STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Pavilion at Villa Pueblo, The	855 Hunter Dr Pueblo, CO 81001

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42192 Based on observations, record reviews, and interviews, the facility failed to ensure one (#226) of four residents reviewed for pressure injuries out of 33 sample residents received care consistent with professional standards of practice. The facility failed to define and implement interventions that were consistent with resident needs, and to monitor and evaluate the effectiveness of interventions and re approach as necessary to prevent the development of pressure injuries for Resident #226. Resident #226 was admitted [DATE] with diagnoses of multiple pelvic fractures, congestive heart failure, and chronic kidney disease. Record review revealed the resident did not have pressure wounds at the time of admission. An interview with the resident's primary care physician revealed the resident had a form of Leukemia. The Resident's medical power of attorney (POA) decided against treatment as it was likely to lead to further impairment of the resident's health, including skin and susceptibility to infections and wounds (see interview below). Record review, observation, and interviews revealed the facility failed to implement timely interventions and adequately monitor his known risks to prevent pressure injuries. Resident #226's acquired a pressure wound within the first week of being admitted to the facility. - The pressure-reducing measures implemented upon admission included a pressure-reducing device for bed upon admission and positioning bars to the bed (2/12/21) were not tracked/utilized/implemented effectively to prevent a wound on the resident heel. A pressure-relieving air mattress was ordered for the resident on 2/22/21 after wound development. - Pressure-relieving measures for the resident's heels were not introduced until after wound development on 2/19/21. - Even though the resident was ordered double protein at meals (2/12/21) and consumed 50% meal intakes, two additional dietary supplementations for (healing/health promotion) were not implemented for nutritional support until 2/23/21 and a third supplement was added on 4/8/21. - Pillows and soft boots for pressure relieving were untracked and informally used by staff since the resident's admission and not ordered as an intervention and tracked until 2/22/21 after the wound had progressed. An off-loading pressure boot was not ordered until 3/1/21. Orders to float resident heels while in bed were not included until 3/12/21. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	- The heel wound modified the resident's ability to ambulate, confining him to a wheelchair, on 2/19/21, to relieve pressure to the wound. Modifications to the resident's wheelchair foot boxes were not implemented until 3/1/21. - The resident risk for skin breakdown admission assessments (Braden) did not account for all the health conditions and risk factors (Leukemia) the resident was admitted with. - The wound was being followed by the facility wound nurse, however, an outside wound physician was not brought in to assess the left heel wound until 3/1/21, nine days after wound development. The left heel wound (initial assessment on 2/19/21) was unstageable, measuring 2.5 centimeters (cm) by (x) 2.0 cm by unmeasurable depth. Later the wound was assessed and determined to be a stage 4 on 3/15/21 measuring 2.5 cm x 3.5 cm by 0.1 cm. -As of 6/9/21, the facility had not developed a patient-centered care plan for skin integrity/pressure areas that identified and addressed the resident's initial resistance to floating heels with pillows, and a variety of boots (known as early as 2/14/21), attempting to do things independently and not understanding own limitations. The resident's skin condition continued to decline; as of 4/19/21, the resident had one active pressure injury and one that resolved on 3/15/21, (unstageable DTI to the right heel). The left heel wound had been improving measuring 2.9 cm x 2.0 cm x 0.1 cm on 6/3/21. The lower left leg/Achilles infection wound was discovered on 4/19/21, measured 10 cm x 3 cm x 0.5 cm. The lower left leg/Achilles wound progressed and measured 15 cm x 2.5 cm x 1.0 cm on 6/3/21. The wound physician determined this wound was unavoidable and possibly caused by a diagnosis of osteomyelitis on 4/19/21. Interviews with facility staff revealed the facility was informally implementing bunny boots and pillows for the resident a couple of days after admission due to the resident propping his heels up on the footboard of his bed and the foot box of his wheelchair, the rejection of pillows and boots as interventions after informal implementation, the development of edema (2/18/21) before the presentation of the wound, pressure reduction mattress, and mobility bars for positioning. The resident propped his heels onto the footboard and box, rejected heel floating measures, and the edema was not documented in a wound, nursing notes, or reviewed as an interdisciplinary team (IDT) for further interventions proceeding wound development. The facility failed to monitor and implement interventions for Resident #226's pressure injuries and known risks for pressure injuries, and failed to comprehensively address known barriers to prevention and healing. Findings include: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A concern was brought to the facility's attention on 6/7/21 at approximately 6:50 p.m. The facility was provided an opportunity to submit documentation of its response to the development of a Stage IV pressure wound for Resident #226. The facility provided documentation related to the resident's condition. However, on 6/8/21 at approximately 2:39 p.m., based on remaining concerns related to care, it was determined that the facility failed to prevent pressure injury development for Resident #226. In the first week of his admission, Resident #226's pressure injury risk was not assessed accurately/thoroughly, monitored, or treated and pressure reduction measures specific to the resident's heels were not implemented until 2/22/21. Further, while the resident had suspected inadequate meal intake of 50% or less of meals, nutritional measures to promote healing were not implemented until 2/22/21, after wound development. By this time, seven days after admission, the resident had new pressure injuries - an unstageable left heel injury, 2/19/21 which worsened to Stage 4 on 3/15/21, and a later deep tissue injury (DTI) was found to his right heel (3/1/21), the unstageable right heel wound resolved on 3/15/21. Record review, interview, and observation also revealed the facility failed to comprehensively and consistently address barriers to prevent the resident's pressure injuries. As of 6/9/21, the facility had not developed a patient-centered care plan for skin integrity/pressure areas that identified and addressed the resident's initial resistance to preventative interventions (known as early as 2/14/21). Further, a nutritional intervention acceptable to the resident was not found until 2/23/21. Modifications to the resident's wheelchair were not implemented until after a second wound had developed on 3/1/21. Finally, observations during the survey revealed the resident's heels were in a protective boot when up in a wheelchair and had wound wrappings in place while in bed but no boots were observed, heels were elevated while in bed. The resident's skin condition continued to decline; as of 3/1/21, the resident had two pressure injuries, including an unstageable right heel injury which resolved 3/15/21. As of 6/7/21, the resident had a current left heel wound measured 2.9 cm x 2.0 cm x 0.1 cm. and a progressing lower left leg/Achilles infection wound measuring 15 cm x 2.5 cm x 1.0 cm. Facility response: On 6/9/21 at 5:45 p.m., the facility submitted a finalized plan. The plan read: Resident who was identified as at-risk for development of pressure injury on initial admission Braden scale development a facility acquired left heel DTI (deep tissue injury) that progressed into Stage IV pressure injury. The facility failed to clearly show preventative measures were put into place to address the prevention and progression of the left heel pressure ulcer. An audit of Braden scale assessments was completed by DON (director of nursing)/Designee on 6/8/21 to identify residents who may have scored high risk or very high risk on the current Braden scale. Both residents identified as high risk have current preventive or treatment measures in place. Residents' records, physician orders, treatment orders reviewed, and care plans updated with current individualized interventions. Skin observations were completed by nurses for current facility residents on 6/7 through 6/9. Skin assessments were reviewed for all current residents with no new issues identified. Full house audit of residents' Braden risk evaluations was reviewed to ensure interventions in place for those identified to be at high to very high risk for skin breakdown on 6/8/21. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An audit of the Braden scale assessment was completed by DON/Designee on 6/8/21 to identify any residents who may have scored high risk or very high risk on the current Braden scale. Both residents identified as high risk have current preventative or treatment measures in place. Resident records, physician orders, treatment orders reviewed, and care plans updated with current individualized interventions. Skin observations were completed by a nurse for current facility residents on 6/7 through 6/9. Beginning on 6/8/21 nursing staff education will be provided by ADON (assistant director of nursing) as they arrive for the next scheduled shift regarding head-to-toe skin observations, implemented/revision of interventions, the effectiveness of interventions, documentation, care-plan revision, notification to physician and responsible party of refusal or non-compliance with the plan of care, and policy on the refusal of cares and offering alternative choices as appropriate to be completed 6/13/21. An alternating air mattress will be provided to residents who have a pressure injury and residents who score high or very high for skin breakdown based off of Braden Risk Evaluations unless determined to be contraindicated. Re-education on quality rounds and expectations of quality rounds was completed on 6/8/21 with assigned IDT (interdisciplinary team) managers by the admission coordinator. DON/designee will review new admission evaluations and risk assessments/observations to ensure identified interventions are in place upon admission. DON/Designee will conduct quality rounds at a minimum of two times per week to ensure current implemented care plan measures are in place for individual residents. Identified issues or trends will be addressed as identified by the observer and reviewed at monitoring meetings by IDT to ensure compliance with implemented interventions. The plan will be ongoing and reviewed at the QAPI (Quality Assurance and Performance Improvement) meeting for the effectiveness of the plan. An ad hoc (when necessary) QAA (Quality Assurance Agency) meeting was held on 6/8/21 to review identified issues and quality round expectations and an action plan was developed with the input of the medical director via phone conference on 6/8/21. The plan will be reviewed at each QAPI meeting until sustained compliance is determined by IDT. Revisions will be made as needed if identified by IDT. However, the deficient practice remained. II. Professional reference A. The NPUAP Pressure Injury Stages | The National Pressure Ulcer Advisory Panel - NPUAP. The National Pressure Ulcer Advisory Panel NPUAP. Web. (updated June 2021) retrieved on June 15, 2021, from: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages reads: A pressure injury is localized damage to the skin and/or underlying soft tissue, usually over a bony prominence as a result of pressure, or pressure in combination with shear. The updated staging system includes the following definitions: -Stage 1 Pressure Injury: Intact skin with a localized area of non-blanchable erythema. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough, and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. -Stage 3 Pressure Injury: Full-thickness skin loss. Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. -Stage 4 Pressure Injury: Full-thickness skin and tissue loss. Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer. Slough and/or eschar may be visible. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. -Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar was removed, a Stage 3 or Stage 4 pressure injury will be revealed. B. According to the National Pressure Ulcer Advisory Panel (NPUAP), Pressure injury prevention points, updated 2016, revealed in part Consider bedfast and chairfast individuals to be at risk for development of pressure injury; Use a structured risk assessment, such as the Braden Scale, to identify individuals at risk for pressure injury as soon as possible (but within eight hours after admission); Use heel offloading devices .on individuals at high risk for heel ulcers. III. Facility policy and procedure Review of the Prevention of Pressure Injuries policy, reviewed April 2020, provided by the DON on 6/8/21 at 9:16 a.m. read in part The purpose of this procedure is to provide information regarding the identification of pressure injury risk factors and interventions for specific risk factors. Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Assess the resident on admission (within eight hours) for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. Evaluate, report, and document potential changes in the skin. Review the interventions and strategies for effectiveness on an ongoing basis. IV. Resident #226 (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A. Resident status Resident #226, age 82, was admitted on [DATE]. According to the June 2021 computerized physician orders (CPO), diagnoses included multiple fractures of the pelvis, dysphagia, difficulty walking, chronic kidney disease, muscle weakness, and chronic heart failure. -The CPO did not document the resident had diagnoses of leukemia or peripheral vascular disease (PVD); however, in the physician and wound physician interviews it was communicated (see below). The 2/18/21 admission minimum data set (MDS) assessment documented the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of eight out of 15. The resident displayed neither behavioral, rejecting care or wandering during the evaluation period. The resident required extensive two-person physical assistance with bed mobility and transfers, required extensive one-person physical assistance with locomotion on/off the unit, dressing, toileting, personal hygiene, and bathing, required supervised one-person assistance with eating. The resident used a wheelchair. The resident was identified as at risk for pressure injuries and a skin tear was present. A pressure-reducing device to bed, nonsurgical dressings, and applications of ointments/medications. The 3/5/21 significant change MDS assessment documented the resident had severe cognitive impairment with a brief interview for mental status score of seven out of 15. The resident rejected evaluation or care four to six days of the evaluation period. The resident required extensive two-person physical assistance with transfers, extensive one-person physical assistance with bed mobility, locomotion, dressing, toileting, bathing, and personal hygiene, required limited one-person physical assistance while walking in the room, and was independent while eating. He was not steady on his feet during transfers, while walking, or rising from sitting to standing and required staff assistance to stabilize. The resident utilized a walker and a wheelchair. The resident had two deep tissue injuries over a bony prominence being treated with pressure-reducing devices for chair and bed, nutrition/hydration interventions/ wound care, ointments/medications, and apply dressings to feet. -Neither MDS documented the resident's diagnoses of Leukemia or peripheral vascular disease. A review of the admission evaluation bundle completed 2/12/21, provided by the DON on 6/8/21 at 9:16 a.m., revealed the resident was DNR, alert and oriented to three factors, had an unsteady gait, confusion, and short term memory problems, was able to understand and make self-understood. -The resident required physical assistance from staff for bed mobility, transfers, locomotion, and dressing, and was totally dependent on staff for walking/ambulating. The resident was not steady on his feet during transfers on/off the toilet, sitting to standings well as from surface to surface, and was only able to stabilize with staff assistance. Walking did not occur. The resident was provided a pressure-reducing device for bed upon admission. The Advantage 500 Mattress product specifications were provided by the DON on 6/8/21 at 6:00 p.m. It read in pertinent part, Advantage 500 Mattress provides a dual-layer of foam designed with surface sculpting to help reduce pressure and shear while creating air channels for reduced heat and moisture buildup, softer foam in heel section also helps reduce pressure and prevent heel breakdown. After the left heel wound was discovered on 2/19/21 the resident was ordered an Equalizaire Mattress: Pressure Redistribution Technology, for the prevention and treatment of pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The 2/12/21 informed consent for restraints/safety devices revealed the mobility bars were initiated to minimize the risk of injury from a fall by aiding mobility and positioning. The resident signed the consent form on 2/12/21. The admission skin assessment revealed the resident had a crescent-shaped skin tear on his left forearm. No integrity issues were documented. The Braden scale completed upon admission revealed the resident had no cognitive impairments, was rarely moist (catheter in place), walked occasionally, very limited (able to make occasional slight changes in position, unable to make frequent/significant changes independently) mobility, probable inadequate nutrition (50% of meals eaten), friction and shearing problems (requires moderate to max assistance in moving. Complete lifting without sliding against the sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance). Resident #226 was determined to be at mild risk for pressure injuries based on the admitting Braden assessment with a score of 15 out of 19. The resident was admitted with a catheter and a follow-up plan for removal. A review of Resident #226's record (set forth below) revealed the resident entered the facility on 2/12/21 with a crescent-shaped skin tear on his left forearm. After the resident requested his buttock to be examined due to discomfort on 2/19/21, the resident's heel was discovered by the wound nurse. As of 2/19/21, the resident had developed his first heel pressure injury, progressing to a stage 4 wound as of 3/15/21, the wound was healing and ongoing; followed by the right heel wound discovered by the wound physician on 3/1/21, which was documented as unstageable and resolved on 3/15/21; and an on-going osteomyelitis infection wound discovered by the wound physician on 4/19/21, being followed by an orthopedic surgeon who, after examination, suggested lower left limb amputation at the knee on 6/9/21. B. Resident observations and wound physician (WP) interview The resident was observed on 6/3/21 at 10:00 a.m. He was laying in bed slightly on his left side, without the soft boots on and under a blanket. The resident was observed on 6/7/21 at 10:15 a.m. He was lying in his room lying slightly on his right side in bed on an air mattress covered with a blanket and lowered to the floor with a mattress on the floor at the bedside. The resident was wearing his soft boots under the blankets - At 11:05 a.m. The resident was seen in his wheelchair with pressure-relieving boots on, being wheeled into the television room for a group activity. The WP was observed and interviewed during wound care to the left lower leg and heel on 6/3/21 at 12:00 p. m. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The February 2021 medication administration record revealed orders, 2/12/21, for Braden Scale assessments upon admission and then weekly for the following three weeks, one of which was missed on 2/26/21, and for weekly skin observations and documentation on the Skin Observation Tool. Orders for the left heel wound treatment and offloading heels due to a DTI and checking the air mattress for proper functioning were added on 2/19/21. The 48-hour Meet and Greet Care Conference Review completed 2/12/21, was provided by the DON on 6/9/21 at 4:00 p.m. The baseline care plan included in the care conference documented the residents nursing needs as requiring assistance for transfers, bed mobility, locomotion of wheelchair and toileting, dependent of staff for walking, independent while eating, the resident can voice concerns and communicate needs effectively and was alert and oriented to three factors. The only skin concern was the crescent-shaped skin tear to the resident's left forearm. The social service concerns documented the resident was at the facility for a short-term stay after suffering a fall at home. Resident was to return home. The resident is DNR and has good family support. Dietary concerns documented the resident was on a regular diet and fluids, no known allergies, no supplementation at this time, full dentures, intake is fair and eats independently, speech therapy (ST) evaluations ordered, has current dysphagia. Therapy services concerns documented current ST, occupational therapy (OT), and physical therapy (PT) services to increase resident activity of daily living (ADLs) and transfer strength and gait. Nursing notes from 2/13/21, 2/14/21, 2/16/21, and 2/17/21 documented the resident was taking medications, able to make some needs known, confused at times, skin is warm, dry, and intact, and had increased weakness requiring one to two-person physical assistance with transfers. The resident was adjusting well and had a call light within reach. A nursing note from 2/14/21 documented the resident needed reminding to use the call light for assistance. The updated care plan, dated 2/15/21, documented the resident's risk for skin breakdown related to fracture and decreased mobility. Interventions documented included check and change upon awakening, before and after meals, at bedtime, and as needed, Provide incontinence care after each incontinent episode and as needed, complete weekly skin observations, and PT/OT as ordered (added 2/15/21); - Barrier cream applied and a cushion placed in wheelchair (added 2/19/21); - Maintenance to remove the anti-rollback system from residents wheelchair, alternating air mattress, bunny boots (encourage use), PT/OT, multivitamin, and supplements for wound healing (2/22/21); - Off-loading boots and foot pedals for wheelchair (added 3/2/21); - Resident educated to be cautious of his hands and upper extremities in an attempt to avoid bumping himself, causing skin injury (3/9/21). (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	There was no mention of floating the resident ' s heels while in bed or in a wheelchair. A physician encounter note dated 2/15/21 and 2/16/21 documented the resident was admitted to the facility after a fall at home resulting in a pelvic fracture. The resident reported having increased issues walking while at home. Other diagnoses included atrial fibrillation, hypertension, coronary artery disease, chronic heart failure, and high cholesterol. While in the hospital the resident was also diagnosed with urinary retention, anemia, and pneumonia. He recovered in the hospital and was referred to an orthopedic surgeon for follow-up. The orthopedic surgeon recommended weight-bearing as tolerated to the lower left extremity until orthopedic follow-up. Due to deconditioning during hospital stay, the resident should be followed by PT and OT. Orthopedic and urology follow-up scheduled. The resident had no peripheral edema and skin was dry, intact, with good turgor, with no redness or cyanosis (blueness). The resident was seated in his recliner at bedside without apparent distress. OT and PT assessments dated 2/15/21 documented the resident could weight bear as tolerated, ADL training had begun and the resident was participating, gait training began, and education about the safe placement of limbs was provided to the resident. There was no follow up documentation that the resident understood the education or demonstrated safe placement of limbs. The assessments did not document if the resident understood or could demonstrate said positioning. A 2/15/21-2/26/21 Quality Rounds checklist was provided by the DON on 6/8/21 at 9:16 a.m. It documented the resident's room number and the date on each form. -On 2/15/21 and 2/22/21 documentation revealed that the resident had appropriate appliances, and in the comment column bunny boots were documented. The form did not document if the boots were on or not. -On 2/16/21 the Quality rounds documented the resident was not wearing bunny boots while in bed. - On 2/17/21, 2/18/21, 2/19/21, 2/20/21, 2/21/21, 2/23/21, 2/24/21, 2/25/21, and 2/26/21 a checkmark documented the appropriate appliances were present but did not specify which appliances. The dietary profile and assessment were completed 2/15/21, documented the resident was on a regular diet with mechanical soft texture, no fluid restrictions, regular portion sizes, fair appetite, used no assistive devices, and independently fed self. Documented the resident's use of laxatives and vitamins, nutritional risk factors included pressure ulcer, difficulty swallowing (dysphagia diagnosis), altered diet texture, and recent fracture. The resident was screened for new admission, current diagnosis of pre-admission pelvic fracture. Diagnosis reviewed. The resident currently was receiving a regular diet, mechanical soft texture, thin liquid, consuming variable intakes per chart, uncertain on the adequacy of intakes to meet baseline needs. Will monitor weights and intakes to assess the need for nutritional interventions. Labs and medications reviewed. A skilled progress note dated 2/16/21 documented the resident's skin was warm, dry, and intact, able to make some needs known, continues to be confused at times, and has increased weakness requiring one to two physical assistance from staff with transfers and repositioning. The resident needs continued supervision with ADLs due to fall risk. A 2/17/21 skin observation form revealed the resident only had a skin tear to the left forearm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065121	A. Building B. Wing	06/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion at Villa Pueblo, The	855 Hunter Dr Pueblo, CO 81001

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A skilled progress note dated 2/17/21 documented the resident was to receive PT and OT services for gait and ADL training four times a week. The resident was resting in bed with his eyes closed, able to make some needs known, no complaints of pain or discomfort, and was compliant with medications. The resident had increased weakness, requiring one to two physical assistance from staff with transfers and repositioning. The resident needs continued supervision with ADLs due to fall risk. A 2/18/21 OT note documented the resident's right ankle was swollen and unable to donn shoe but could donn non-skid socks. Reported swelling to nursing staff. Nursing notes between 2/12/21-2/19/21 failed to document the resident had any skin concerns/breakdown/edema/blistering/redness. <br[TRUNCATED]