STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065324	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Frasier Meadows Health Care Center	4950 Thunderbird Dr Boulder, CO 80303

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** 19262 Based on observations, record review and interviews the facility failed to ensure one (#31) of three residents reviewed for pressure-related skin conditions out of 19 sample residents received care consistent with professional standards of practice to prevent pressure ulcers from developing. Resident #31, who was at risk for developing pressure injuries due to a recent surgery to replace his left hip joint, was admitted to the facility on [DATE]. According to the facility's assessment of the resident's skin on 3/8/24, the resident was admitted without any pressure injuries. The facility implemented a pressure reducing mattress upon the resident's admission, however, there were no interventions implemented for offloading the resident's heels, which were at an increased risk for skin breakdown due to the resident's decrease in mobility following the left hip surgery. On 3/11/24, a left heel blister was observed to the resident's left heel and a right heel blister developed later that same day. The facility did begin appropriate treatment of the wounds and implemented further interventions to address offloading the resident's heels after the wounds were identified, however, they failed to implement appropriate interventions of heel booties or an air mattress overlay until after the wounds developed. Despite providing treatment to the wounds after they developed and implementing further interventions, Resident #31's wounds continued to worsen. The resident was discharged to the hospital on 3/27/24 for further treatment of the wounds. Once at the hospital, Resident #31's heel wounds required surgical debridement down to the bone. Due to the facility's failures to identify upon admission that Resident #31 was at risk for pressure injuries related to his recent hip surgery and the facility's failure to implement timely interventions to offload and protect the resident's heels, Resident #31 developed pressure wounds to both of his heels within three days of his admission which resulted in his discharge to the hospital 16 days after the wounds developed for further wound treatment. Findings include: I. Professional reference (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	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 4/17/24, 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). 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. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	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 procedures The Pressure Injuries policy, revised on 1/9/24, was provided by the director of nursing (DON) on 4/11/24 at 5:42 p.m. The policy revealed the purpose of the policy was to assure that all residents received an accurate assessment of pressure injuries, and the appropriate documentation was completed. The compliance guidelines revealed skin assessments would be completed by a licensed nurse upon admission and weekly thereafter. The information provided by the initial comprehensive assessment, established baseline data for the ongoing assessment of the resident's skin status. Accurate assessments that addressed each resident's skin status would be conducted by qualified staff and correctly documented in the medical record. A qualified health professional would correctly document the presence, number, size and stage of any pressure injury on the wound documentation form in the medical record. The nurse completing the skin section of the minimum data set (MDS) assessment would record the appropriate number and stage of pressure injuries as reflected in the pressure injury documentation. A licensed nurse would conduct or coordinate each assessment with the appropriate participation of health professionals. The director of nursing (DON) would be notified of any pressure injury. If it was determined a consultation was necessary, the wound nurse would be notified. If the wound nurse was notified, the DON, or designee, would be present during his/her visit. A Weekly Wound Evaluation would be completed and added to the pressure injury log. Education regarding pressure injuries would be provided to the nurses at least annually. Dressing treatments would be determined based on recommendations from the wound nurse, ordering physician, or best practice. The care plan would be updated indicating the presence of a pressure injury, the goal, and appropriate interventions. The physician would be informed of the presence of a pressure injury and treatment orders would be obtained. III. Resident #31 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A. Resident status Resident #31, age 82, was admitted on [DATE] and was discharged to the hospital on 3/27/24. According to the March 2024 computerized physician orders (CPO), diagnoses included aftercare following joint replacement, left artificial hip joint, chronic atrial fibrillation, cardiomyopathies and chronic kidney disease. The 3/11/24 MDS assessment revealed the resident had intact cognition with a brief interview for mental status (BIMS) score of 13 out of 15. The resident required substantial/maximal staff assistance for upper and lower body dressing. He also required substantial/maximal staff assistance for putting on/taking off footwear. The resident was at risk for the development of a pressure ulcer. The resident did not have any pressure, venous or arterial ulcers upon admission. C. Record review A care plan, initiated 3/8/24, revealed Resident #31 was at risk for a pressure ulcer related to a recent fracture. The goal was for the resident's skin to remain intact with no new open areas caused by pressure or friction throughout his stay in the facility. Interventions included a skin risk assessment Braden Scale would be completed upon admission, quarterly and with a significant change in condition. The resident would use a pressure reducing mattress when in bed (start 3/8/24). A new recliner was ordered to try a different pressure relieving technique (start 3/8/24). The resident would allow staff to float his heels while in bed (start 3/11/24). On 3/18/24, a new boot for his heels was ordered according to physician recommendations. The care plan (started 3/11/24) further revealed the resident had a blister to his left heel and the resident was to wear booties when in bed. On 3/11/24, the resident's room recliner was replaced with a new recliner. On 3/13/24, the new recliner was not comfortable for the resident and another one was ordered by central supply. The staff were to provide treatment as ordered as necessary. An air mattress was placed on the resident's bed. The resident started on a nutritional supplement twice a day. The care plan (started 3/15/24) further revealed the resident had a blister on his right heel. A new air mattress was placed on his bed(start 3/15/24). The staff were to provide treatment as ordered as necessary. An air mattress was placed on the resident's bed. The resident started on a nutritional supplement twice a day (start 3/15/24). A Skin Evaluation Form, dated 3/8/24 at 2.16 p.m. by a registered nurse (RN) did not reveal any pressure injuries to the resident's heels. The Braden Scale assessment for predicting pressure sore risk, dated 3/8/24 at 1:33 p.m., documented Resident #31 was not at risk for the development of pressure ulcer/injury development. A Skin Evaluation Form dated 3/11/24 at 11:35 a.m. by a RN revealed a pressure injury to the left heel with an onset date of 3/11/24. The left heel pressure injury measured 3.8 centimeters (cm) by 2.2 cm by 0.0 cm depth. The wound was an unstageable unopened blister that was purple in color. The wound bed was not visible and there was no exudate. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A nurse note dated 3/11/24 at 11:54 a.m. by a registered nurse (RN) revealed the resident complained of pain in his bilateral heels that morning in occupational therapy. The nurse assessed the resident and found a purple blister to the left heel and the wound bed was not visible. The right heel was pink with a blanchable (skin turns white when pressed then returns to pink when pressure is removed) surface. Booties for his heels were requested from supply. An addendum to the 3/11/24 nurse note, documented at 3:24 p.m., revealed during the day the resident developed an unstageable blister to the right heel. The nurse practitioner (NP) assessed and agreed to use the same treatment for both heels. The recommended treatment was skin prep (a skin barrier wipe which creates a thin film on the skin to protect skin by reducing friction) with optifoam (gauze pad) and protective booties while in bed. A Skin Evaluation Form dated 3/11/24 at 3:26 p.m. by a RN revealed a pressure injury to the right heel with an onset date of 3/11/24. The wound was an unstageable blister that measured 3.0 cm by 3.0 cm by 0.0 depth. A nurse note dated 3/12/24 at 2:07 p.m. by a licensed practical nurse (LPN) revealed the resident wore bunny boots (heel protection cushions) to his bilateral feet. The resident had slight edema to his bilateral lower extremities and was also wearing thigh high compression stockings. -The facility failed to implement protective heel booties until after Resident #55 developed the blisters on his heels. A nurse note dated 3/13/24 at 10:56 a.m. by a LPN revealed large fluid filled blisters were noted to bilateral heels that appeared to be from the middle to the lateral (outer) side. The resident had bunny boots to be worn when not working with therapy. The optifoam was removed, skin prep was applied and new optifoam was applied. Facility supply was working on getting a new recliner for the resident so he could elevate his legs. A nurse note dated 3/15/24 at 11:44 a.m. by a RN revealed large blisters on both heels. Skin prep and a dressing were applied. The resident had booties on with compression hose. An air mattress overlay was placed on his bed to help prevent skin breakdown. A recliner was ordered so that the resident could recline with his feet up. -The facility failed to implement the mattress overlay until four days after the blisters on the resident's heels were first noted. A nurse note dated 3/16/24 at 9:29 a.m. by a RN revealed the resident had slight edema to his legs and compression stockings were in place. The dressings to his heels were clean, dry and intact. The resident had booties in place and an air mattress (overlay) on his bed to help prevent skin breakdown. A nurse note dated 3/17/24 at 3:20 p.m. by a RN revealed a right heel blister had opened with drainage on a pillowcase. The left heel blister was intact. The dressings were changed as ordered and the resident was concerned about the blisters/wounds on his heels. The right foot looked swollen and the compression stockings were not on. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A nurse note dated 3/18/24 at 10:54 a.m. by a RN revealed no edema was noted to the resident's legs and his legs were elevated on a stack of pillows and the heels were floated. The dressings were clean, dry and intact to bilateral heel blisters. The bunny boots were off due to bruising to the tops of his feet. His bed had an air overlay in place to relieve pressure. A nurse note dated 3/18/24 at 10:48 p.m. by a RN revealed the bandage to the left heel was replaced and a seeping (slow leak) of pink fluid was observed from the site. An absorbent pad was placed under his feet and the resident requested his socks be applied before the placement of the bunny boots. A nurse note dated 3/19/24 at 10:01 a.m. by a RN revealed open blisters to bilateral heels and the dressings were changed. A physician assessed the wounds and new booties were ordered. A new recliner for the resident had arrived and needed to be placed in his room. The resident had low albumin levels and the physician ordered a protein shake in addition to a nutritional supplement. A nurse note dated 3/21/24 at 2:37 p.m. by a LPN revealed the resident's left heel was hurting during a walk to the bathroom with therapy staff. The dressings to his heels were removed and saturated with drainage. The heel wounds were slightly macerated (soft with breaking down of skin due to prolonged exposure to moisture). The heels were cleaned and dried. Skin prep was applied to the periwound and to the wound areas. Calcium alginate was applied to the wound bed and covered with optifoam. Two optifoams were used on the left heel because the wound was too big. Larger heel dressings and blue offloading air boots were requested from facility supply. The resident had a low protein level on his last set of labs and he was now on a nutritional supplement. A nurse note dated 3/21/24 at 11:49 a.m. by a LPN revealed requested offloading blue air boots from supply, as well as bigger heel dressings. A nurse note dated 3/22/24 at 5:11 p.m. by a RN revealed physician orders for vitamin C chewable 500 milligrams tablets twice a day and zinc 220 milligrams, 50 capsules twice a day for 14 days. Wound care orders were to cover the wound bed and periwound with zinc barrier cream and apply calcium alginate with the alginate cut to fit the wound bed. Cover with silicone bordered foam dressing, wrap with kerlix (gauze) and Coban (wrapping material) to keep in place. The dressings were to be changed twice a week. The resident was to avoid walking until further notice. It was okay for the resident to use the Nu step machine (exercise machine) and use a bike. A nurse note dated 3/22/24 at 10:56 a.m. by a RN revealed wound rounds were completed. The right heel measured 5.6 cm by 6.5 cm by 0.2 cm depth. The left heel measured 6.0 cm by 8.0 cm by 0.2 cm depth. Large serous (pale yellow watery fluid) drainage from both heels that were boggy (soft and watery). Both heels were debrided (removal of dead or unhealthy tissue) and the dressings were to be changed three times a week. The resident was to remain off his heels as much as possible. A Skin Evaluation Form dated 3/22/24 at 11:06 a.m. by a RN revealed a pressure injury to the right heel with an onset date of 3/11/24. The right heel measured 5.6 cm by 6.5 cm by 0.2 cm depth. The wound was an unstageable opened blister that was boggy. There was a large amount of serous exudate and the wound tissue was 50% slough (yellow/white material of dead cells in a wound bed). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A Skin Evaluation Form dated 3/22/24 at 11:12 a.m. by a RN revealed a pressure injury to the left heel with an onset date of 3/11/24. The left heel measured 6.0 cm by 8.0 cm by 0.2 cm depth. The wound was an unstageable opened blister that was boggy. There was serous exudate and the wound tissue was slough. A nurse note dated 3/23/24 at 12:37 p.m. by a RN revealed dressings were clean, dry and intact to bilateral feet. No edema was noted in the resident's ankles but he had slight edema in his feet below the Coban wrapping. The resident said, I am off the heels. A nurse note dated 3/25/24 at 4:29 p.m. by a RN revealed the resident sat in a recliner in his room with his feet off the end of the recliner footpad with booties on his heels. The resident said just in case I forget to put my feet up. The dressings were changed to his bilateral heels and a small amount of drainage was observed to the dressings when removed. The dressings for both heels required rolled gauze around the feet so there was a cushion from the protective bootstraps. A nurse note dated 3/26/24 at 3:54 p.m. by a LPN revealed the resident continued to have wounds to his bilateral heels. The resident was seated in a recliner with his feet elevated and floated off the edge of the recliner. He had bunny boots on both feet and his feet were warm with normal color. The resident was accepting the protein shakes and nutritional supplement. The resident said his heels did hurt at times. No edema was observed. A nurse note dated 3/27/24 at 11:40 a.m. by a RN revealed no edema was observed. The resident reported pain in his heels. Wound care was completed. The wounds were smelly with black necrotic (dead cells) tissue on both heels. The right heel measured 4.5 cm by 5.5 cm by 0.1 cm depth. The left heel measured 4.9 cm x 5.0 cm by 0.3 cm depth. There was a new order for skin prep, silver alginate, optifoam with silver and rolled gauze with kerlix to be changed daily. A referral was made to (physician's name) for possible surgical debridement. The referred provider wanted the resident to have restrictions on walking on his heels. A Skin Evaluation Form dated 3/27/24 at 11:54 a.m. by a RN revealed a pressure injury to the left heel with an onset date of 3/11/24. The left heel measured 4.9 cm by 5.0 cm by 0.3 cm depth. The wound was unstageable with black tissue. There was serous exudate and the wound tissue was necrotic/eschar (dry dead tissue in a wound). A Skin Evaluation Form dated 3/27/24 at 11:56 a.m. by a RN revealed a pressure injury to the right heel with an onset date of 3/11/24. The right heel measured 4.5 cm by 5.5 cm by 0.1 cm depth. The wound was unstageable with black necrotic tissue. There was serous exudate and the wound tissue was 100% eschar. A nurse note dated 3/27/24 at 4:18 p.m. by a RN revealed the writer received physician's orders to send the resident out to the hospital for deep tissue concerns to the bilateral heels. The resident was sent out by a transport service at 3:58 p.m. via stretcher to the hospital. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A physician's assistant (PA) note dated 3/27/24 at 8:12 p.m. revealed a deep tissue injury (unstageable) to the right heel measuring 4.5 cm by 5.0 cm by 0.1 cm depth. There was no undermining (space that occurs under the wound's edges as tissue erodes) or tunneling (a channel that has opened underneath the skin). There was a large amount of sero-serosanguinous exudate with slough and a foul odor. There was 90% firmly adherent slough and dark purple necrotic tissue with 10% granulated tissue. Last week's measurement was 5.6 cm by 6.5 cm by 0.2 cm depth. The left heel was a deep tissue injury (unstageable) with no undermining or tunneling. There was a large amount of sero-serosanguinous exudate with slough and a foul odor. There was 80% firmly adherent slough with 20% beefy red granulation tissue. The previous week's measurement was 5.0 cm by 8.0 cm by 0.2 cm depth. Both heels were debrided on 3/22/24. The resident was very edematous when the wounds were started and now the edema was controlled. The procedures performed were Sharps debridement (use of forceps, scissors or scalpel to remove devitalized tissue, foreign material or debris from a wound) attempted to remove slough, but nearly all was firmly adhered. An attempt was made to probe to find viable tissue, but the necrosis was too deep and extensive. The resident was in pain and did not tolerate the procedure very well. Very little of the slough was removed due to the resident's pain and the severity of the tissue necrosis. A Hospital History and Physical dated 3/27/24 at 7:20 p.m. revealed a chief complaint of bilateral heel pain. The resident presented with bilateral pressure injuries on his heels. The wounds present with eschar and necrosis. The wounds would need Sharp debridement in the morning. The resident also presented with severe life threatening conditions including pressure injuries that required close monitoring and complex decision-making. It appeared the resident had very limited mobility since his most recent surgery and despite attempts to be more mobile and offloading his heels, the resident had developed bilateral heel wounds associated with significant pain. A Hospital Assessment and Plan dated 4/1/24 at 9:39 p.m. revealed full thickness necrotic pressure ulcers of bilateral heels due to pressure injuries suffered after a hip fracture and fixation (surgical repair). It did not appear there was any arterial compromise to the wounds to complicate the healing, and there was significant tissue space to recover. The relevant laboratory findings, dated 3/28/24, revealed 3+ Proteus mirabilis (A) and Rare Staphylococcus aureus (A). The Proteus isolates (bacterial organisms) from the debrided necrotic tissue did not guarantee or clearly imply direct pathogenicity. The local isolates would be considered when choosing the covering antibiotics during the preoperative and post-operative period. The resident complained of heel pain when his legs were moved dependently. The wounds initially came from pressure ulcerations after he had a hip fracture that required hospitalization and surgical stabilization. He had significant debridement of both necrotic heels on 3/28/24 (during hospitalization) that required debridement down to the bone. The resident was currently tolerating the ampicillin/sulbactam (antibiotics). IV. Staff interviews The DON and the assistant director of nursing (ADON) were interviewed on 4/15/24 at 3:30 p.m. The DON said the resident was admitted to the facility on [DATE] and the admission skin assessment did not reveal the resident had any skin issues with his heels. The DON said the resident was ambulatory and liked to wear slippers. She said during the last two days in the facility, the resident only walked to the bathroom. The DON said on 3/11/24 (after the resident developed the wounds) an air mattress overlay was placed on the resident's mattress. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The DON said the 3/11/24 nurse note revealed the resident had a blister to his right heel and a purple blister to his left heel. From 3/11/24 at 11:54 a.m. to 3:30 p.m. the right heel went from a blister to an unstageable (fluid filled) pressure ulcer. The DON said bunny boots were put in place on 3/11/24. His heels were also floated on pillows at times. They agreed on measurements in the clinical record that were taken by a physician assistant (PA) that had wound certifications. They said the resident never refused any treatments, never refused to offload his heels and was compliant with interventions such as wearing the bunny boots. The DON said the facility thought the resident's heel pressure ulcers might be due to the resident digging his heels into the carpet to engage his chair recliner into the reclining position. The facility purchased a new electric recliner to remedy the action and to help him to be able to elevate his feet easier. She said the facility ordered the resident a special set of boots (more padding past the ankle and up to the calf) for the resident two days before he left the facility. The resident was provided with protein smoothies and a nutritional supplement. The DON said the resident was sent to the hospital on 3/27/24 at 4:00 p.m. using non-emergent transportation due to the fast progression of his bilateral heel pressure ulcers. The PA at the facility had recommended the resident be assessed by a wound physician, however the next available appointment was not until 4/17/24. The resident's family was okay with waiting until that date, but the PA spoke with the family and the resident's son, who was a physician, and they were in agreement to send the resident to the hospital. The PA called the hospital and provided a detailed report on the resident's wounds. The DON and registered nurse (RN) #2 were interviewed on 4/16/243 at 9:00 a.m. RN #2 said she did the resident's admission assessment and he had no skin issues on his heels. The DON and RN #2 agreed the resident was observed, on 3/11/24, to have blisters on his heels. RN #2 said a PA assessed and measured the resident's bilateral heel wounds on three separate dates. RN #2 said on 3/11/24 (after the development of the wounds) the resident had facility bunny boots applied to both heels. The facility ordered a specialty set of bunny boots on 3/19/24 and they arrived at the facility on 3/26/24. RN #2 said the resident's room recliner was too short for him and the facility purchased a new recliner for the resident. The new recliner was electric and kept the resident from digging his heels into the floor to push back in the recliner. She said the resident had a standard mattress and an air overlay was placed on his mattress. She said he did ambulate in the facility while wearing his own shoes. She said the only time he did not ambulate was when the PA did not want him to make his heel worse by walking. She said the PA debrided both heels only once at the facility and he was not seen by another wound physician. She said that he was sent to the hospital because the PA wanted the heels to be debrided better. She said the pressure wounds were unstageable and had a foul odor when he went to the hospital. They both said they were unsure how the pressure ulcers started. V. Physician letter The facility sent a typed/signed physician letter dated 4/16/24 at 5:11 p.m. (after the survey exit date). The letter revealed the resident had bilateral heel blisters with acute and rapid onset due to comorbidities of poor cardiac perfusion, and frailty, recent hip fracture with surgical repair and malnutrition per labs. The blisters escalated to pressure wounds quickly despite close monitoring, intervention with wound care and nutritional supplementation. This was unavoidable despite close monitoring, and rapid and appropriate interventions including wound care by a wound specialist, off-loading, and nutritional supplementation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Frasier Meadows Health Care Center	4950 Thunderbird Dr Boulder, CO 80303

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	-However, the facility failed to implement appropriate interventions, such as heel booties or a specialty mattress to offload Resident #31's heels, until after Resident #31 developed the bilateral heel wounds. -Additionally, the facility failed to have the physician document the wounds were unavoidable until after the survey exit.