STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065223	A. Building B. Wing	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkley Manor Care Center	735 S Locust St Denver, CO 80224

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** 46851 Based on observation, interviews, and record review, the facility failed to assess and monitor an existing pressure injury for one (#50) of seven residents reviewed for wounds out of 32 sample residents and failed to take steps to prevent the resident's development of pressure injuries. Resident #50 who required hands on assisance from staff to complete activities of daily living such as toileting, bed mobility, dressing and personal hygiene and who was at high risk for developing pressure injuries developed facility acquired pressure injury. The resident's pressure injury was first discovered on 4/27/23 and started as a redness spread over the bony part of the resident's left hip. The wound care physician classified the wound as a trauma wound. There was no documentation in the resident's chart to identify what type of trauma caused the wound to develop other than the resident lying on the hip creating skin damage for pressure to the wound site. A note written by the facility's occupational therapist (OT) documented that the pressure injury was discovered on 4/27/23 after the resident had been sitting up in her wheelchair for an extended period. The injury was linked to the resident seating system and position in the wheelchair from the wheelchair components and the cushion putting pressure on the resident's left hip. Following the observation, the OT adjusted the resident's wheelchair seating system and the wound improved by 5/24/23 but emerged again a month later. On 6/28/23 the resident medical record revealed the wound to the resident left hip emerged again as an open wound measuring 1.3 centimeters (cm) in length by 2 cm in width by 2 cm in depth. The wound bed was covered with 100% slough (stringy yellowish dead skin). The facility physical therapist (PT) assessed the resident and recommended the resident lay off of her left side to facilitate wound healing to the left hip. Following this recommendation, the resident developed a pressure injury to the right hip (on 9/4/23). The wound was assessed as an unstageable pressure injury on the resident's right posterior (back) hip with full-thickness of the skin (extending beyond two layers of skin tissue) and tissue loss. The wound measured 0.5 cm in length by 0.7 cm in width with no measurable depth. (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	The PT reassessed the resident's seating system following the progression of the facility acquired pressure injuries and documented that the resident had had an inappropriate wheelchair and positioning program causing poor posture and skin related issues. The assessment documented that the resident required more frequent repositioning assistance to offload pressure from the left him with added side and back laying positions. The assessment documented that the resident had been tolerating the recommended repositioning; however, observations revealed the resident was not being respositioned as recommended (see observations below). The wound care physician (WCP) assessment of the pressure injuries reviewed the WCP believed the wounds were avoidable (see the WCP interview below). Interventions were not implemented consistently and observation of the resident's care revealed a lack of timely repositioning and staff not following the PT's recommendations to assist resident to offload pressure alternating from side to side and back lying on a frequent basis in order to promote healing the left hip wound and improved skin integrity. The facility failed to promote full healing of the wound and failed to prevent the formation of a second wound from worsening. The facility's failure to develop and implement timely and effective interventions led to the development of two unhealed pressure injury wounds one of which caused the resident severe pain. On 11/22/23, the pressure injury to the resident's left hip while healing persisted and measured 0.7 cm, in length by 0.7 cm in width by 0.1 cm in depth. However, the pressure injury wound to the right rear hip, first observed 9/4/23, worsened from intact skin to an unstageable pressure injury measuring 1.2 cm in length by 1.2 cm in width by 0.1cm depth with a build-up of dead tissue and severe pain at the wound site. The wound required surgical debridement to remove dead tissue and progressed to a stage 4 pressure ulcer measured 1.2 cm in length by 1.2 cm that began to spread under the surface of the skin at the wound edges. Findings include: I. Professional reference According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA: 2019, retrieved from https://www.internationalguideline.com/guideline on 12/7/23, 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 (continued on next page)

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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. 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 (dark dead skin) 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. 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 The Skin Integrity and Pressure Ulcer/Injury Prevention and Skin Management policy, reviewed 3/31/23, was provided by the nursing home administrator (NHA) on 11/30/23 at 1:26 p.m. It revealed in pertinent part, Provide associates and licensed nurses with procedures to manage skin integrity, prevent pressure, ulcer injury, complete, wound assessment/documentation, and provide treatment and care of skin and wounds utilizing professional standards of the NPIAP (National Pressure Injury, Advisory Panel) and WOCN (Wound, Ostomy, Continent, Nurse Society). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A comprehensive skin inspection/assessment on admission and readmission to the center may identify pre-existing signs of possible deep tissue damage already present. These signs include purple or very dark areas, surrounded by edema; profound, redness, or induration; bogginess; and or discoloration. These signs possibly indicate an unavoidable stage three or four with slough, drainage, or even eschar within a few days. A risk assessment to Braden Scale, or Norton Scale determines the resident's. Risk of pressure injury development. The score is documented on the tool and placed in the resident's medical record using the appropriate form. Certain risk factors have been identified that increase a resident's susceptibility to develop or impair healing of pressure injuries. Examples include, but are not limited to; impaired/decreased mobility and decreased functional ability. Morbid conditions, such as end-stage, renal disease, thyroid disease, diabetes mellitus, or other end-of-life concerns. Drugs such as steroids that may affect wound healing. Impaired diffuse, or localized blood flow. A patient's refusal of some aspects of care treatment especially in multi-system organ failure, or end-of-life conditions. Exposure of skin to urinary and fecal incontinence. Under nutrition, malnutrition, and hydration deficit, edema and history of a healed injury. Measures to maintain and improve resident's tissue tolerance to pressure and implemented in the plan of care. All residents upon admission are considered to be at risk of pressure injury development due to medical issues requiring nursing care and related disease processes and illness or need for rehabilitation services. Upon admission and throughout stay at minimum distribution surface is in use with her and repositioning as needed with ADL care/assistance in care, if needed to include skin barriers, application as needed, preventative, wheelchair cushions, if indicated, etc. Skin inspections with particular attention to bony prominences. Skin cleansing with appropriate cleanser at the time of swelling and at routine intervals. Minimize skin exposure to incontinence using devices and skin barriers. Minimize injury due to shear friction through proper positioning, transfers, and turning schedules. Encourage PO food and fluid intake and improve residence, mobility and activity when potential exists. Measures to protect the resident against the adverse effect of external mechanical forces, such as pressure friction, and are implemented in the plan of care; reposition, at least every 2 to 4 hours, as consistent with overall patient goal and medical condition. Utilize positioning devices to keep prominences from direct contact and ensure proper body alignment protection/suspension if indicated. A distribution mattress surface is placed under the resident. When positioned in the wheelchair, the resident is to be placed on a pressure reduction device and repositioned. When positioned in a wheelchair consideration is given to postural alignment, distribution, weight, balance, and stability. When skin breakdown occurs, it requires attention and a change in the plan of care may be indicated to treat the resident. III. Resident #50 A. Resident status Resident #50, age 75, was admitted on [DATE]. According to the November 2023 computerized physician orders (CPO), the diagnoses included Parkinson's, dementia with behavioral disturbances and major depressive disorder. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	According to the 11/10/23 minimum data set (MDS) assessment, the resident was cognitively severely impaired and was unable to complete a brief interview for mental status (BIMS). She was dependent on one person with transferring and dressing. She required substantial assistance from one person with toileting, bed mobility, dressing, personal hygiene and eating. The resident was dependent on a wheelchair and needed moderate assistance with locomotion. The resident was at risk for developing pressure ulcers. The resident had unhealed pressure ulcers. The resident had one unstageable pressure ulcer. The pressure ulcers were not present at admission. B. Observations On n 11/27/23 Resident #50 was observed and revealed: -At 9:00 a.m. the resident was in her bed lying on her right side. -At 10:00 a.m. the resident was in her bed lying on her right side. -At 11:58 a.m. the resident was in her bed lying on her right side. On 11/28/23 Resident #50 was observed and revealed: -At 10:26 a.m. the resident was in her bed lying on her right side. -At 10:40 a.m. an unknown CNA went into the Resident #50's room but did not reposition her and the resident remained lying on her right side. -At 12:30 a.m. a unknown CNA went into Resident #50's room to help her roommate, but did not assist Resident #50 with any care. Resident #50 remained on her right side. -At 1:30 p.m. the Resident #50 remained on her right side. On 11/30/23 Resident #50 was observed and revealed: -At 9:00 a.m. the resident was in her wheelchair in the hallway. -At 12:00 p.m. an unknown staff member transported the resident, who was still up in her wheelchair to the dining room for lunch. -At 12:45 p.m. after the resident finished lunch, an unknown staff member transported the resident to her room and transferred her to bed using a hoyer (mechanical) lift. The staff laid her down on her right side. C. Record review According to the Braden scale (a scale to measure risk of developing pressure ulcers) dated 5/11/23 Resident #50 was at mild risk of developing pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	According to the health status note dated 5/1/23 at 11 a.m., the resident had a new skin issue discovered on 4/27/23. The resident had redness spread over her left hip. The registered nurse (RN) on duty cleansed the skin and placed prophylactic (preventative) foam dressing on the left hip. A seating cushion that was previously placed for positioning the resident in the wheelchair was removed and OT had been working with the resident on positioning. OT removed a rigid lateral support (lateral trunk support) and adjusted lateral support so it would not rest on the bony prominence of her hip. According to a care management note dated 5/4/23 OT was discontinued due to the resident meeting all her wheelchair goals. According to the OT discharge summary dated 5/6/23 the resident received therapy between 3/15/23 and 5/6/23. The resident had been assessed by OT due to the resident being at risk for falling out of her wheelchair due to inability to sit up in the chair without leading to the left. The initial intervention for positioning was causing additional rubbing and pressure on the residents left hip. As a part of the assessment and treatment the OT made adjustments to preventing the support from rubbing against the resident's hip. According to an event note dated 6/28/23 the resident had an open area to her left hip on the bony prominence. The affected area had been padded with mepilex dressing for the past four weeks due to non blanchable redness (when the skin is unable to return to a normal pigment when pressed) that developed from using equipment to help her sit upright in her wheelchair. The resident was evaluated by the wound team. According to the wound observation tool dated 6/28/23 the resident acquired a new skin impairment on 6/28/23, on her left hip. The first observation revealed the resident's skin had epithelial tissue (normal healthy skin) present and granulation tissue (beefy red tissue an indicator that skin was healing) the wound had a small amount of serous drainage (normal clear yellow fluid an indicator of a healing wound). The wound measured 1.3 cm in length, 2.2 cm in width and 0.2 cm in depth. According to the wound note dated 7/5/23 the resident's left hip was identified as a trauma wound with a status of not healed. The wound measurements were 1.3 cm in length by 1.9 cm in width with no measurable depth with 100% slough. There was a small amount of serous drainage noted. The physician performed surgical debridement (procedure to remove dead tissue). Post debridement measurements were 1.3 cm in length by 1.9 cm in width by 0.1 cm in depth. According to the wound note dated 7/12/23 the resident had an unhealed left hip trauma wound. The wound measurements were 1.3 cm in length by 2.2 cm in width with no measurable depth.There was a small amount of sero-sanguineous (watery bloody) drainage noted. The wound bed had 95% eschar and 5% slough. There was no change noted in the wound progression. The left hip wound was still developing but not enough to allow for debridement. According to wound notes dated 7/19/23 the resident's left hip trauma wound and had received a status of not healed. The wound measured 1.5 cm length by 2.5 cm in width with no measurable depth. There was a small amount of serous drainage noted. Wound bed had 100% slough. There was no change noted in the wound progression. The wound was surgically debridement; post debridement measurements were 1.5 cm in length by 2.5 cm in width by 0.3 cm in depth. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	According to the PT evaluation and treatment plan dated 7/19/23 the resident had a pressure wound. The resident had poor posture, adverse effects to skin integrity and there was inconsistent use of hoyer lift. The resident's goal was to be able to sit in an upright position and transfer safely in the hoyer lift to decrease further risk of skin trauma. The PT assessment recommended making changes to the resident's wheelchair cushion. According to the wound note dated 8/2/23 the resident's left hip wound measured 1.7 cm in length by 2.4 cm in width with no measurable depth, muscle was exposed. There was a moderate amount of serous drainage noted. Wound bed had 100% slough. The wound was surgically debrided with post debridement measurements of 1.7 cm length by 2.4 cm width by 0.3 cm. According to the August 2023 treatment administration record (TAR) treatment orders included instructions for staff to reposition resident every two hours and ensure offload of the left hip at all times every shift for wound on left hip, ensuring the resident was not laying on left hip until wound was resolved. Order dated 8/2/23 and discontinued 9/24/23. According to the wound note dated 8/9/23 the resident's left hip wound measurements were 2.5 cm in length by 1.3 cm in width with no measurable depth. Muscle was exposed and tunneling (occurs when a chronic wound has progressed to form an opening underneath the surface of the wound's edge) was present at a distance of 1.4 cm. There was a moderate amount of serous drainage noted. Wound bed had 100% slough. The wound was surgically debrided. The post debridement measurements were 2.5 cm in length by 1.3 in cm width by 0.1 cm in depth. According to the PT evaluation and treatment plan dated 8/30/23 the resident's wheelchair was modified but continued to require monitoring for adverse effects. The assessment recommended that the resident be encouraged to lay on her side while in bed to alleviate pressure to aid with left wound healing but this resulted in a non-blanchable redness on the resident's right hip. The resident continued to require education on participants in a rotating program reposition and promote overall skin integrity. According to the comprehensive care plan focus for impaired skin integrity dated 8/24/23 the resident had a trauma injury wound. Interventions included providing treatment as ordered. Weekly skin checks in wound rounds. Air pressure mattress. Clean and dry skin after each incontinent episode. Encourage the residents to wear geri-gloves (non-compression, seamless knit material that contours to the body to protect thin, sensitive skin from tears, abrasions, and light bruising) as tolerated, to avoid skin tears on hands. Staff should make certain nails are trimmed. Added padding to the resident's wheelchair arms. Ensure the resident's hands on her lap when assisting her with ambulation. According to the altered skin integrity care focus dated 9/11/23 interventions included assisting the resident to reposition when in bed off of her back with the use of wedges, as tolerated, to prevent skin breakdown. According to an event note dated 9/4/23, the resident had a non-blanchable wound to the right hip bony prominence. The affected area was maroon in color. The resident had been laying mostly on her right side due to the wound on her left hip. The resident did not like to lay on her back to relieve pressure from both bony prominences. Affected area was cleansed with normal saline, skin prep and covered with mepilex dressing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	According to wound notes dated 9/6/23, the resident developed an unstageable pressure injury on her right posterior hip with full-thickness skin and tissue loss. The pressure ulcer had received a status of not healed. The wound measured 0.5 cm in length by 0.7 cm in width with no measurable depth. The wound bed had 100% epithelialization with obscured full-thickness skin and tissue loss. According to wound note dated 9/6/23 the resident's left hip wound measured 1.2 cm in length by1.5 in cm width by 1 cm in depth with undermining (occurs when significant erosion occurs underneath the outwardly visible wound margins resulting in more extensive damage beneath the skin surface) with a maximum distance of 2.3 cm. According to event note dated on 9/11/23,the resident had a non blanchable wound. The resident was sleeping and resting on an air mattress with order for staff to provide repositioning assistance and wound care treatment and dressing changes. According to the wound observation tool dated 9/13/23 the resident had an unstageable pressure ulcer facility acquired on 9/4/23, on her right hip. The wound was worsening and had slough tissue. The wound measurements were 3.0 cm in length and 5.0 cm in width According to the PT evaluation and treatment plan dated 9/20/23 the resident tolerated the position throughout the day with no adverse effects to the left hip wound. The resident tolerated a rotating positioning program in supine (on back) to promote overall skin integrity. The resident currently had an inappropriate wheelchair and positioning program. The resident needed a smaller wheelchair and to be repositioned more frequently. According to the September 2023 treatment administration record (TAR) treatment orders included instructions for staff to reposition the resident and offload bilateral hip as allowed every shift for skin management order dated 9/24/23 and discontinued 10/19/23. According to the PT discharge summary dated 10/2/23 the resident was discharged with a good seated and supine positioning with no worsening wounds. According to the pressure ulcer care focus dated 11/13/23 the resident had an unstageable pressure ulcer on her right hip. Interventions included administer medications and treatments, as ordered. Provide enhanced barrier precautions. Inform the resident and family of any new skin breakdown. Perform lab and other diagnostic work as ordered, report the results to the medical doctor and follow up as indicated. Observe and report changes in skin status; appearance, color, wound healing, sign of infection, wound size and stage of wound. Serve diet as ordered and monitor intake and record. According to the wound note dated 11/15/23 The resident had an unstageable pressure injury on her right, posterior hip with obscured full-thickness skin and tissue loss and had received a status of not healed. The wound measured 1.2 cm in length by 1.2 cm in width with no measurable depth, with undermining at a distance of 2.6 cm. There was a large amount of serous drainage noted. The patient reports a wound pain of level 0/10. The wound bed had 80%, granulation, 20% slough. The wound was surgically debrided, post debridement measurements were 1.2 cm in length by 1.2 cm in width by 0.1cm depth. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	According to the wound observation tool dated 11/22/23 the resident acquired a skin impairment on her left hip, due to trauma of equipment use on 6/28/23 (seating and transferring devices, see above). The left pressure wound was assessed to have been healing with granulation tissue (beefy red) the wound had serous and scan drainage. measurements were 0.7 cm, in length by 0.7 cm in width by 0.1 cm in depth. According to the wound observation tool dated 11/22/23 the resident had a stage 4 pressure ulcer facility acquired on 9/4/23, on her right hip. The wound was worsening and had granulation and slough tissue . The wound measurements were, 1.2 cm in length and 1.2 cm in width with tunneling. IV. Staff interviews The wound care physician (WCP) was interviewed and observed on 11/29/23 at 1:20 p.m. while performing wound care on Resident #50's left hip. The WCP said the resident was admitted to the facility on [DATE], with a left hip trauma injury. The wound had been unstable. The wound had worsened and was now classified as a stage 4 pressure injury with tunneling and had a large amount of drainage. The WCP said the wound likely had severe colonization and was possibly an infection but he was unable to determine the severity of the infection because he was unable to see the bottom of the wound. The WCP said if the resident acquired the left hip wound at the facility then the wound on her right hip was avoidable. The wound doctor said the resident would not have acquired the right hip wound if she did not have the left wound. The WCP said the resident was positioned on the right hip because it was painful to lay on her left hip. The WCP said the resident should be repositioned supine (on her back) to avoid the wound's progression. The WCP said both wounds were stage 4. Registered nurse (RN) #1 was interviewed on 11/29/23 at 2:20 p.m. RN #1 said the resident's left hip trauma wound developed because the resident would propel herself in her wheelchair and would lean to the left side. RN #1 said the pressure ulcer on the right side developed because the resident was in pain and preferred to only lay on her right side. RN #1 said the resident should be positioned on her back to relieve pressure on both hips. RN #1 said the resident had wedge cushions on her bed to help the resident stay positioned on her back. Certified nursing aide (CNA) #1 was interviewed on 11/30/23 at 8:59 a.m. CNA #1 said if there was a change in skin condition the CNAs would report to the nurse and the nurses would report it to the resident's physician. CNA #1 said residents should be repositioned every two hours. CNA #1 said the residents in the facility should not have pressure ulcers if they were repositioned. CNA #1 said Resident #50 acquired pressure ulcers because she was not repositioned properly. CNA #1 said the resident initially had skin issues due to poor positioning in the wheelchair and because the resident was consistently laying on her left side due to not wanting to face the wall while in bed it made her wounds worse. CNA #1 said the resident's bed was facing the other way so now the resident was willing to lay on her right side. CNA #1 said the resident had bed wedges to keep her laying on her back and off her hips. CNA #1 said the other staff did not reposition the resident correctly; she knew this because she observed the other CNAs position the resident consistently on to her right side because the resident moved around when she was on her back. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065223	A. Building B. Wing	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkley Manor Care Center	735 S Locust St Denver, CO 80224

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	The director of nursing (DON) was interviewed on 11/30/23 at 12:06 p.m. The DON said if a change in the resident's skin was found the CNAs were to notify a nurse and the nurse would notify DON and start the risk management assessment documentation. The DON said residents who could not reposition themselves should be repositioned every two hours. The DON said Resident #50 had first developed a skin tear because she was not seated properly in her wheelchair and was leaning to the left causing friction. The DON said therapy staff put a wedge positioning cushion in place to prevent further skin issues but the resident did not tolerate laying on her back to offload pressure on her hips. The DON said the resident was not eating enough so she was at high risk of pressure ulcers. V. Facility follow-up On 12/1/23, the nursing home administrator (NHA) provided an addendum to the physician's 11/17/23. The addendum note dated 12/1/23 (after exit), documented the wound progress note demonstrates that the wound was unavoidable. The resident was combative during care and repositioning. -The note provided no other rationale about why the wound development was now determined to be unavoidable. Additionally, the WCP said during the interview that the resident's right hip wound was avoidable and would not be there if not for the left wound causing the resident pain and making her reluctant to off load pressure from the right hip and lay on her back.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47064 Based on observations and interviews, the facility failed to ensure all drugs and biologicals were properly stored and labeled in one of two medication storage rooms. Specifically, the facility failed to ensure vaccines and insulins (medications used to regulate blood glucose levels) were not stored in a dormitory style fridge. Findings include: I. Professional reference According to the Vaccine storage and Handling Toolkit retrieved on 11/30/23 from: https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf it revealed in pertinent part Do not store any vaccines in a dormitory-style or bar-style combined refrigerator/freezer unit under any circumstances. These units pose a significant risk of freezing vaccines, even when used for temporary storage. II. Facility policy and procedure The Storage and Expiration Dating of Medication, Biologicals policy, revised 7/21/22, was received from the nursing home administrator (NHA) on 11/30/23 at 12:50 p.m. It revealed in pertinent part, facility should ensure that medications and biologicals were stored at their appropriate temperatures according to the United States Pharmacopeia guidelines for temperature ranges. III. Observation On 11/30/23 at 9:19 a.m. the first floor medication room was observed to have a dormitory style refrigerator used to store vaccines and insulins. -The following insulin medications were stored in the refrigerator: three Trulicity pens, five Lantus pens, one Novolog pen, one insulin emergency kit containing one vial of each Lispro, Humalog, Humulin R and Lantus. -The following vaccines were stored in the refrigerator: eight Influenza quadrivalent 2023-2024 formula vials and 18 Prevnar 20 (vaccine for pneumonia) vials. -The freezer was observed with ice built up in and around the freezer compartment affecting the first shelf of the refrigerator. IV. Staff interviews (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered nurse (RN) #1 was interviewed on 11/29/23 at 9:19 a.m. She said the freezer had a lot of ice built up around it and needed to be cleaned out. RN #1 said she did not believe the medications or vaccines in the refrigerator were compromised by the freezer or the ice build up. RN #1 said it was the responsibility of the night shift nurse to log temperatures and clean the medication refrigerators. The director of nursing (DON) was interviewed on 11/30/23 at 12:27 p.m. She said medication refrigerators were to be cleaned by nursing staff. The DON said medications and vaccines were not to be stored in a dormitory style refrigerator as they could freeze medication. The DON was not aware the first floor medication refrigerator was a dormitory style refrigerator and that it had a large amount of ice built up around the freezer. The infection preventionist (IP) was interviewed on 11/30/23 at 2:03 p.m. He said medications and vaccines should be stored at the manufacturer's recommendations. The IP was unaware there was a dormitory style refrigerator in use for medication/vaccine storage and said it should not be used as it was not good at regulating temperature within the compartment.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48113 Based on observations and staff interviews, the facility failed to provide adequate outside ventilation by means of windows and/or mechanical ventilation. Specifically, the facility failed to ensure the soiled linen laundry room exhaust fan was functional. Findings include: I. Observations An observation of the soiled linen laundry room was completed on 11/30/23 at 10:45 a.m. An exhaust fan was installed in the ceiling of the soiled linen laundry room. The fan was not audible and did not create air movement with the switch turned on. The fan was covered with thick gray and black debris. As a measure of checking the function of the fan, a small square of single ply toilet paper was placed against the vent. The exhaust fan was unable to hold the toilet tissue in place which indicated the fan did not function properly. -Soiled linen odors such as urine were observed during multiple observations in the soiled linen laundry room. The soiled linen laundry room exhaust fan was not functional. II. Staff Interview The environmental tour was conducted with the director of maintenance (DM) and the housekeeping director (HKD) on 11/30/23 at 10:46 a.m. The HKD said the exhaust fan had not worked in the soiled linen laundry room for the past [AGE] years. The DM confirmed the exhaust fan was not functional because he had shut it off from the main breaker three months prior to the survey because it was too loud and therefore he had to turn it back on to demonstrate it was functional during the survey. He said the fan had been serviced recently to ensure it was functional. -The DM attempted to turn on the fan from the main breaker, however, the fan did not turn on. -The DM was unable to provide documentation that the exhaust fan had been previously serviced. The DM said the ventilation fan should be in good working condition to protect staff from foul odors and ensure there was adequate airflow within the room.