024 CPO revealed a physician's order that directed staff to treat Resident #1's coccyx with soap and water and cover it with bordered foam sacral dressing, ordered on 10/29/24 and discontinued on 12/15/24.<br><br>-The EMR did identify documentation of a coccyx wound found on 10/29/24 requiring treatment or if coccyx was treated as directed by the physician.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the November 2024 and December 2024 medication administration record (MAR) and treatment administration record (TAR) did not identify Resident #1's coccyx was cleansed with soap and water and covered with bordered foam sacral dressing per the physician's order.<br><br>The 10/29/24 Braden Scale assessment (a tool for predicting pressure ulcer risk) identified Resident #1 was at moderate risk for developing pressure sores.<br><br>-Review of the resident's electronic medical record (EMR) did not reveal the reason the nurse requested treatment on 10/28/24 (see interviews below).<br><br>The 10/29/24 skilled charting assessment documented Resident #1's skin was pale, warm and dry.<br><br>-The skilled charting assessment did not identify concerns with the resident's skin.<br><br>The 10/29/24 skin and wound total body assessment documented the resident had no new wounds.<br><br>The 11/10/24 nursing progress note identified Resident #1's resident representative was told the resident had a wound on his coccyx. According to the note, the resident's coccyx would be looked at during wound care on the following morning (11/11/24).<br><br>-Review of Resident #1's electronic medical record (EMR) did not reveal the resident was assessed by the wound care team on 11/11/24.<br><br>A 11/11/24 general note documented Resident #1 did not have an open area or a wound but had a dressing over his sacral area to prevent skin breakdown due to his bony prominence. According to the note, the resident's representative felt the resident was not being assisted out of bed. The note documented the resident was given a choice to get out of bed and he wanted to eat in his room. The note documented the staff could encourage Resident #1 to spend time out of bed.<br><br>-Review of the pressure ulcer risk care plan, dated 11/2/24, did not identify staff were directed to encourage the resident to spend time out of bed or interventions for the resident to offload pressure off his bony prominences.<br><br>The 10/29/24 skin and wound total body assessment documented the resident had no new wounds.<br><br>Review of Resident #1's skin and wound total body assessment on 11/5/24, 11/12/24, 11/19/24 and 11/26/24 did not document the resident had new wounds.<br><br>The 11/28/24 progress note documented a certified nursing assistant (CNA) notified the nurse of an open area to Resident #1's sacrum when she was changing his brief. The open area measured 1.9 centimeters (cm) length by 1.9 cm width. According to the note, the area was cleansed and hydrocolloid dressing (moist dressing designed to absorb fluids) was applied to the area. The physician was notified.<br><br>Review of the November 2024 and December 2024 CPO did not reveal a physician's order for hydrocolloid dressing or how often the open area should be cleansed and covered with hydrocolloid dressing.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the November 2024 and December 2024 MAR and TAR between 11/28/24 and 12/15/24, did not identify Resident #1's open area to his sacrum was cleansed and treated hydrocolloid dressing with coccyx was cleansed with soap and water and covered with bordered foam sacral dressing.<br><br>The 11/28/24 situation background assessment and recommendation (SBAR) summary for providers note identified Resident #1 had a change of condition related to a skin wound or ulcer. According to the note, the resident did not like to lay on his side so a pillow was placed behind him to help him offload pressure from his back.<br><br>-The intervention to place a pillow behind Resident #1 to help him offload pressure was not included on the resident's above care plan.<br><br>The 12/10/24 nursing progress note documented Resident #1 had two more open areas to his buttocks. According to note, the open areas were cleansed and re-dressed. The note did not identify the location of the open areas on his buttocks, the condition, the appearance or the causation of the two additional open areas to his buttocks.<br><br>Review of the resident's EMR did not identify the nurse assessed and documented measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate on 12/10/24 or shortly after the identification of the new wounds.<br><br>The 12/13/24 nutrition note documented Resident #1 was not interested in eating but he requested to walk to the dining room because he still felt he had pep. The registered dietitian (RD) increased his oral nutritional supplement to three times a day with meals. The RD recommended Resident #1 be encouraged to get out of bed for repositioning/off-loading due to his stage 2 pressure injury to his coccyx.<br><br>-The review of the resident's care plan did not direct staff to encourage and assist the resident to get out of bed for repositioning and off-loading. The care plan did not direct staff to assist or encourage the resident to walk to the dining room for meals.<br><br>The 12/13/24 skin and wound evaluation revealed Resident #1 had a stage 3 pressure ulcer with full thickness skin loss on medial sacrum (on the center of his sacrum bone). The stage 3 injury was identified as a new wound, facility acquired and deteriorating with 100% slough. The pressure injury measured 3.3 cm length by 2.2 cm width with fragile surrounding skin with risk for breakdown. The pressure injury was identified as healable. According to the evaluation, the wound was treated with generic wound cleanser and hydrocolloid foam dressing. The wound documented the resident had pain during the dressing application. The evaluation indicated the use of a low air loss air mattress, educating staff to turn and reposition the resident frequently and to get the resident up out of bed for meals. The evaluation documented the facility was waiting for the arrival of a low air loss air mattress.<br><br>-The review of the December 2024 TAR revealed the pressure redistribution mattress/low air loss/alternating pressure mattress for prevention and pressure relief, was not in place for use until 12/21/24, seven days after it was identified as intervention to his pressure ulcer.<br><br>-The evaluation did not identify a second open area to the resident's buttock as identified in the above 12/10/24 nursing note.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #1's December 2024 CPO revealed the following physician's orders:<br><br>Daily wound review on every shift for wound management of Resident #1's sacrum, ordered 12/15/24 and remained an active till his discharge.<br><br>Daily wound review on every shift for wound management of Resident #1's left gluteus, ordered 12/15/24 and remained an active till his discharge.<br><br>Left gluteal wound care: Cleanse with wound cleanser; apply 3 by 3 hydrocolloid and cover with bordered foam dressing; change every dressing on Monday, Wednesday and Friday, ordered 12/15/24 and discontinued 12/21/24.<br><br>Sacral wound care: cleanse wound with wound cleanser; apply 3 by3 hydrocolloid; cover with bordered foam dressing; change every Monday, Wednesday and Friday, ordered 12/16/24 and discontinued 12/21/24.<br><br>The 12/18/24 electronic medical administration record (EMAR) general note documented Resident #1 received a daily wound review on 12/18/24. The note identified Resident #1 had a wound on his sacrum and on his left gluteus.<br><br>According to the note, staff should document every shift for his sacrum and left gluteus wound management document the condition of his wound bed, drainage amount, odor, surrounding skin and pain level and dressing situation.<br><br>The 12/19/24 wound initial note identified Resident #1 had a consultation from a wound care physician (Physician #1) to review two pressure ulcers/injuries. The note documented Resident #1 had an unstageable pressure injury to his sacrococcyx and a stage 3 pressure injury to his left buttock. The wound note revealed the sacrococcyx unstageable pressure injury measured 3.5 cm by length 3.5 cm width by 0.4 cm depth with 100% slough. The stage three pressure injury to the resident's left buttock measured 2.5 cm length by 2.5 cm width x 0.1 cm depth with 100% granulation. According to the note, the treatment recommendations were identified as the following: clean the sacrococcyx with normal Saline (a salt water solution); apply Santyl (ointment to remove dead skin) and gauze; change the dressing daily and as needed if the dressing became dislodged, saturated or soiled.<br><br>The wound initial note identified the wound care physician directed staff to implement pressure relieving measures and offloading as tolerated; prevent contact of his heels with the bed or other surface and TO consult with the RD to optimize nutrition per facility or dietary protocol to promote wound healing. The wound care note indicated the wound care physician would re-evaluate Resident #1 in one to two weeks.<br><br>The 12/20/24 interdisciplinary note (IDT) note documented the Resident #1 was placed on weekly wound arounds as of 12/19/24 and was currently getting up for meals.<br><br>Review of wound treatment notes between 1/2/25 and 2/13/25 identified the wound physician continued to evaluate Resident #1's wound and adjust the treatment plan. On 1/2/25 the unstageable Sacrococcyx pressure was documented as unavoidable. On 1/9/25 the pressure to his left buttock was resolved.<br><br>III. Staff interviews<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The director of nursing (DON) and the nursing home administrator (NHA) were interviewed on 4/15/25 at 4:29 p.m. The DON said the facility inspected the resident's skin weekly, applied lotion to the skin after bathing and changing the resident, encouraged food and fluid intake, encouraged them to spend time out of bed and had the RD assess the resident's nutritional needs for pressure injury prevention. The DON said the facility provided specialty cushions depending on the needs of the resident and air mattresses if the resident was at high risk for pressure injuries and or had current pressure injuries. She said the air mattresses were low air low mattresses that helped alternate pressure for residents that were not able or unable to reposition on their own. She said the staff repositioned the residents at least every two hours and that should be included on the resident's care plan.<br><br>The DON said Resident #1 was identified a risk for pressure injuries and developed pressure injuries while admitted to the facility. Resident #1 was not placed on an alternating pressure air mattress when his risk for pressure injuries was identified because his discharge plan was to receive therapy and return to the community. She said the alternating pressure air mattress was usually reserved for long term residents with an actual pressure injury. The NHA said all residents were provided a pressure redistribution mattress.<br><br>The DON said the facility did not have a wound care certified nurse. She said she was not sure if Resident #1 was seen by his physician after the resident was identified to have an open area to his sacrum on 11/28/24. She said the resident was seen by a wound care physician on 12/19/24. The DON said she reviewed the resident's EMR and said the physician was notified of the open area on 11/28/24 but she could not find documentation to show the resident's physician saw the wound or was updated on the status of the wound between 11/29/24 and 12/17/24.<br><br>The nursing home administrator (NHA) and the DON were interviewed together on 4/16/25 at 11:00 a.m. The DON said the nurses were responsible for nursing care provided but she was responsible for the overall wound care of the facility residents. The DON said Resident #1's pressure injuries were facility acquired. The DON said the resident was provided the alternating pressure air mattress in December 2024 because he had an open area, he refused to get out of bed or reposition and had bony prominences.<br><br>-However, review of the progress notes and care plan did not identify the resident refused to be repositioned. The review of the progress notes only documented the resident refused to get out of bed on 11/11/24 when his representative asked why was not out of bed and on 11/16/24 when he did not want to get out of bed to take a phone call at the nursing station.<br><br>The DON said she did not know why the nurse on 10/28/24 requested a treatment order for Resident #'s coccyx on 10/28/24. The DON said she was not informed of a concern to his coccyx and an assessment was not completed to identify the resident would need treatment orders.<br><br>The DON said she did not know why a nurse told the resident's representative on 11/10/24 that Resident #1 had a wound to his coccyx and he would be included in wound rounds. The DON said she thought there may have been some miscommunication to the nurse and the resident was not scheduled to be seen in wound rounds. She said wound rounds would be documented in the resident's medical record.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The DON said the resident was not placed on wound rounds after an open area was identified on 11/28/24 because the nurses were doing the wound care. She said she conducted the wound wounds but all nurses were responsible for wound care. She said the wound on his sacrum worsened while he was admitted to the facility.<br><br>The DON said the open area to the resident sacrum was a pressure injury due to lack of nutritional intake and refusal to get out of bed. She said staff would have repositioned him every two hours but the repositioning would not have been documented.<br><br>The DON said the care plan should have included repositioning, encouraging him to get out of bed and that he refused. She said the care plan did not direct staff on what to do if the resident refused. She said the care plans needed improvement.<br><br>The DON said she did not know why a nurse documented the resident had two more open areas on his buttocks or if one of the areas referenced the open area on his sacrum. She said if there were additional open areas then there should have been an assessment, new orders, interventions and tracking.<br><br>The DON said she observed the resident's sacrum/coccyx on 12/17/24 and identified an open area with slough and determined the resident required mechanical debridement (the physical removal of unhealthy tissue). The DON said Resident #1 was seen by the wound physician through telehealth on 12/19/24 where he found two open areas.<br><br>The DON and the NHA were interviewed again on 4/16/25 at 1:45 p.m. The DON said when a resident had a change in condition such as a change in the resident's skin, the facility would document the change and monitor the resident for 72 hours on every shift. The DON said a wound care specialist would not be involved in the resident's skin care if the facility nurse felt the management of Resident #1's wound could be handled by staff. The DON said there was no wound care documentation of Resident's sacrum wound and thinks he may have been missed or tracked. The DON said in December 2024 she did not know the resident should have had daily a wound review after a wound was identified. The DON said the nurses did not complete the weekly skin assessments for Resident #1.<br><br>The DON said she assessed Resident #1 on 12/13/24 and the wound worsened from 1.9 cm by 1.9 cm to 3. 3 cm by 2.2 cm with 100% slough. The DON said she continued the same intervention of hydrocolloid until the resident was seen on 12/19/24 with the wound physician.<br><br>The DON said the facility needed to continue to improve on documentation, communication, showing refusals and interventions and tracking skin concerns. She said the facility needed to increase their education on wound care and she was in the beginning stages of working becoming wound care certified. The NHA said the facility would immediately start educating staff. She said in May 2025, a wound care physician would be able to see the resident's in person and not on telehealth.<br><br>The NHA was interviewed on 4/16/25 at 2:25 p.m. The NHA said she spoke with the facility's clinical consultant and was directed to start a whole facility review of resident skin and wounds. She said based on the findings, new treatment and interventions would be implemented and the care plans would be updated. |