STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065198	A. Building B. Wing	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens, The	104 Lois LN Colorado Springs, CO 80904

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 - Minimal harm or potential for 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** 47351 Based on observations, interviews, and record review, the facility failed to ensure residents received care consistent with professional standards of practice to prevent the development and worsening of pressure injuries for one (#14) resident reviewed for pressure injuries out of 25 sample residents. Specifically, the facility failed to ensure interventions for Resident #14's pressure injury were consistently implemented. Findings include: I. Professional reference According to the National Pressure Injury Advisory Panel, Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA: 2019, retrieved from https://www.internationalguideline.com/guideline on 12/1/23. Pressure ulcer classification is as follows: 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)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Risk Factors and Risk Assessment -Consider individuals with limited mobility, limited activity and a high potential for friction and shear to be at risk of pressure injuries; -Consider individuals with a Category/Stage 1 pressure injury to be at risk of developing a Category/Stage 2 or greater pressure injury; -Conduct a pressure injury risk screening as soon as possible after admission to the care service and periodically thereafter to identify individuals at risk of developing pressure injuries; and, -When conducting a pressure injury risks assessment: Use a structured approach; Include a comprehensive skin assessment; Supplement use of a risk assessment tool with assessment of additional risk factors; Interpret the assessment outcomes using clinical judgment. Skin and Tissue assessment -Assess the pressure injury initially and as soon as possible after admission/transfer to the healthcare service; -Re-assess at least weekly to monitor progress toward healing; -Assess the physical characteristics of the wound bed and the surrounding skin and soft tissue at each pressure injury assessment; and, -Monitor the pressure injury healing progress. Support Surfaces For individuals with a pressure injury, consider changing to a specialty support surface when the individual: Cannot be positioned off the existing pressure injury. Support surfaces are specialized devices for pressure redistribution and management of tissue load and microclimate. The importance of using a high specification pressure redistribution support surface in all individuals at risk of pressure ulcers or with existing pressure ulcers is highlighted. II. Facility policy and procedures The Skin Management policy, dated June 2022, was provided by the director of nursing (DON) on 12/4/24 at 1:05 p.m. The policy read in pertinent part: Residents receive care to aid in the prevention or worsening of wounds and/or pressure ulcers. Individuals at risk for skin compromise are identified, assessed, and provided treatment to promote healing, prevent infection, and prevent new pressure injuries from developing. Ongoing monitoring and evaluation are provided for optimal resident outcomes. III. Resident #14 A. Resident status (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #14, under the age of 65, was admitted on [DATE]. According to the computerized physician orders (CPO), the diagnoses included sepsis (infection) of right knee with unspecified organism, effusion (fluid accumulation) right knee, unilateral osteoarthritis right knee, unspecified severe protein calorie malnutrition and pressure induced deep tissue damage of left heel, right heel and right buttock. The 11/7/23 minimum data set (MDS) assessment revealed the resident had intact cognition with a brief interview for mental status (BIMS) score of thirteen out of 15. The resident required partial/moderate assistance with activities of daily living (ADL) from staff members for bed mobility, positioning, and transfers (toileting not assessed due to medical condition). The resident was at risk for the development of pressure injuries and had two unstageable pressure injuries. B. Resident interview Resident #14 was interviewed on 11/29/23 at 4:38 p.m. The resident said he developed the wounds to his heels and buttock due to lying in bed too long. The resident said he was hospitalized prior to admission to the facility due to an infection in his right knee. The resident said the right knee was extremely painful and he could not roll left to right and could not extend or straighten his leg due to the pain. The resident said he could not walk, had trouble putting pressure on the right leg and tried to extend the knee but could not. The resident said the hospital doctors drained a lot of red/yellowish fluid from the knee and he had to take antibiotics for six weeks. The resident said staff come in to check on him but don't know how often, staff tried to reposition him but it was too painful. The heel protectors did not stay in place because he used his feet to raise himself in bed to eat and drink. C. Resident observations On 11/29/23 at 2:03 p.m. the resident was covered with a sheet with his lower extremities exposed. The resident has bilateral heel protectors on but both heel protectors were covering his calves, not his heels. On 11/30/23 at 8:04 a.m. the resident had the left heel protector on his left foot, the right heel protector was not positioned correctly on his foot and instead was covering his right calf. There was no pressure reducing or air mattress on the resident's bed. -At 9:40 a.m. registered nurse (RN) #1 entered the resident's room to perform wound care. RN #1 removed the resident s non-skid sock from the right foot and the right heel protector was on the resident's right calf. -At 11:00 a.m. both heel protectors were on the bed and not on his heels. -At 12:51 p.m. there was an air mattress inflating outside the resident's room to replace the resident's mattress. D. Record review (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan last revised on 11/3/23, revealed the resident had potential for skin breakdown and documented the resident admitted with right knee surgical site, open area to right buttocks and deep tissue injury to left heel, deep tissue injury to right heel (11/5/23). The primary goal was the skin will remain intact. Wounds will show signs/symptoms of healing through the next review. Target date 11/26/23. Interventions included applying skin moisturizer/barrier as needed. Check frequently for incontinent episodes and assist with wash, rinse and dry soiled areas and change clothes prn (as needed). CNA (certified nurse aide) to monitor skin daily and licensed nurse to check skin thoroughly on a weekly basis. Encourage adequate fluid and nutritional intake. Encourage/assist with turning and positioning frequently. Heel boot while in bed. Pressure reducing mattress on bed. Report any changes or abnormalities in skin to the charge nurse/MD (medical doctor) immediately. Treatment as ordered. Wound doctor to follow. The 11/1/23 Braden scale assessment (scale for predicting pressure injury risk) documented the resident was at mild risk (lower probability of developing a pressure injury, but needs to be managed with routine procedures as a preventative measure) for developing a pressure injury. The assessment revealed the resident had no sensory perception impairment, was rarely moist, his mobility was slightly limited and his nutrition was adequate. The resident required moderate to maximum assistance with repositioning, therefore, required a lift to avoid sliding against the bed sheets. Scoring: 17.0 or at lower risk for the development of pressure ulcers. Nursing note dated 11/4/23 During wound care intact deep tissue injury noted to the right heel. Skin prep applied, heel floated, and heel boot applied. Resident did not report pain during examination to right heel. Director of Nursing aware. Writer placed a call to the resident's power of attorney, unable to leave a message, voice messaging not set-up. The Head to Toe Skin Check dated 11/5/23 documented that the resident did not refuse a skin check. The resident had existing bruises, existing pressure ulcers to his upper buttocks, a left heel deep tissue injury, a right knee status post surgical incision that was well approximated a left knee abrasion, scabbed areas all over body in various stages of healing due to recent recovery from scabies and lice. Interdisciplinary team (IDT) note dated 11/7/23 documented the IDT met and reviewed new skin issues related to the right heel. Place heel boot to float right heel. On 11/7/23 at 3:32 p.m. a skin/wound note documented the resident refused to be seen by the wound care doctor. The wound care evaluation note dated 11/21/23 written by the wound care physician assistant documented the resident was seen as a new patient for an evaluation of pressure injuries and moisture associated skin damage of the sacrum. Patient had scabies several weeks ago and the hospital cleared him. Patient now states he's been having itching on the left buttock and hip recently. Recommended PCP (primary care physician) evaluation to assess possible Scabie recurrence. The patient is at high risk for new or worsening wounds, recommended continuing off loading measures and floating heels. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified nurse aide (CNA) #1 was interviewed on 11/30/23 at 12:49 p.m. CNA #1 said the resident kept his right knee flexed and could not straighten it without extreme pain. The DON was interviewed on 11/28/23 at 3:35 p.m. The DON said the resident had two wounds. One on the right heel and one on the left heel. The DON said she was unaware of the right buttock wound. The DON said the right heel wound was found on 11/7/23 and heel protectors were recommended at that time. The DON said the left heel wound was pre-existing and occurred prior to his admission to the facility.