STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065233	A. Building B. Wing	10/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmark Nursing Center	3701 W Radcliff Ave Denver, CO 80236

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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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on interviews and record review, the facility failed to ensure one (#17) of two out of 40 sample residents was treated with dignity and respect and cared for in an environment that promoted her quality of life. Specifically, the facility failed to ensure Resident #17 did not suffer from emotional distress by registered nurse (RN) #4. The facility failed to provide Resident #17 an environment free to share her concerns without fear of humiliation, retaliation or intimidation. The facility's failure caused continued emotional distress experienced by the Resident #17. Findings include: I. Resident #17 A. Resident status Resident #17, age 78, was admitted on [DATE] and readmitted on [DATE]. According to the October 2022 computerized physician orders (CPO), the diagnoses included chronic obstructive pulmonary disease and depression. The 7/29/22 facility assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. She required supervision with activities of daily living. It indicated the resident did not have any signs or symptoms of depression. The resident did not reject any care during the assessment period. B. Resident interviews Resident #17 was interviewed 10/11/22 at 10:32 a.m. She said about two to three months ago that RN #4 was short with her and embarrassed her in front of other staff members. She said she approached the unit manager, licensed practical nurse (LPN) #1 to make a doctor appointment for the next day regarding a procedure to remove eyelashes on her left eye because the unit manager for her unit was not at work. She said her eyelashes grow inwards and she was experiencing a lot of pain in the left eye. (continued on next page)

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

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F 0550 Level of Harm - Actual harm Residents Affected - Few	She said RN #4 approached her in the hallway and chewed me out and said that I didn't need to bother anyone else and I had to wait until my unit manager returned to make the appointment. Resident #17 said she approached the unit manager, licensed practical nurse (LPN) #2, upon her return to the facility, about the incident and told her that I felt like I was at fault and wanted to apologize to RN #4. LPN #2 told Resident #17 that she did not have to apologize. Resident #17 said she continued to feel badly and approached RN #4 the next day to apologize. RN #4 told the resident that she had been chewed out by LPN #2 regarding the incident. Afterwards, Resident #17 said that RN #4 was very cold towards her and would only come in to give her medications and leave. She said RN #4 would not speak with her. During the interview, Resident #17 became emotional and had tears in her eyes when speaking of the encounter with RN #4. Resident #17 said, They were supposed to investigate it and write up a report and they never did that. Resident #17 said RN #4 was no longer employed at the facility because she followed a member of the administrative team to another facility. She and there has been a positive change since she has been gone in the attitudes of the CNAs (certified nurse aides) and residents. C. Record review The mood care plan, initiated on 11/11/18, documented the resident had a diagnosis of depression. It indicated the resident had a history of feeling tearful, hopeless and socially isolating. The interventions included administering antidepressant medications as ordered, completing the PHQ-9 (patient health questionnaire for depression) quarterly and as needed, providing the resident time to discuss concerns, feelings and thoughts as needed. -It did not include any person-centered approaches to manage the resident's depression. The impaired visual function care plan, initiated on 10/10/18 and revised on 1/22/2020, documented the resident's vision was severely impaired to the left eye and had right eye blindness related to macular degeneration, [NAME] disease of the eye and corneal ulceration of left eye (from misalignment of eyelashes as they rub against the eyeball). The interventions included consulting with an eye practitioner as required, explaining activities/sounds in the environment as needed and explaining care and services. II. Additional resident interview Resident #28, who was cognitively intact according to the facility assessment, was interviewed 10/17/22 at 10:30 a.m. Resident #28 said that RN #4 was a good nurse but she was abrupt with many residents and her attitude was someone who was not very happy with her job. She said RN #4 had an air about her where she felt RN #4 thought she was better than the residents and other staff members. III. Staff Interviews LPN #2 was interviewed on 10/13/22 at 5:00 p.m. LPN #2 said she was the unit manager of the unit where Resident #17 resided. She said that RN #4 butted heads with a lot of residents and was no longer employed at the facility. She said she followed the former NHA to another facility. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	LPN #2 said, in early July 2022, she had to take a day off of work. She said when she returned, Resident #17 said she went to LPN #1 to make an appointment for her to remove the eyelashes for her left eye, because she was experiencing pain. She said Resident #17 told her RN #4 accosted (approached aggressively) her in the hall and told Resident #17 that she did not need to bother anyone about her appointment and that she needed to speak with LPN #2 when she returned to work. LPN #2 said Resident #17 felt bad and wanted to smooth things over with RN #4. She said Resident #17 wanted to write an apology note to RN #4. LPN #2 told Resident #17 apologies were not necessary and that she should not feel bad about asking for the appointment. Resident #17 wrote the note and left it for RN #4 on the medication cart. She said she saw RN #4 take the note, unopened, to Resident #17's room. She said Resident #17 told her she found the note she had written RN #4 in her nightstand, unopened. LPN #2 said it was the ultimate (expletive) to someone who was just trying to offer an apology. LPN #2 said Resident #17 continued to feel badly and was emotional about the incident. LPN #2 said she reported this incident, in writing, to the former nursing home administrator (NHA) along with many other complaints from family, staff and residents regarding RN #4. LPN #2 said the former NHA was always smoothing things over and making excuses for RN #4. LPN #2 said the complaint was not addressed and felt the grievance, along with all the other grievances about RN #4, probably ended up in the shredder. LPN #2 said the former NHA and RN #4 were now employed at another facility. The NHA was interviewed on 10/17/22 at 8:15 a.m. He said he was unable to find an investigation regarding the incident between Resident #17 and RN #4. He said he interviewed Resident #17 that day (10/17/22) and she was very tearful and upset when recounting the incident regarding RN #4. He said he was not the NHA at the facility when this event occurred. LPN #2 was interviewed on 10/17/22 at 2:30 p.m. She said the issue regarding Resident #17 not feeling like RN #4 had been giving her the antidepressant medication (which had happened the weekend before the incident, see the former NHA interview below) and the issue with making the appointment were two separate instances. She said she was not aware of the incident with the medications. She said Resident #17 had come to her, the day she returned to work, and told her about the incident with RN #4. She said she immediately informed the former NHA that same day. LPN #6 was interviewed on 10/17/22 at 2:35 p.m. She said any allegations of abuse should be reported immediately to the unit manager, the director of nursing (DON), supervisor on duty and the executive director. She said the types of abuse reported were physical, mental, verbal and neglect. The NHA and former nursing home administrator (FNHA) were interviewed on 10/17/22 at 11:00 a.m. The FNHA said she had completed an investigation regarding Resident #17 reporting RN #4 had not been giving her the antidepressant medication she was prescribed, which was the weekend before the incident with RN #4. She said she had conducted an investigation and resolved the concern with the resident by ensuring the medications were shown to the resident prior to being crushed and mixed with applesauce. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	She said LPN #2 had not reported the incident between Resident #17 and RN #4 to her, however she was able to recount the entire event between Resident #17 and RN #4. She said that event had not been included in the investigation she completed about the medication concern.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46851 Based on observations, record review and interview, the facility failed to provide the necessary treatment and services to prevent the development of pressure injuries for one (#42) of two residents reviewed for pressure injury out of 40 sample residents. Resident #42 was identified by the facility as a high risk for developing pressure injuries upon his admission to the facility. On 9/13/22, the resident developed a pressure injury to the right trochanter (hip). The facility failed to ensure an initial assessment of the pressure injury was completed upon the residents admission, The physician was not notified timely and a treatment order was not put into place until 9/26/22; 13 days after the pressure injury was identified. A treatment note dated 9/27/22, by the wound physician, documented the resident had a stage 3 facility acquired pressure injury to her right hip. The facility failed to take sufficient steps to promote wound healing and prevent further skin breakdown. Additionally, the facility failed to ensure that repositioning and incontinence care were provided to the resident in a timely manner. Findings include: I. Professional reference According to the National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline, [NAME] Haesler (Ed.), Cambridge Media: [NAME] Park, Western Australia; 2018, retrieved from https://www.ehob.com/media/2018/04/prevention-and-treatment-of-pressure-ulcers-clinical-practice-guidline.pdf on 10/27/22, Pressure ulcer classification is as follows: Category/Stage 1: Nonblanchable Erythema Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage I may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk). Category/Stage 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.This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Bruising indicates suspected deep tissue injury. Category/Stage 3: Full Thickness Skin Loss (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	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 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 (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed. Suspected Deep Tissue Injury: Depth Unknown Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. II. Facility policy and procedure The Pressure Ulcer Prevention policy and procedure, last reviewed April 2022, was provided by the nursing home administrator (NHA) on 10/18/22 at 3:41 p.m. It revealed, in pertinent part, To provide associates and licensed nurses 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 NPUAP (national pressure injury advisory panel) and WOCN (wound, osteomyelitis, continence nurses society). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Based on the comprehensive assessment of a resident the facility must ensure that a resident receives care consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individuals clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection and prevent new ulcers from developing. A skin assessment/inspection occurs on admission/readmission. Skin observations also occur throughout point of care provided by CNA's (certified nurse aide) during ADL (activities of daily care) care (bathing, dressing, incontinent care, etc.). Any changes or open areas are reported to the nurse. A risk assessment tool, Braden scale or Norton Scale, determines the residents risk for pressure injury development. The scores documented on the tool and placed in the resident's medical records 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, comorbid conditions, cognitive impairment, exposure of skin to urinary and fecal incontinence, and the history of healed injury. A skin assessment/inspection should be performed weekly by a licensed nurse. Measures to maintain and improve the resident's tissue tolerance to pressure are implemented in the plan of care. All residents upon admission are considered to be at risk for pressure injury development due to medical issues requiring nursing care related to disease process and illness or need for rehabilitation services. Upon admission and throughout stay at a minimum a pressure redistribution surface is in use with turning and repositioning as needed with ADL care/assistance incontinent care if needed to include skin barriers application as needed, preventative wheelchair cushion is indicated, etc. Skin inspections with particular attention to bony prominences, skin cleansing with appropriate cleanser at time of swelling and routine intervals, treat dry skin with moisturizers, minimize skin exposure to incontinence using devices (i.e. briefs) and skin barriers, minimize injury due to shear and friction through proper positioning, transfers and turning schedules, improve residents mobility in activity when potential exists(restorative). Measures to protect the resident against adverse effects of external mechanical forces, such as pressure, friction, and shear are implemented in the plan of care: reposition at least every two to four hours (per NPIAP standards) as consistent with overall patient goal in medical condition; utilize positioning devices to keep bony prominences from direct contact; ensure proper body alignment when side-lying; heel protection/suspension if indicated; maintain HOB (head of bed) at the lowest degree of elevation consistent with medication conditions;, a pressure redistribution mattress service is placed under the resident; when positioned in a 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. The Documentation and Assessment of Wounds policy and procedure, reviewed April 2022, was provided by the NHA on 10/18/22 at 3:41 p.m. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	It revealed, in pertinent part, To guide the associates and licensed nurse in the assessment of the wounds to include pressure ulcer/injuries, venous, arterial, diabetic, dehisced surgical wounds, and other (not otherwise specified). Based on the comprehensive assessment of a resident, the facility must ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. A wound assessment/documentation is required to occur at a minimum weekly. Nurses performing the treatment would perform an prn (as needed) assessment/documentation if noted change has occurred i.e. wound has healed/resolved, appears infected, or appears to have declined. It may not be practical for the weekly assessment to occur on the 7th day deadline due to dressing not required to be changed on due date, wound round or MD (medical doctor) schedule changes, follow-up appointments, or resident's refusal. For those purposes would obtain wound assessment/documentation prior to if able or within the calendar week to maintain assessment and documentation compliance. Documentation is located in the EHR (electronic health record) progress notes, wound observation tool and/or skin integrity data collection tools. Additional documentation from MD office visits or wound clinic notes may be located in the hard copy medical record. III. Failure to provide the necessary treatment and service to prevent the development of pressure injuries for Resident #42 A. Resident #42's status Resident #42, age 72, was admitted on [DATE]. According to the October 2022 computerized physician orders (CPO), diagnoses included hemiplegia and hemiparesis (paralysis) affecting right dominant side, unspecified dementia with behavioral disturbances, contracture of muscle of left ankle and foot, contracture of right shoulder right elbow and right hand and specified depressive episodes. According to the 8/16/22 minimum data set (MDS) assessment, the resident had short-term and long-term memory impairment with severe impairment in making decisions regarding tasks of daily life. The resident required extensive assistance of one person with bed mobility, transfers, dressing, toileting and personal hygiene. The MDS documented the resident was incontinent of bowel and bladder and did not have any unhealed pressure ulcers. The resident was on hospice care. B. Observations On 10/12/22, during a continuous observation, beginning at 2:06 p.m. and ended at 3:18 p.m., Resident #42 was observed laying in the supine position (laying on his back) with his feet directly onto the mattress. -At 2:55 p.m. Resident #42 remained in the same position. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-At 3:18 p.m. Resident #42 was laying in bed, awake. He attempted to sit up in bed but was unable to reposition himself. On 10/13/22, during a continuous observation, beginning at 8:30 a.m. and ended at 1:25 p.m. Resident #42 was observed sitting in the day room, in front of the television, in a Broda chair. -At 8:48 a.m. the resident was observed eating breakfast in the day room, in the Broda chair. -At 9:10 a.m. Resident #42 remained in the day room, in the Broda chair. -At 9:34 a.m. licensed practical nurse (LPN) #2 and LPN #5 took Resident #42 to his room and helped him to bed by standing the resident and doing a pivot transfer. They placed a pillow behind his head and positioned him supine. The resident's feet were placed directly on the mattress. Certified nurse aide (CNA) #4 came into the resident's room, put his oxygen on, lowered the bed and positioned the resident at 45% angle. -At 9:45 a.m. CNA#4 brought the resident a blanket and put it on him. The resident's feet remained directly on the bed. -At 10:08 a.m. the Resident #42 remained in the same position. -At 11:05 a.m. LPN #5 checked to ensure dressing was on his pressure ulcer. She did not check the resident's incontinence brief or offer to reposition the resident. -At 11:18 a.m. hospice agency staff went in but left because the resident was asleep. The hospice agency staff did not provide the resident care. -At 12:14 p.m. Resident #42 remained in the same position. -At 12:22 p.m. CNA #4 closed the resident's door. She did not enter the resident's room. -At 12:34 p.m. LPN #5 entered the resident's room and gave the resident his medication. She did not offer or provide repositioning to the resident. -At 12:35 p.m. CNA #4 brought the resident his lunch tray, set it on the overbed table and assisted him with eating. -At 12:52 p.m. CNA#4 was finished assisting the resident with his lunch. CNA #4 lowered Resident #42's bed and kept the resident at a 45 degree angle. CNA #4 did not offer to reposition the resident or provide incontinence care. -At 1:17 p.m. Resident #42 remained in the same position. -At 1:25 p.m. CNA #4 entered the resident's room and provided Resident #42 with incontinence care. CNA#4 said the resident was incontinant with urine and the brief was wet. The soiled brief was observed in a trash bag. The brief was heavy, sopping wet, and the moisture could be felt with a gloved hand. CNA #4 said she had not provided Resident #42 incontinence care since the resident was transferred to the Broda chair for breakfast. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	After providing incontinence care, CNA#4 did not float the resident's heels. The resident was still laying in the supine position. Cross-reference F677: the facility failed to provide incontinence care and repositioning timely for Resident #42. C. Record review The cognition care plan, revised 10/5/22, documented the resident had impaired cognitive skills related to dementia, had trouble word findings and had short-term and long-term memory loss. The activities of daily living (ADL) care plan, revised on 10/11/22, documented the resident had a self-care deficit related to a CVA (cerebral vascular accident) with subsequent impaired mobility. It indicated the resident required one person assistance with bed mobility and totally dependent upon staff for personal hygiene and toileting. The interventions included providing the resident with body pillows for positioning while in bed, encouraging the resident to participate in ADLs as he was able, floating the resident's heels while in bed, repositioning the resident in bed as tolerated, placing the resident's call light on the left side of the resident due to visual impairments. The skin integrity care plan, revised on 10/10/22, revealed Resident #42 was at risk for an alteration in his skin integrity due to impaired mobility, incontinence and a right hand contracture. The interventions included placing an arm rest pad on the left side for skin integrity, applying lotion to the resident's bilateral upper and lower extremities daily, cleaning and drying the resident's skin after each incontinent episode with barrier ointment being applied, completing the Braden scale assessment quarterly or as indicated, checking for proper positioning when the resident was up in the Broda chair, following wound care orders, a pressure reducing mattress to the bed and cushion for the wheelchair and weekly skin checks. The skin impairment care plan, revised on 10/11/22, documented the resident had a stage three pressure injury to the right trochanter (any of two bony protuberances by which muscles are attached to the upper part of the thigh bone). The interventions included assessing the location, size, and treatment of the skin injury, cleaning and drying the resident's skin after each incontinent episode, identifying and documenting potential causative factors and resolving where possible, using a draw sheet or lifting device to move the resident and documenting weekly treatments to include the measurements of each area of skin breakdown with any notable changes or observations. The 10/6/22 Braden assessment documented the resident was at a high risk for pressure ulcers with a score of 11 out of 23. A lower score indicates more risk. III. Failure to assess, notify the physician and put a treatment in place timely upon the identification of a pressure injury A. Record review (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The 9/13/22 weekly skin integrity data collection documented the resident's skin was intact, however the 9/13/22 nursing progress note documented the resident had an open area to the right hip, was improving in size and condition, and it did not have any signs and symptoms of infection. It indicated the nurse applied skin prep to the open area. The September 2022 medication administration record (MAR) and the treatment administration record (TAR) did not reveal documentation of a treatment of the pressure injury to the resident's right trochanter until 9/26/22, 13 days after the pressure injury was identified, according to the 9/13/22 nursing progress notes. The wound physician note dated 9/27/22 documented that resident had a stage three pressure ulcer located on the right hip, that was acquired at the facility. The 9/27/22 weekly skin integrity data collection documented the resident sustained friction/shearing to the right hip. The 9/27/22 wound observation tool assessment documented Resident #42 acquired a stage three pressure injury to the right trochanter on 9/21/22. It revealed the wound was unchanged with 20 % (percent) slough (part of the inflammatory process consisting of fibrin, white blood cells, bacteria and debris, along with dead tissue and other proteinaceous material) The wound observation document revealed the wound was 2 cm (centimeters) length x 1.7 cm width x 0.2 cm depth. The treatment order was to apply Medihoney with a foam dressing every day. A review of the resident's medical record revealed the wound was not thoroughly assessed until 9/27/22, when the wound was identified on 9/13/22. A wound physician note dated 10/4/22 documented that resident had a stage three pressure ulcer located on the right hip. The wound physician used an anesthetic instrument 2% lidocaine intervention used as an anesthetic to numb sensation of pain. Also in place was an alternating pressure mattress. A wound physician note dated 10/11/22 documented that resident had a stage three pressure ulcer located on the right hip, the progress was better, complexity was high. Preventive measures care in place, offloading heels and plan in care. -The physician did not give any other details for preventative measures. B. Observations -On 10/13/22 at 11:00 a.m. LPN #2 was observed providing a treatment to Resident #42's stage three pressure injury to the right trochanter. -LPN #2 removed the treatment dressing and a small amount of light yellow purulent (pus) drainage was observed on the dressing. The wound edges appeared pink and the wound bed was difficult to visualize due to residual slough and drainage in the wound. -The measurements were: 0.5 cm length x 0.3 cm width x 0.1 cm depth. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065233	A. Building B. Wing	10/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmark Nursing Center	3701 W Radcliff Ave Denver, CO 80236

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	IV. Staff interviews LPN #4 was interviewed on 10/17/22 at 1:30 p.m. LPN #4 said Resident #42 had a pressure ulcer to the right hip that was being monitored daily. LPN #2 said Resident #42 was a high risk for developing pressure injuries and should be repositioned every two hours. When a new wound was identified, the registered nurse (RN) should be notified to perform an assessment and physician to obtain treatment orders. The director of nursing (DON) was interviewed on 10/17/22 at 7:00 p.m. The DON said that skin observations should be conducted every day during ADL care. She said any indication of skin breakdown should be reported to the nurse and an assessment should be completed. She said the physician should notify the physician to obtain a treatment order as soon as a wound was identified. She said she and the unit manager observed all wounds in the facility with the wound physician every Tuesday. She said the wound physician would assess the wound, provide treatments and document any changes to the treatment orders. The DON said any skin breakdown observed should be reported to the physician and a treatment should be put in place immediately. The DON said Resident #42 required assistance from staff for bed mobility and repositioning. She said repositioning should be provided or offered to Resident #42 approximately every two to three hours. She acknowledged the MAR and TAR did not reveal a treatment had been put into place until 9/26/22, 13 days after the nurse documented the wound to the right hip.