STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065267	A. Building B. Wing	12/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winding Trails Post Acute	2800 Palo Pkwy Boulder, CO 80301

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** 41172 Based on observations, record review, and interviews, the facility failed to provide care and services to prevent the development and worsening of pressure injuries for one (#1) of four residents reviewed out of eight sample residents. Specifically, the facility failed to identify, six deep tissue pressure injuries (DTPI), a pressure injury to Resident #1's penis from an indwelling catheter, a perianal wound, and a skin tear, which were only identified by the hospital staff once the resident was discharged to the hospital. The facility also failed to complete routine skin audits, and therefore did not identify and treat the six DTPI's and three additional wound injuries. Additionally, the facility knew the resident was at risk for skin breakdown. Resident #1 had an existing, facility acquired, chronic stage four pressure injury to his left inner ankle, and a new unstageable pressure injury to his outer ankle. Despite the facilities knowledge of the two existing wounds to Resident #1's left ankle, the facility failed to monitor Resident #1 for further skin breakdown, and therefore failed to implement treatment and further preventive measures for an additional eight areas of skin breakdown and one skin tear. Findings include: I. Professional reference According to the National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline, [NAME] Haesler (Ed.), Cambridge Media: [NAME] Park, Western Australia; 2014, retrieved from https://www.ehob.com/media/,d+[DATE]/prevention-and-treatment-of-pressure-ulcers-clinical-practice-guidline.pdf on [DATE], pressure ulcer classification is as follows: Category/Stage I: Nonblanchable Erythema Intact skin with non-blanchable 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 I may be difficult to detect in individuals with dark skin tones. May indicate at risk individuals (a heralding sign of risk). Category/Stage II: Partial Thickness Skin Loss (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	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. Bruising indicates suspected deep tissue injury. Category/Stage III: 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 III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable. Category/Stage IV: 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 IV 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 IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as ' the body's natural (biological) cover ' and should not be removed. Suspected Deep Tissue Injury: Depth Unknown Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. (continued on next page)

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(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	According to the National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline, [NAME] Haesler (Ed.), Cambridge Media: [NAME] Park, Western Australia; 2014, from https://www.ehob.com/media/,d+[DATE]/prevention-and-treatment-of-pressure-ulcers-clinical-practice-guidline.pdf ([DATE]), Skin assessment is crucial in pressure ulcer prevention because skin status is identified as a significant risk factor for pressure ulcer development. The skin can serve as an indicator of early pressure damage. Skin and tissue assessment underpins the selection and evaluation of appropriate preventive interventions. II. Facility policy and procedure The Pressure Injury Prevention Pathway, revised 2013, was received from the nursing home administrator (NHA) on [DATE] at 11:27 a.m. The policy documented in pertinent part, If a pressure ulcer is identified .a comprehensive evaluation is completed and documented in the patient's clinical record .Daily skin evaluations are completed by the licensed nurse for any patient with a pressure ulcer. Weekly skin evaluations are completed by the licensed nurse for any other patient. Current or healed pressure ulcers-daily body audit. Skin evaluations are documented in the clinical record. III. Resident #1 A. Resident status Resident #1, age 77, was admitted on [DATE], and readmitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included pressure ulcer of the left ankle, and multiple sclerosis. The [DATE] minimum data set (MDS) assessment revealed a brief interview for mental status (BIMS) was not completed. On [DATE] at 10:10 p.m., a nurses note documented he was alert and oriented times four, and able to make his needs known. The MDS assessment further documented, Resident #1 required extensive two person assistance with bed mobility, transfers, dressing, and toileting. He required extensive one person assistance with personal hygiene. Resident #1 was at risk of pressure injuries, and had one stage three pressure injury. The assessment documented he had no other wounds or injuries. B. Record review and interviews On [DATE] at 7:17 p.m., the nurses notes documented in pertinent part, that Resident #1 had a scab to his left ankle with redness around it. The family and physician were notified. -The size or cause of the scab were not documented. The nurses notes on [DATE] at 5:48 a.m. documented in pertinent part, inner ankle have a small area with eschar. On [DATE], the nurses notes documented Resident #1's skin was dry and intact. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE] the wound physician (WP) #1 documented, the wound to the left inner ankle was unstageable pressure injury, obscured full thickness skin and tissue loss .1.2 c.m. by 1.2 c.m., no depth, small amount of yellow drainage, wound bed 100% slough (dead tissue). The wound was debrided and had the same measurements, but with a depth of 0.1 c.m., subcutaneous tissue was removed. Alternating pressure mattress in place, offloading and nutritional supplements . Healing is expected to be delayed due to identified impaired mobility, incontinence, and the inevitable effect of aging. -It is unclear from the documentation if this is when the wound was classified as a stage three pressure injury. The WP records over the next seven months, until [DATE] were reviewed. The inner left ankle wound remained about the same, stage three, with measurements of 2.0 c.m. to 2.8 c.m.long, to 2.5 to 3 c.m. wide, with a depth of 0.1 c.m. The last measurements of the left inner ankle wound documented, by WP #2, on [DATE], stage three, 2.0 c.m. by 2.5 c.m. by 0.1 c.m. On [DATE] at 2:00 p.m.the nurses notes documented in pertinent part open area to outer ankle, measures 1. 8 c.m x 1.8 c.m., scanty amount of serous and sluggish tissue noted .reported burning pain when pressure on affected area, called physician and got order for treatment . Resident said he will inform his daughter and son. -There was no documentation of the outer ankle wound on the wound physician report on [DATE]. The nurse practitioner (NP) documented on [DATE] at 1:38 p.m. in pertinent part, inner ankle wound approx. 2.5 c.m., periwound pink (sic), good viable tissue, inner wound with culture today. Right lower extremity (RLE) with ,d+[DATE]+ weeping edema .history of edema and poor circulation. -There was no documentation of an outer left ankle wound. The Braden skin risk assessment, dated [DATE], was reviewed. The resident was documented at risk for skin breakdown due to occasional moisture, chairfast, and friction and shearing. The [DATE] physician orders were reviewed. Resident #1 had the following orders: -Foley catheter care every shift, ordered [DATE]; -Bilateral prevalor boots while in bed every shift, dated [DATE]; -Nystatin Cream 100000UNIT/GM apply to L foot topically, dated [DATE]; -Body audit every week, every day shift, fridays, ordered [DATE]; -Triamcinolone AcetonideCream 0.1 %, Apply to flank, back, shoulders, daily at bedtime, ordered [DATE]; -Wound Care: Left Inner ankle pressure stage three: Cleanse with NS (normal saline), pat dry, apply collagen, ag alginate to wound bed, cover with foam dressing, change every other day and prn (as needed), ordered [DATE]; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Wound care to left outer ankle wound: Clean with NS and pat dry, apply calcium alginate and cover with border dressing, change daily, ordered [DATE]; and, -Wound team consult for left outer ankle wound, ordered [DATE]. -There was no documentation in the progress notes or the physician's orders for [DATE], for the other nine pressure injuries and skin wounds as documented by the hospital on [DATE]. Resident #1's risk for alteration in skin integrity care plan, initiated [DATE], six months after the development of the inner ankle wound, documented in pertinent part, At risk for alteration in skin integrity related to: impaired mobility, MS (multiple sclerosis), use of motorized wheelchair in his room and hallways. Resident with open area to left inner ankle. Resident likes sitting outside in in court yard in hot weather, decrease/minimize skin breakdown risks, administer treatment per physician orders, diet and supplements per physician order, elevate heels as able, encourage fluids, encourage to reposition as needed; use assistive devices as needed, observe skin condition with ADL(activities of daily living)care daily; report abnormalities, offer and apply sunscreen when outside in hot, sunny weather, pressure redistributing device on bed, prevalor boots bilateral feet when in bed, if resident allows, provide preventative skin care routine and prn (as needed), use pillows/positioning devices as needed. Resident #1 had a second care plan which documented, Resident has pressure ulcer to inner left ankle related to immobility, initiated [DATE], six months after the wound to the inner ankle developed. It documented in pertinent part, administer treatment per physician orders, APM (alternating pressure mattress), friction reducing transfer surface, incontinence management, pain evaluation prior to treatment, repositioning during ADLs, skin barrier. Resident #1 had a third care plan related to the wound on the outer ankle, titled, Open area at left outer ankle related to: stage three pressure injury, initiated [DATE]. It documented in pertinent part, administer treatment per physician orders, diet and supplements per physician orders, elevate heels as able, encourage and assist as needed to turn and reposition; use assistive devices as needed, pressure reducing surface on bed and wheelchair, prevalor boots in bed bilaterally. On [DATE] at 12:22 a.m., Resident #1 was sent to the hospital with a low blood pressure of ,d+[DATE] and , d+[DATE]. The hospital admission record, titled, Wound Care Consult, dated [DATE] at 12:39 p.m. was reviewed. The following wounds were documented as present on admission to the hospital [DATE]: Left Medial (inner) Malleolus (ankle), Stage 4 Present on Admission (POA), measured 2.5 c.m. (length) by 3. 5 c.m. (centimeters) (width), no depth, black eschar (dead tissue) necrotic, periwound (tissue on wound edges) edematous (swelling), erythematous (reddening), hyperkeratosis (rough), peeling skin; -Left lateral (outer) malleolus, unstageable pressure injury, POA, measured 1.5 c.m. by 3 c.m., no depth, back, eschar, necrotic, periwound edematous, erythematous, hyperkeratosis, peeling skin; -Left heel deep tissue pressure injury (DTPI), POA, measured 0.8 c.m. by 1 c.m. blister intact, periwound edematous, erythematous, hyperkeratosis, peeling skin; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Left lateral heel DTPI POA, 2 c.m. by 1.5 c.m., burgundy blister, periwound edematous, erythematous; -Left hip DTPI POA, 1.5 c.m. by 0.5 c.m., black, burgundy, non-blanching (persistent redness with applied pressure), red, intact. -Left first distal Toe, DTPI POA, 0.2 c.m. by 0.2 c.m., blister, burgundy, intact; -Left lateral first metatarsal head (toe), DTPI POA, 0.5 c.m. by 1 c.m., burgundy, red: -Right lower Back DTPI POA 11c.m. by 1 c.m., burgundy, intact red, non blanching; -Distal penis, device related (foley catheter) mucosal pressure injury, POA, 0.5 c.m. by 0.5 c.m., mucosal, full thickness, black, periwound edematous, erythematous foley catheter in place, due to the hypospadias (opening on underside of penis), the catheter moves around in the meatus causing friction and partial thickness wounds and a mucosal pressure injury from the catheter. The wound is draining moderate amounts of purulent (thick, miky) drainage, the scrotum is denuded from the drainage from the meatus wound; -Right peri-anal wound, 0.6 c.m. by 0.6 c.m., no depth, black and pink and red. Wound is mostly intact and black with a small partial thickness opening. Etiology of the wound is unknown. -Skin tear to right shoulder, POA, 2 c.m. by 2.5 c.m. by 0.2 c.m. deep, dry, pink, partial thickness; -Wound team plan, initiating offloading measures, debridement of unstageable wounds, moist wound healing and moisture management of peri-anal wound and scrotum. The facility body audits (skin audits) for July, August and [DATE] were reviewed on the treatment administration record (TAR). The ,d+[DATE], ,d+[DATE], and [DATE] body audit were signed off the TAR with a number nine. The TAR legend was reviewed. The legend documented a number nine indicated to see nurses notes. The nurses notes were reviewed for ,d+[DATE], ,d+[DATE] and [DATE]. -There was no documentation regarding the resident's skin for these dates. There was no documented assessment of the resident's skin, head to toe, since [DATE], three weeks preceding his hospitalization on [DATE], when nine new wounds were found by the hospital. Additionally, the body audits were scheduled for weekly, not daily, as indicated in the facility policy for a resident with current pressure injuries. IV. Interviews (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #1's family member was interviewed on [DATE] at 10:09 a.m., via telephone. He said Resident #1's first wound on his inner ankle developed from rubbing on the electric wheelchair according to his nurse in 2020. The family member said it was a bruise at first. He said the nurse told him Resident #1 had the same socks on for two days and when they were removed the bruise had become a wound. The family member said that wound never did heal. The family member said Resident #1 went to the hospital [DATE] with urosepsis and concerns with his catheter. He said at that time the hospital documented only the one wound to the left inner ankle. The family member said on [DATE], Resident #1 was put in isolation, by the facility, for a fever. He said Resident #1 was in isolation for three days or so. During that time, the family member said Resident #1 would text him with concerns that the facility was not repositioning him. The family said Resident #1 went to the hospital again on [DATE], at that time, the hospital assessed him and he had the two left ankle wounds, and nine additional wounds that the family was unaware of. The family member said Resident #1 was discharged from the facility to another long term care facility, where he later died of sepsis due to his wounds. V. Interviews and record review The interim director of nursing (IDON) was interviewed on [DATE] at 2:22 p.m. She said she was only aware of the two wounds Resident #1 had on his left ankle. She was not aware of the wounds listed above discovered by the hospital. She looked at her laptop computer and reviewed the residents body audits for August and [DATE] on the TAR and in the nursing progress notes. She said there was no documentation in the progress notes for the body audits on [DATE], [DATE], and [DATE]. She said there should have been a nurse note if they had done a head to toe body check. The IDON said the last skin assessment looked like it was on [DATE]. The IDON said because the skin assessments were not completed, that must be how the facility missed the additional wounds noted at the hospital on [DATE]. The IDON said the body checks include a head to toe skin assessment and should have been documented in the progress notes. She said the note should describe any wound, bruising or redness. The area should be measured and described in terms of color, odor and drainage. The IDON said if it was a new wound the physician should have been notified for orders and the responsible party. The IDON said the resident would then be out on alert charting. She said the unit manager or IDON would then review the alert charting to see if there were new identified wounds. She said there was no alert charting for the additional wounds discovered at the hospital for Resident #1. She said the primary physician could refer a resident to the wound physician, or the nursing staff can review a resident if for example a wound is not healing after two weeks. The IDON said the wound physician visits weekly. She said there was no facility wound nurse. The IDON said, one of the nurses would do rounds with the wound physician. She said the wound physician looked at only wounds identified by the facility, and did not do a head to toe skin assessment. The IDON said she did not know how the wound to the resident's left inner ankle began on [DATE], or how the wound to the outer ankle began on [DATE]. She said she would investigate. Certified nurse aide (CNA) #2 was interviewed on [DATE] at 9:00 a.m. She said she remembered Resident #1, but did not know how he got the wound on his left ankle. She said he only had one wound to the inner ankle. CNA #2 said he was on an air mattress and we used to put a pillow between his legs because they were contracted and blue boots on him. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Licensed practical nurse (LPN) #1 was interviewed on [DATE] at 9:05 a.m. She said she remembered Resident #1. She said Resident #1 only had one wound that she knew of to the left inner ankle. She said she did not know how he got it. LPN #1 said Resident #1 would call the staff when he needed to be repositioned. She said he was also on an air mattress and wore pressure relieving boots. Licensed practical nurse (LPN) #2 was interviewed on [DATE] at 10:44 a.m. She said skin or body audits should be done weekly. She said a head to toe assessment of the skin is done. She said the nurse should have then signed it off the TAR and documented a note in the progress notes describing the skin, even if there were no concerns. She said if there were a new wound or a concern with an existing wound, the nurse should have written it on the alert charting board and notified the physician and responsible party. She said the nurse should have described the wounds in the progress notes including size, shape, color drainage and odor. Additionally, she said, the CNA, when they are giving a shower or bath, should fill out a skin sheet to document any skin concerns and give it to the nurse. Resident #1's CNA skin sheets for all showers and baths in August and [DATE] were requested from the IDON on [DATE] at 10:00 a.m. At 12:08 p.m. the IDON provided a document titled Skin Worksheet dated [DATE]. She said that was the only bath skin sheet she had. She said the facility had been using agency staff and therefore they may not have been filled out. She said she could not locate any others. The skin worksheet documented redness and sore to the groin area and left hip, and sore to the left heel. The [DATE] nurses notes were reviewed. There was no documentation related to a sore of the left hip. Wound physician (WP) #2 was interviewed via telephone on [DATE] at 11:11 a.m. He said Resident #1 had the inner ankle wound for over a year. He said it was a pressure injury, but had not healed due to the resident's arterial insufficiency and end stage MS. The WP #2 said Resident #1 wore boots to relieve pressure, but would frequently refuse the boots. He said due to his poor circulation he did not expect the wound to heal and thought it was unavoidable due to his arterial insufficiency and his fragile skin. He said he anticipated Resident #1's skin would break down really quick. WP #2 did not know if the resident had ever had any vascular studies done. WP #2 said he was not aware of any other wounds to Resident #1. The IDON was interviewed again on [DATE] at 11:15 a.m. She said the wound to the left inner ankle was classified as a stage 3 according to WP after it was debrided on [DATE]. -However, this was not documented. She did not have any vascular studies, except for a doppler study done on [DATE] of the left lower extremity to rule out a clot. The results were provided by the IDON. The document titled, Radiology Report, dated , d+[DATE], documented in pertinent part, negative exam, no deep vein thrombosis involving the left lower extremity veins. Additionally, the IDON said there was no investigation of the initial inner left ankle scab that occured on [DATE]. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The NP was interviewed on [DATE] at 11:24 a.m. She said Resident #1 had poor circulation and end stage MS. She said she did not anticipate his left inner ankle wound would heal and was most likely unavoidable. The NP said he had a newer wound to his left outer ankle. She said Resident #1 was alert and oriented and very involved in his own care. She did not know how the ankle wounds occurred. The NP said she was not aware of any further wounds as observed and documented by the hospital on [DATE]. She said he had pressure relieving interventions in place, and he wore bunny boots when she saw him. The NP looked at her laptop and said she did not see any vascular studies for Resident #1 in her records.