STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065153	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Grande Rehabilitation and Healthcare Center	680 E Hospital Dr Cortez, CO 81321

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** Based on record review and interviews, the facility failed to ensure residents received the necessary treatment and services according to professional standards of practice to prevent or heal pressure injuries for one (#1) of three residents reviewed for pressure injuries out of five sample residents. Specifically, the facility failed to implement interventions to prevent the development of a pressure injury for Resident #1. 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 on 4/17/25, Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage) 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 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. The 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/Stage3 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. (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 - Minimal harm or potential for actual harm Residents Affected - Few	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 ulcer 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) on 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 and procedure The Pressure Injuries Overview policy, revised April 2020 was provided by the nursing home administrator (NHA) on 4/10/25 at 5:59 p.m. The policy read in pertinent part, Pressure ulcer/injury refers to localized damage to the skin and or underlining soft tissue, usually over a bony promise or related to a medical or other device. A pressure injury will present as intact skin and maybe painful. A pressure injury will present as an open ulcer, the appearance of which will vary depending on the stage and it may be painful. Pressure injuries occur as a result of intense and or prolonged pressure or pressure combined with a shear. The Prevention of Pressure Injuries policy, revised April 2020, was provided by the NHA on 4/10/25 at 5:59 p.m. According to the policy, staff should review the resident's care plan, identify the pressure injury risk factors and interventions designed to reduce or eliminate the risk factors. The policy read in pertinent part, Assess the resident on admission for existing pressure injury factors. Repeat the risk assessment weekly and upon any changes of condition. Use a standardized pressure injury screening tool to determine and document risk factors. Supplement the use of a risk assessment tool with assessment of additional risk factors. Check the skin on a daily basis when performing or assisting with personal care or activities of (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	daily living. Identify any signs of developing pressure injuries, including non-blanchable erythema (redness). Inspect pressure points, including sacrum, heels, buttocks, coccyx, elbows, ischium (base of pelvis) and trochanter (upper thigh). Reposition resident as indicated on the care plan. Do not rub or otherwise cause friction on skin that is at risk for injuries. Select appropriate support surfaces based on the resident's risk factors in accordance with the current clinical practice. Evaluate, report and document potential changes in the skin. Review the interventions and strategies for effectiveness on an ongoing basis. III. Resident #1 A. Resident status Resident #1, age greater than age [AGE], was admitted on [DATE], readmitted on [DATE] and discharged on 3/12/25 to home with hospice services. According to the March 2025 computerized physician orders (CPO), diagnoses included dementia, type 2 diabetes mellitus without complications, muscle weakness, muscle wasting and atrophy, personal history of transientischemic attack (TIA) and cerebral infarction without residual deficits (stroke). The 3/9/25 minimum data set (MDS) assessment revealed Resident #1's cognition was moderately impaired and she exhibited a memory problem. The resident was dependent on staff for her activities of daily living (ADL) and used a wheelchair for mobility. According to the MDS assessment, the resident was at risk for developing pressure ulcers and had an unhealed pressure ulcer. The MDS assessment revealed the resident had an unstageable pressure ulcer. B. Record review The care plan for skin, initiated 3/23/23, indicated Resident #1 was at risk for impaired skin integrity related to muscle wasting, atrophy and moisture associated skin damage. The care plan interventions directed staff to provide a redistribution mattress to the resident's bed, provide a non-irritating service to reduce friction or shearing forces, assist the resident with turning and repositioning as needed, encourage her to reposition herself if able, complete a wound evaluation to monitor the progress of her skin, encourage the resident to comply to the interventions/treatments to minimize further skin impairment, complete a skin inspection every seven to 10 days and as needed, notify the physician/nurse practitioner (NP) of noted worsening skin or any new areas of skin breakdown and notify the nurse of any new areas of skin breakdown noted during bathing or daily care, including redness, blisters, bruises and skin discoloration. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 12/2/24 quarterly nursing evaluation was provided by the NHA on 4/10/25 at 11:56 a.m. The evaluation identified Resident #1's factors of risk to pressure injury. The nursing evaluation identified Resident #1's ability to respond to pressure related discomfort was slightly limited, she could not always communicate discomfort or had some sensory impairment which limited her ability to feel pain, her skin was occasionally exposed to moisture, she was chairfast, her ability to change and control her body position was very limited, her usual food intake pattern was probably inadequate and she had a skin friction and sheering potential problem. The 2/25/25 skin care plan intervention directed staff to provide pressure reducing boots to Resident #1's bilateral feet as tolerated with an option to remove during care. The 3/10/25 skin care plan intervention directed staff to elevate Resident #1's heels off the mattress as needed and tolerated. Review of the electronic medical record (EMR) identified Resident #1 was diagnosed with adult failure to thrive on 12/13/24, indicating the resident had a decline in her health (see interview below). Review of Resident #1's March 2025 CPO revealed the following physician's physician's orders: Pressure relieving mattress, protective footwear/heel protectors while in bed and decubitis (pressure ulcer/injury) precautions as needed, ordered 2/12/23. Mighty shake (high calorie supplement) three times a day for risk of malnutrition, ordered 12/3/24. Heel protectors to bilateral heels at all times for every shift, ordered 2/6/25. Air mattress overlay to be placed on the bed due to poor skin integrity, ordered 3/8/25. -However, review of the physician's orders revealed the resident had a physician's order for a pressure relieving mattress and heel protectors in bed ordered on 2/12/23 (see above). Review of Resident #1's December 2024, January 2025 and February 2025 medication administration records (MAR) and treatment administration records (TAR) did not identify that a pressure redistribution mattress was being utilized for the resident. Further review of Resident #1's December 2024 and January 2025 MAR and TAR did not identify heel protectors were being used for the resident. Review of Resident #1's February 2025 MAR documented heel protectors were used beginning on 2/6/25. From 2/1/25 through 2/5/25 there was no documentation the resident was using heel protectors. -However, according to the March 2025 CPO, the resident had a physician's order for a pressure relieving mattress and heel protector to be available for the resident's use, ordered on 2/12/23 (see physician's orders above). The 2/6/25 Braden Scale assessment (a tool for predicting pressure ulcer risk) was provided by the NHA on 4/10/25 at 11:33 a.m. The Braden Scale assessment identified Resident #1 was at risk for pressure ulcer development. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/6/25 change of condition note identified a certified nurse aide (CNA) notified the nurse of a discoloration to Resident #1's right heel. A physical assessment documented the discoloration to her right heel measured 2 centimeters (cm) by 2 cm by 2 cm and was non-blanchable (skin discoloration, usually redness, that doesn't turn lighter or disappear when pressed upon). The 2/6/25 wound evaluation was provided by the NHA on 4/10/25 at 11:33 a.m. The evaluation identified the new right heel wound was facility-acquired. The physician and the resident's representative were notified. According to the wound evaluation, the intervention was to encourage Resident #1 to reposition herself and use a pressure redistribution mattress on her bed. The evaluation documented the wound was evaluated by licensed practical nurse (LPN) #1. -However, according to the physician's orders, Resident #1 already had a physician's order for a pressure redistribution mattress which was ordered on 2/12/23 (see physician's orders above). -The wound evaluation did not identify the source of pressure to the resident's right heel. A 2/6/25 skin impairment incident report documented Resident #1 had been on a steady decline. The 2/13/25 wound evaluation was provided by the NHA on 4/10/25 at 11:33 a.m. The wound evaluation documented Resident #1 had discoloration to her right heel measuring 2 cm by 2 cm and was improving. The evaluation did not identify the determining factors of the improvement. According to the evaluation, the wound was evaluated by registered nurse (RN) #1. -The evaluation did not identify if the wound was evaluated by a physician/nurse practitioner or wound care specialist. -The evaluation did not identify the determining factors of the improvement. The 2/20/25 wound evaluation was provided by the NHA on 4/10/25 at 11:33 a.m. The wound evaluation documented Resident #1 had discoloration to her right heel measuring 2 cm by 2 cm and was improving. According to the evaluation, the wound was evaluated by registered nurse (RN) #1. -The evaluation did not identify if the wound was evaluated by a physician/nurse practitioner (NP) or wound care specialist. -The evaluation did not identify the determining factors of the improvement. A 2/24/25 skin inspection form completed by LPN #1 documented there were no new skin injuries. -The skin inspection form did not identify the condition of Resident #1's right heel wound. The 2/27/25 Braden Scale assessment was provided by the NHA on 4/10/25 at 11:33 a.m. The 2/27/25 Braden Scale assessment identified Resident #1 was at moderate risk for pressure ulcer development. The 2/28/25 change in condition evaluation identified Resident #1 would open her eyes but not respond vocally. The evaluation documented the resident was seen by the NP on 2/25/25 due to her recent (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	decline. The evaluation did not identify the NP evaluated or saw Resident #1's right heel wound. A 2/28/25 health status note identified Resident #1's family took the resident to the emergency department at the hospital. Hospital records between 2/28/25 and 3/7/25 documented Resident #1 was admitted to the hospital and was treated for pneumonia symptoms with complications and was provided wound care to her right heel. The hospital records identified the resident's wound on her heel as a pre-existing right heel unstageable pressure injury that was present from the facility. A wound consultation conducted at the hospital documented Resident #1's right heel injury was identified as the pressure injury unstageable and measured 2 cm by 3 cm with unknown depth. The right heel pressure injury had semifirm eschar (a hardened, dry, black or brown dead tissue) and peeling of the epidermis (outer layer of skin). The unstageable pressure injury was not open and there was no drainage and no erythema. The resident's heel was painted with Betadine, a border dressing was applied and both her heels were offloaded with pillows. The hospital discharge orders directed caregivers to float Resident #1's heels, apply Betadine and keep a padded dressing on her right heel. The 3/7/25 admission summary note identified Resident #1 was admitted back to the facility on 3/7/25. The 3/7/25 wound report identified the NP saw the Resident #1's pressure injury on 3/7/25. According to the wound report, the NP documented the measurements of the right heel wound on 3/7/25 as 4.5 cm by 4 cm by 0.1 cm. The NP documented the wound as a stage 2 pressure injury. The wound report directed staff to continue Bedadine daily and have the residents wear heel protectors at all times. The 3/7/25 Braden Scale assessment was provided by the NHA on 4/10/25 at 11:33 a.m. The Braden Scale assessment identified Resident #1 was at risk for pressure ulcer development. IV. Staff interviews The NHA, the director of nursing (DON) and RN #1 were interviewed together on 4/10/25 at 1:53 p.m. RN #1 identified herself as the facility's wound nurse. She said she was not wound care certified and the NP would assess wounds that were stage 2 or greater. She said if a wound was identified, the facility nurses would start standing wound physician's orders and then RN #1 and the NP would look at the wound on the following Monday. The DON said on 2/6/25, LPN #1 identified Resident #1 had a reddened area on her right heel. RN #1 said LPN #1 initiated a change of condition, requested the physician's order for heel protectors and notified RN #1 and the NP of the discoloration to Resident #1's heel. RN #1 said she saw Resident #1's heels on 2/10/25 but did not document it. She said she assessed Resident #1's heel on 2/13/25. She said the resident's heel was non-blanchable with discoloration and the wound was not open. RN #1 said the immediate intervention was to relieve the pressure from Resident #1's right heel so a heel protector was implemented on 2/6/25. She said there were no changes in her interventions because the heel did not worsen. She said the coloring started to improve and a (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blister was not formed. RN #1 said Resident #1 had been declining since December 2024. She said the resident had been losing weight and was less active. She said Resident #1 was at risk for pressure injuries. She said the resident's condition continued to decline. RN #1 said the more the resident declined in condition, the more she was at risk for pressure injury development. She said Resident #1 wore tennis shoes on her feet until 2/6/25 when the heel protectors were implemented. The NHA said a pressure relieving mattress was not implemented after Resident #1 was identified as being at risk for pressure injuries or after discoloration was identified on her right heel on 2/6/25. The NHA said the resident was at high risk for falls and used a scoop mattress instead to help decrease the risk of her falling. She said the resident was turned every couple hours when in bed, as standard practice. RN #1 said the NP saw Resident #1 on 2/25/25 but did not look at the resident's right heel. She said the NP reviewed the resident's overall decline and swallowing concerns. RN #1 said she did not assess Resident #1's for any changes to her heel after 2/20/25 and before she went to the hospital on 2/28/25. She said the resident's skin was looked at by the floor nurse (on 2/24/25), but only to identify if there were new wounds. She said the floor nurse did not assess the condition of the resident's right heel. RN #1 said Resident #1's heel was not seen by the NP until the resident returned from the hospital on 3/7/25. She said the NP saw the resident and implemented a pressure relieving air mattress when she returned from the hospital. RN #1 was interviewed again on 4/10/25 at 6:48 p.m. RN #1 said the facility needed to do a better job at identifying the root cause of pressure injuries. RN #1 said she thought Resident #1's shoes and leg rests caused the pressure to the resident's right heel when Resident #1 was in a declining condition, had weight loss and was moving less.