



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 17, 2022

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: CCN: 245184
Cycle Start Date: May 27, 2022

Dear Administrator:

On June 17, 2022, we notified you a remedy was imposed. On August 5, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 11, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 2, 2022 be discontinued as of July 11, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of June 17, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 27, 2022. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 17, 2022

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

Re: Reinspection Results
Event ID: 519H12 and MEV712

Dear Administrator:

On August 5, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on May 27, 2022 and June 16, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 29, 2022

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: CCN: 245184
Cycle Start Date: May 27, 2022

Dear Administrator:

On June 17, 2022, we informed you of imposed enforcement remedies.

On June 16, 2022, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 2, 2022, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 2, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 2, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of June 17, 2022, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting

An equal opportunity employer.

Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 27, 2022. However, due to the extended survey the new NATCEP loss date is May 27, 2022.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 27, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Rochester East Health Services

June 29, 2022

Page 5

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing

Minnesota Department of Health

Licensing and Certification Program

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/16/2022
NAME OF PROVIDER OR SUPPLIER ROCHESTER EAST HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/14/22, through 6/16/22, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.		2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

07/01/22

Minnesota Department of Health

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H51842025C (MN83975) with a licensing order issued at 0830 and 0900. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at	2 000		

Minnesota Department of Health

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2 000	Continued From page 2 the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess, monitor, follow physician ordered treatments and care plan for 1 of 4 residents (R2) who developed and had ongoing painful moisture associated skin damage (MASD) Findings include: R2's admission record identified an admit date of 1/20/20, with diagnoses that included: type 2	2 830	F 684 R2 is not currently at the facility. Needs will be reassessed upon R2's return. Residents with skin conditions and orders for hypoallergenic briefs or soaps have the potential to be impacted by this practice. Review of treatment orders will be completed by 7/11/2022 to identify like residents and validate products are		7/11/22

Minnesota Department of Health

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2 830	Continued From page 3 diabetes mellitus (DM), congestive heart failure (CHF), atrial fibrillation, chronic kidney disease, peripheral venous disease (PVD), and morbid obesity. R2's annual Minimum Data Set (MDS) assessment dated 4/8/22, indicated R3 had moderate cognitive impairment, did not have behaviors or rejection of care, required limited one person assist with locomotion, extensive assistance with most activities of daily living (ADL's) other than eating. R2 noted to be frequently incontinent of bladder and occasionally incontinent of bowel. The MDS identified R2 was at risk for pressure ulcer development and did not identify moisture associated skin damage (MASD). Skin care interventions included pressure reducing device for chair and bed, application of nonsurgical dressings other than to feet, and applications of ointments/medications other than to feet. R2's skin care plan dated 6/7/22, indicated R2 was at risk for skin integrity conditions and pressure sores related to impaired mobility and incontinence. Interventions included: -Assess skin for redness or pressure related changes with each care encounter. Report any changes immediately. -Conduct pressure injury skin assessments (i.e. Braden scale) as indicated. -Frequent repositioning in bed and chair. -Head-to-toe assessment by licensed nurse performed weekly at minimum. -No wipes, only wash cloths with water, and hypoallergenic soap. R2's bowel/bladder care plan dated 1/21/22, R2 had alteration in bowel and bladder incontinence related to impaired mobility, mood/behavioral	2 830	available. Education will be provided by the Director of Nursing or designee to nurses on completing treatments as ordered, following MD orders, and completing medication error reports for missed treatments. The Director of Nursing or designee will complete monitor the facility dashboard to identify any missed treatments Monday-Friday and follow up with nurses on any missed treatments following the center process for educational or disciplinary action. This will be an ongoing change of practice.		

Minnesota Department of Health

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2 830	Continued From page 4 issues, and medication. Interventions included keeping R2 clean and dry, use barrier cream after good peri-care, apply incontinent products as needed. A revised intervention dated 6/9/22, indicated scheduled toileting program every two to three hours and as needed while awake. R2's physician note dated 5/12/22, indicated R2 was frustrated due to the quality of care she is receiving at the facility, skin is being "rubbed" with scented wipes as she has noted significant irritation with the product, the care she receives overnight, and not being properly dressed with pants as staff are unable to assist. R2 had pain located in her inner thighs due to "urine burns" related to poor skin care and the products used. Bilateral inner proximal thighs incontinence associated dermatitis with open skin areas. R2 noted with significant erythema, non-blanchable with several small about 1 centimeter (cm) size open skin areas on both proximal inner thighs close to the groin area. No erythema noted underneath her breasts or abdominal pannus/folds. Physician orders included "DO NOT USE WIPES" - only use a wash cloth, water, and hypoallergenic soap to clean her three times per day and as needed if she is soiled, clean the region with soap and water allowing to dry completely. "PAT DRY, DO NOT RUB." Apply barrier cream (zinc oxide). Notify if area affected worsens. R2's physician note dated 5/17/22, indicated R2 stated caregivers have been grumbling and wanting to use regular soap on her skin. Licensed practical nurse (LPN)-A placed several notices in R2's room and bathroom stating not to use regular soap and wipes on R2's skin any longer. Current skin management seems to be helping as no rash nor open areas were noted today.	2 830			

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2 830	Continued From page 5 Orders placed to use hypoallergenic briefs and registered nurse (RN)-A notified and will order incontinence products. Physician skin care orders included: -Cleanse groin and intergluteal areas with warm washcloth, pat dry, and apply Clotrimazole cream two times a day until resolved. Once resolved then continue as needed (start date 2/22/22). -Do not use wipes, only use a wash cloth, water, hypoallergenic soap every shift, apply zinc oxide cream 13% topically three times a day for rash and as needed to bilateral proximal inner thighs (start date 5/12/22). R2's record lacked evidence that the order for hypoallergenic briefs from the 5/17/22, visit was transcribed into the medical chart. R2's Treatment Administration Record (TAR) identified R2's prescribed treatments and treatments were not completed per physician orders: -Cleanse groin and intergluteal area with warm washcloth, pat dry and apply Clotrimazole cream two times a day until resolved. Not completed on 5/4/22, 5/6/22, 5/20/22, and 6/9/22. -Peri area and buttocks open to air while in bed. Not completed on 5/4/22, 5/6/22, 5/20/22, and 6/9/22. R2's record was reviewed from 5/1/22 to 6/16/22, although the record identified R2's Weekly skin Reviews were completed, there was a lack of a completed comprehensive assessment. R2's skin reviews are as follows: -On 5/16/22, redness in groin and down inner thighs which is currently being treated. -On 5/23/22, no current skin conditions as R2 refused shower and skin check.	2 830			

Minnesota Department of Health

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2 830	Continued From page 6 -On 5/30/22, no current skin conditions. -On 6/4/22, redness in groin from MASD and open area on back/front of right leg. -On 6/7/22, documented blisters, redness, and open area to right lower leg. During an observation and interview on 6/15/22, at 11:52 a.m. LPN-A and NA-F were observed changing R2's saturated incontinent brief. Buttocks, bilateral groins, and abdominal folds observed moist, yeasty, very inflamed, fire engine red, and raw. R2 screamed out in pain as facility staff wiped her buttocks. R2 informed LPN-A and NA-F that some NAs were still using wet-wipes on her skin despite current physician orders and the NAs on nightshift would not even cleanse skin prior to putting on a dry brief. NAs put a new brief back on R2. LPN-A stated R2 was incontinent of bowel and bladder. LPN-A stated they use hypoallergenic incontinence briefs on R2, however, the facility had not ordered yet so not available. An opened package of Cardinal Health Personal Cleaning Cloths - Scented were found in R2's room on top of the dresser. LPN-A took opened package of wet-wipes and placed it on second floor East wing treatment cart. LPN-A stated since R2 had a lot of urinary incontinence staff could not leave her peri area and bottom open to air. During an observation and interview on 6/16/22, at 7:52 a.m. R2 observed sitting on edge of bed with bedside table in front of her. R2 stated she remains in a wet brief until 20 to 30 minutes prior to the end of night shift every night without getting changed. R2 stated she is frequently incontinent and does not always know when the brief is wet. R2 stated her incontinence brief was last changed at 5:30 a.m.	2 830			

Minnesota Department of Health

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2 830	Continued From page 7 During an observation and interview on 6/16/22, at 8:54 a.m. R2 observed sitting on edge of bedside eating breakfast. R2 had not been toileted or changed since 5:30 a.m. During an observation on 6/16/22, at 9:15 a.m. R2's call light observed on. At 9:21 a.m., NA-G answered R2's call light. R2 wanted to use the bedpan to have a bowel movement, NA-G pulled down R2's brief that was saturated with urine and assisted R2 on the bedpan. At 9:37 a.m., NA-G assisted R2 off of bed pan and cleansed R2's skin using wet washcloths and applied DermaCerin barrier cream (moisturizing cream petroleum based, R2 did not have a physician order for this type of cream). NA-G stated she alternates barrier creams every other time with PeriGuard ointment (contains zinc 3.8%). NA-G stated R2 is on a toileting schedule every two to three hours and needs assistance to reposition. NA-G confirmed R2 had not been toileted or her incontinence brief since 5:30 a.m. as she had not assisted R2 yet this morning. NA-G stated she saw wet-wipes in R2's room two weeks ago despite having a physician order not to use them. NA-G stated facility was not using hypoallergenic incontinence briefs yet either. NA-G stated R2 allows staff to properly wash her skin and stated she has never seen a residents buttocks look that reddened and inflamed before. During an interview on 6/14/22, at 2:19 p.m. NA-C stated R2 was a dependent resident with no skin conditions; however, stated R2 required the use of dry tissues, wet washcloths, barrier cream, and could not use wet wipes on skin for cleansing. NA-C did not articulate and/or mention the intervention of R2's peri area and buttocks were to be open to air while in bed.	2 830			

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2 830	Continued From page 8 During an interview on 6/14/22, at 3:09 p.m. NA-E stated R2's buttocks were extremely red and sometimes had open areas involved. NA-E stated aides apply different barrier creams to buttocks and nurses will apply dressings to open areas. NA-E stated R2 was on a turning, repositioning, and toileting schedule was every two to three hours and as needed. NA-E stated R2 required the use of wet wash cloths and no wet-wipes were to be used on R2's skin due to allergies. NA-E did not articulate and/or mention the intervention of R2's peri area and buttocks were to be open to air while in bed. During an interview on 6/15/22, at 8:46 a.m. RN-B stated R2 had a very painful, reddened, and inflamed buttocks. RN-B stated R2 required physician orders to cleanse skin with wet washcloth, soap, and water and could not use wet-wipes as it worsened R2's MASD. During an interview on 6/15/22, at 3:28 p.m. NA-A stated R2 was on a toileting and repositioning schedule up to five times per shift. NA-A stated NAs should be assisting R2 to the bedpan a couple times per day. NA-A stated R2 occasionally refuses; however, does well with redirection and reapproach. NA-A stated NA's document refusals and informed nurse each time. NA-A stated R2 could not use wet-wipes due to a skin allergy and was cleansed with soap and water. NA-A stated R2 had MASD and there were signs posted in R2's room and bathroom to alert staff to not use wet-wipes. NA-A did not articulate and/or mention the intervention of R2's peri area and buttocks were to be open to air while in bed. During an interview on 6/15/22, at 12:09 p.m. R2 stated her buttocks "burned like hell." R2 stated the night shift NAs do not clean her up well after	2 830			

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2 830	Continued From page 9 an incontinence episode; which also occasionally happens on day shift as well. R2 stated staff take off wet brief, do not dry her skin or wash her skin, and re-apply a dry clean brief. R2 stated nurses remove wet-wipes from her room, but then they reappear after they have been removed. R2 stated RN-A completed wound care measurements today; however, was not getting completed every week. During an interview on 6/16/22, at 8:09 a.m. NA-B stated R2's entire buttocks and groin folds were very reddened and moist. NA-B stated facility transitioned from using wet-wipes to using a damp wash cloth or toilet paper and applying barrier cream as needed. NA-B stated R2 will put on call light when she needs to be toileted. NA-B stated she was uncertain if R2 was on a turning, repositioning, or toileting schedule. NA-B stated R2 does not always know when she is incontinent and wet. During an interview on 6/16/22, at 8:29 a.m. LPN-E stated NAs should be following toileting and repositioning schedules every two hours as ordered so all residents skin remained dry and intact. LPN-E stated NAs and nursing staff must follow physician prescribed orders if wet-wipes are not allowed for a resident. LPN-E stated if she found a NA not following orders, she would attempt to re-educate the aide, speak to the unit manager, and possibly the director of nursing (DON) if needed. LPN-E stated concern for further skin breakdown and skin sores that could worsen developing into pressure ulcers (PUs) which could lead to infections and sepsis. During an interview on 6/16/22, at 11:16 a.m. LPN-A stated R2's bowel and bladder functioning has declined since she started at facility in	2 830			

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2 830	Continued From page 10 February. LPN-A stated R2 is frequently incontinent most of the time. LPN-A stated R2 was on a toileting schedule every two hours; however, was not certain if NAs complete this task as she stated R2 will let staff know when she's incontinent. LPN-A stated NAs do not need to check R2's incontinence brief for dryness. LPN-A stated she had not seen wet-wipes in R2's room in the past two weeks so the package that was found in R2's room on 6/15/22 was recently used on resident. LPN-A stated concern for possible further skin breakdown as R2 is allergic to the wet-wipes that are perfumed. During an interview on 6/16/22, at 11:35 a.m. RN-A stated she thought R2 was not necessarily on a toileting or repositioning schedule. RN-A stated R2 had morning and bedtime cares only or if R2 had an incontinent episode. RN-A stated she asked the staff member who is responsible for ordering supplies to order hypoallergenic briefs one month ago; but has not followed-up to see if R2 received the supplies. RN-A stated facility does not have hypoallergenic soap as they use the "total bath and body wash" which is orange colored. RN-A stated she would have to follow-up on the soap. RN-A stated R2 did not have MASD or skin sensitivity redness a few months ago and R2's skin has worsened. RN-A stated she would need to re-educate nursing staff on following physician orders to not use wet-wipes on R2's skin despite efforts LPN-A had utilized with posting signs on R2's room and bathroom. RN-A stated her concern of staff using wipes and applying dry brief over non-cleansed soiled skin could lead to further skin breakdown and possible infection. RN-A stated that weekly skin assessments are to be completed on bath days. Facility has bath sheets that the aide fills out and gives to the floor nurse to be signed and	2 830			

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2 830	Continued From page 11 reviewed; then turned in to RN-A for final review. RN-A stated these were not completed by floor nurses and was not certain if skin conditions had been addressed. RN-A stated she had fallen behind on completing these timely. RN-A stated weekly skin trackers are to be completed by her every seven days on residents with pressure and non-pressure related wounds. RN-A admitted she was not keeping up on weekly wound measurements and completing management duties as she was pulled to work the floor as a nurse. RN-A stated wounds and PUs were reviewed during their IDT meetings which included updating the plans of care and interventions for residents; however, was uncertain if these were getting completed timely as DON primarily updated care plans During an interview on 6/16/22, at 1:09 p.m. DON stated expectation for pressure and non-pressure wounds to be documented and measured weekly on all residents, turned and repositioned according to orders, and checked and changed as ordered, reminding and reapproaching residents on importance of repositioning, and following doctor prescribed wound care as ordered. DON indicated risk factors that may lead to worsening or new development of PUs which included, not repositioning timely, following physician orders, range of motion, and debility. DON stated an awareness of wound supply shortages. DON stated facility does IDT or "weekly at risk" (WAR) meetings every Wednesday to discuss new admissions, falls, skin concerns, new behaviors, service intensive families, new antibiotics in the past week, nutritional needs and weights, and any other concerns or issues identified with all residents. DON stated care plans and interventions were updated after IDT meetings by herself, MDS	2 830			

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2 830	Continued From page 12 nurse, or RN-A. DON indicated if care plans were not updated; then residents were not receiving the best possible care and staff would not complete what needs to be done. DON stated her expectation for nursing staff to assist R2 with toileting, check and change her incontinence brief, and reposition her so the MASD does not cause further skin breakdown. DON stated facility has been unable to locate any hypoallergenic incontinence briefs for R2. The facility policy titled, Pressure and Non-pressure Injuries dated 8/2/21, indicated this center will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measures intended to achieve the goal of prevention of pressure injuries in our residents. For those residents admitted with, or who subsequently developed a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity. -A head-to-toe body evaluation will be completed on every resident upon admission/readmission and will be documented on the Admission/Readmission Evaluation UDA. -Initiate the Pressure Injury Weekly Tracker UDA - one per wound. -Ensure primary care physician (PCP) is aware of wounds/location of wounds and current treatment orders. -Ensure resident/responsible party is aware of wounds and current treatment plan. -Ensure appropriate treatment orders for each wound area, as needed. -Initiate the baseline plan of care related to current skin status and skin risk level.	2 830			

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2 830	Continued From page 13 -Complete a head-to-toe skin check and document findings on the Skin Review - Weekly NSHC UDA. -Assess current wounds at least every seven days, or more frequently as needed (e.g., decline in wound, presence of infection, wound healed). If a wound fails to show some evidence of progress toward healing within 2-4 weeks, the area and the resident's overall clinical condition should be reassessed. Re-evaluation of the treatment plan includes determining whether to continue or modify the current interventions. Results may vary depending on the resident's overall condition and interventions/treatments used. The complexity of the resident's condition may limit responsiveness to treatment or tolerance for certain treatment modalities. The clinicians, if deciding to retain the current regimen, should document the rationale for continuing the present treatment to explain why some, or all, of the plan's interventions remain relevant despite little or no apparent healing. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate nursing staff on monitoring systems and corresponding assessment completion. The DON or designee could then develop an auditing system as part of QA program to ensure ongoing compliance. DON or designee could re-educate staff on completing comprehensive fall assessments, identification of root cause and appropriate implementation of immediate interventions. DON or designee could then develop an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830			

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2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to prevent pressure ulcers development or deterioration and promote healing by failing to follow physician ordered treatments, follow the care plan, and ensure comprehensive assessments and monitoring for 2 of 4 residents (R1 and R3) reviewed for pressure ulcers. The facility's failures resulted in actual harm for 2 of 4 residents (R1, R3) when new ulcers developed and/or worsened. The deficient practice has the potential to effect all residents in the facility that are at risk for pressure ulcers. Findings include: Pressure Ulcer/Injury (PU/PI) is localized	2 900	F 686 R1 no longer resides at the facility. R3 reviewed for weekly monitoring and measuring needs, assessments, treatments, and care planning by Director of Nursing and/or Designee by 07/11/22. Center residents to have full body skin assessments completed and if skin impairments present reviewed for weekly and measuring needs, comprehensive wound assessments, treatments, and care planning by Director of Nursing and/or Designee by 07/11/2022. Wound		7/11/22

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2 900	Continued From page 15 damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. The appearance will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Stage 2 Pressure Ulcer: Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. Stage 3 Pressure Ulcer: Full-thickness of the skin may extend into the subcutaneous tissue layer; granulation tissue and epibole (rolled wound edges) are often present. At this stage, there may be undermining and/or tunneling that makes the wound much larger than it may seem on the surface. R1's hospital discharge summary dated 3/1/22, indicated R1 had new dermatitis in gluteal cleft associated with incontinence that developed on 2/18/22. R1's admission record identified an admit date of	2 900	Discovery Checklist/Packet initiated by 07/11/2022 that allows staff to utilize a checklist approach to ensure proper actions are taken for residents upon discovery of a new wound. Wound team members identified for weekly wound round duties. Nursing Staff re-educated by Director of Nursing and/or Designee skin/wound protocols to include; identification, documentation, comprehensive wound assessment, intervention implementation and care planning by 07/11/2022. The director of nursing and/ or designee will complete audits of compliance with comprehensive skin assessments for five residents weekly for four weeks, audits of weekly comprehensive wound assessment for five wounds weekly for four weeks, and observation of completion of wound treatments three times weekly for four weeks. Results of audits will be submitted to the QAPI committee for review and recommendations.		

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2 900	Continued From page 16 3/1/22, with diagnoses that included: Parkinson's disease, dementia without behavioral disturbance, peripheral vascular disease (PVD), and chronic obstructive pulmonary disease (COPD). R1's Minimum Data Set (MDS) assessment dated 4/5/22, indicated R1 had moderately impaired cognition, no behaviors or rejection of care, required supervision with eating, and extensive two-person assistance with all other activities of daily living (ADL's) and used a wheelchair for mobility. MDS identified R1 was frequently incontinent of bowel and bladder. The MDS also identified R1 was at risk for pressure ulcers and did not have pressure ulcers or other impaired skin integrity (the MDS did not identify R1's impaired skin integrity according to the record); associated interventions included pressure reducing device for chair and bed, application of nonsurgical dressings other than to feet, and applications of ointments/medications other than to feet. R1's admission physician note dated 3/4/22, indicated R1 was negative for any skin integrity conditions including wounds. On 3/10/22, physician note indicated R1 was negative for wounds R1's care plan dated 3/10/22, indicated urinary incontinence and bowel related to impaired mobility and will be free from skin breakdown and be maintained in as clean and dry, dignified state as possible. Care plan indicated R1 had actual skin integrity break and/or pressure sore(s) - see wound assessment pressure sore, skin tear - bilateral legs, elbows, underlying PVD, upper extremity fractures, and COPD. On 3/23/22, revised interventions included:	2 900			

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2 900	Continued From page 17 -Assess and measure all skin integrity areas per policy. -Follow pressure ulcer prevention guidelines to prevent additional skin problems, promote health, and prevent complications. -Initiate skin monitoring forms per facility policy. -Initiate treatment per physician order. -Monitor and report any new open areas, draining, increased drainage or pain to nurse immediately. -Provide treatment to wound(s) per current treatment order. Assess wound(s) for signs and symptoms (s/s) of infection with each dressing change/treatment. Report findings of redness, warmth, swelling, increased drainage or increased pain to physician immediately. -Report wound progress or decline to medical doctor (MD) with any changes or lack of response to treatment per facility guidelines. R1's record was reviewed between 3/1/22 to 5/31/22. The record identified R1 was admitted to the facility with moisture associated skin damage and within two weeks of admission developed a stage 2 PU that continued to deteriorate to a stage 3. R1's record identified the physician had been following R1's wounds after notification and provided new treatment orders as the wound changed. However, in review of R1's treatment administration record and interviews, the treatments were not always completed per physician orders. The record also identified the facility was not completing comprehensive weekly skin assessments that would identify or determine potential causal factors and modifiable risk factors for appropriate care plan interventions that would reduce the risk of worsening and/or new pressure ulcer development. R1's progress note dated 3/6/22, indicated R1	2 900			

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2 900	Continued From page 18 had developed pressure areas on his coccyx and elbow. R1's record lacked a comprehensive assessment and physician notification. R1's progress note dated 3/9/22, indicated R1 now had a red open area on his coccyx and the physician was notified. A Non-pressure Weekly Tracker form was completed on 3/10/22, with wound measurements and description which included open area on sacrum which was pink and blanchable. The center has an open area that measures 1.4 cm x 1.1 cm x 0.1 cm. Skin is pink, no drainage, no odor, and no tunneling or undermining. R1's record lacked a comprehensive assessment for causal factors. R1's physician visit dated 3/15/22, identified "open area at sacrum measuring 1.4 centimeters (cm) x 1.1 cm x 0.1 cm. Skin around area is pink". Wound continued to heal with pink skin area, no worsening open area or drainage. Nursing to continue to keep it clean and covered with a bordered foam dressing. Nursing was instructed to offload/turn resident at least three times daily to prevent further skin break. Nursing to continue monitoring skin with weekly skin check and update physician if worsening skin area." R1's wound tracker dated 3/17/22, included open area on sacrum measuring 1.4 cm x 0.7 cm x 0.1 cm and indicated wound was improving. R1's physician visit dated 3/23/22, indicated given the onset of coccygeal wound, he is getting closer to being appropriate for hospice. R1's Wound Tracker dated 3/24/22, indicated open area on sacrum measuring 1.7 cm x 1.0 cm x 0.5 cm and indicated wound was worsening and	2 900			

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2 900	Continued From page 19 notified nurse practitioner on 3/22/22. R1's physician visit dated 3/30/22, indicated registered nurse (RN)-A reported coccyx is healing well without redness, drainage, or signs of infection. R1 enrolled with hospice on 3/30/22 per family consent R1's physician visit dated 4/1/22, indicated moisture associated open skin damage measuring 1.5 cm x 0.8 cm x 0.3 cm. R1's record included subsequent weekly Wound Trackers completed on 3/31/22, 4/7/22, 4/14/22, 4/21/22, 4/27/22. The wound trackers indicated the wound measurements remained relatively consistent in size and depth, however, continued to lack a comprehensive assessment to identify and remove potential causal factors. R1's physician visit dated 5/2/22, indicated R1's sacrum PU stage 3 and measured 1.5cm x 0.5 cm x 0.3 cm. R1's record identified weekly Wound Trackers were not completed after 4/27/22 through 5/19/22. R1's weekly Wound Tracker dated 5/19/22 included open area on sacrum measuring 1.5 cm x 0.6 cm x 0.4 cm. On 5/26/22, RN-A documented open area on sacrum measuring 2.2 cm x 1.0 cm x 0.4 cm and peri-wound tissue pink or normal for ethnic group; but indicated wound was worsening with larger open area measurements. When interviewed on 6/15/22, at 12:36 p.m. hospice registered nurse stated R1 was admitted	2 900			

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2 900	Continued From page 20 to hospice on 3/31/22, with diagnoses of Parkinson's dementia and an unstageable PU on coccyx. Hospice RN stated she did not visualize the coccyx wound upon admission as facility LPN-B stated the wound was currently stable. Hospice nurse coordinated with LPN-B to be able to assess and change coccyx dressing on the second visit on 4/7/22; however, when hospice nurse called facility on 4/7/22, at 8:40 a.m. LPN-B stated she had already completed wound care for R1. LPN-B stated coccyx wound was stable, appeared smaller, and facility was continuing on with current treatment orders of acidic acid soaks and mepilex dressing. On 4/28/22, hospice RN had a conversation with RN-A who stated the coccyx PU length and width were staying the same and the dimensions were getting shallower with acidic acid gauze. Hospice RN stated she was uncertain if facility was staging PU at this time. On 4/28/22, hospice nurse stated R1's coccyx wound was upgraded to a stage 2 PU with scant drainage and measured 1.6 cm x 0.5 cm x 0.4 cm with undermining and slough present and she completed dressing change and measurements with RN-A. On 4/29/22, hospice physician wound care orders were faxed to the facility for wound care coccyx pressure area: cleanse with wound cleanser (i.e. Skintegrity) and gauze, allow to dry. Apply skin protectant (i.e. Sure-prep wipe) to intact peri-wound skin, let dry. Apply bordered gauze dressing. Perform wound care every three days and as needed for soiling and loosening. Routine wound care was to be performed by facility staff per these orders. Hospice nurse stated she faxed over the new wound care orders. Hospice nurse stated she then started noticing there was a pattern with R1 not being provided wound care per physician orders. There was a total of three to four visits made by the hospice RN when there was no	2 900			

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2 900	Continued From page 21 dressing in place on R1's coccyx wound. Hospice nurse stated she brought this to the attention of RN-A; RN-A stated the facility had supply issues and there were no bordered dressings to cover the wound. Hospice RN stated it became pattern for facility to not have supplies for R1 so she brought supplies with her and gave facility supplies to use. On 5/24/22, hospice RN stated R1 was found with bowel incontinence in his brief and no dressing found on coccyx wound. Hospice RN stated wound was upgraded to stage 3 PU with undermining, surrounding skin tissue erythema, scant drainage, and measured 1.5 cm x 0.6 cm x 0.5 cm. Hospice RN was unable to locate RN-A at this time to notify her of worsening PU; but notified the floor nurse. On 5/26/22 at 12:10 p.m., hospice nurse called RN-A discussing her concerns with R1 repeatedly found without proper physician prescribed dressings in place for his coccyx PU. On 5/31/22, hospice nurse completed last visit with R1 prior to him discharging to hospice house. R1 was found in bed without coccyx dressing in place with a worsening Stage 3 Coccyx PU which then measured 2.0 cm x 1.2 cm x 0.5 cm with undermining and erythema on surrounding skin. R1 was showing some signs of terminal decline, more swallowing decline, and hospice believed he was already transitioning at that time. R1's treatment administration record (TAR) identified physician orders which included apply in house barrier cream and cover open area with large mepilex 4x4 to coccyx once every day-shift and to update physician if worsening skin area starting on 3/12/22. On 3/24/22, the order was changed to apply acetic acid solution-soaked gauze twice daily and as needed and cover with mepilex dressing. Treatment was not completed on 3/26/22, 4/1/22, 4/9/22, 4/11/22, 4/15/22,	2 900			

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2 900	Continued From page 22 4/18/22, 4/20/22, 4/24/22, 4/25/22, 4/26/22, 4/27/22, and 4/29/22. On 5/3/22, order indicated to cleanse wound with wound cleanser and gauze and allow to dry. Apply skin protectant (i.e. Sure-prep wipe) to intact peri-wound skin, let dry. Apply bordered gauze dressing. Perform wound care every three days and as needed for soiling or loosening. Notify hospice if worsening, has increased drainage, size redness, warmth, pain. Treatment was not completed on 5/3/22 and 5/12/22. When interviewed on 6/15/22, at 3:28 p.m. nursing assistant (NA)-A stated R1 was incontinent of bowel frequently and required frequent checks and changes. NA-A stated aides would get floor nurse to change R1's coccyx dressing if soiled or if it fell off. NA-A stated R1 was repositioned every 2 hours and was unable to sit up in his wheelchair towards the end due to increased pain in coccyx area. When interviewed on 6/16/22, at 8:09 a.m. NA-B stated R1 had a stageable PU on his coccyx that was deep and worsened over time since his admission to facility. NA-B stated she found R1 without coccyx dressing in place usually in the mornings after night shift would say R1 was incontinent of bowel. NA-B stated aides were to notify nurses if dressing was soiled so a new one could be applied. NA-B stated R1 would grimace in pain if bowel movement in the wound and staff had to clean it out and when the nurses had to measure the depth of the wound. When interviewed on 6/16/22, at 11:35 a.m. RN-A stated a comprehensive head-to-toe assessment is completed on every resident upon admission, quarterly, and at change of condition which included: skin and bowel assessments. RN-A	2 900			

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2 900	Continued From page 23 stated that weekly skin assessments are to be completed on bath days. Facility has bath sheets that the aide fills out and gives to the floor nurse to be signed and reviewed; then turned in to RN-A for final review. RN-A admitted these were not completed by floor nurses, RN-A had found them not signed and dated by floor nurses, so she was uncertain if the skin conditions had been addressed. RN-A stated she had fallen behind on completing these timely. RN-A stated weekly skin trackers are to be completed by her every seven days on residents with pressure and non-pressure related wounds. RN-A stated R1 developed a stage 1 PU on his coccyx after his admission to facility. RN-A stated she completed R1's admission comprehensive assessment; however, failed to complete a thorough skin assessment which included looking at R1's buttocks. RN-A stated she found R1's open area on coccyx and moisture associated skin damage (MASD) two weeks after admission to facility. RN-A stated she was aware R1 was found numerous times without proper wound care dressings to his PU and floor nurses would report to her that "oh, I was just going to put that on now." RN-A stated R1 was frequently incontinent of stool and the coccyx dressing needed to be replaced; however, was not completed often because of some staff completely disregarded R1's need. RN-A stated the aides would get R1 cleaned up well but citric acid was not used by nursing staff to cleanse the inside of R1's wound during incontinence episodes as it should have been. RN-A stated R1 was on a turning and repositioning schedule every two hours; but thought this was not getting completed by aides timely. RN-A admitted she was not keeping up on weekly wound measurements and completing management duties as she was pulled to work the floor as a nurse. RN-A stated facility	2 900			

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2 900	Continued From page 24 completes weekly interdisciplinary team (IDT) meetings on Wednesdays which included: Administrator, DON, RN unit manager, MDS nurse, and dietician. RN-A stated she was unable to go to these meetings in May as she was working as a floor nurse primarily. RN-A stated wounds and PUs were reviewed during their IDT meetings which included updating the plans of care and interventions for residents; however, was uncertain if these were getting completed timely as DON primarily updated care plans. During a returned call telephone interview on 6/21/22, at 1:17 p.m. NP stated R1 was admitted to facility without a PU. NP stated physician was notified approximately two weeks after admission that R1 developed an open area on his coccyx. NP expressed concern of not being able to find facility staff to assist with wound measurements and dressing changes when at facility which could have affected R1's care he received. NP stated she initiated a wound care protocol for DON to give her a list of all residents with current wounds every Friday at 9:00 a.m. for physician rounds so they were able to properly assess and measure all PUs and non-pressure ulcer wounds. R3's admission record identified diagnoses that included: dementia with behavioral disturbance, type 2 diabetes mellitus (DM), anxiety, and eczema. R3's quarterly MDS assessment dated 5/12/22, indicated R3 was cognitively intact, displayed no behaviors or rejection of cares, required setup help for most ADL's, however required limited one-person assist for dressing and personal hygiene. The MDS identified R3 had occasional incontinence of bladder. R3's MDS indicated R3	2 900			

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2 900	Continued From page 25 was at risk for pressure ulcer development, did not have pressure ulcers, however, did have MASD, skin care interventions included pressure reducing device for chair and bed and application of ointments/medications other than to feet. R3's care plan dated 8/13/18, indicated R3 was at risk for bowel and bladder incontinence as evidenced by the resident needing some assistance with toileting as needed due to dementia, anxiety, weakness, and use of diuretic. Provide incontinence care/perineal care after each incontinent episode and use barrier cream each time. R3 was at risk for skin integrity related to dementia, weakness, dermatitis/eczema, sleeps in recliner per resident choice, MASD to chest area/under breasts/groin/right buttocks with interventions that included: -Conduct pressure injury skin assessments (i.e. Braden scale) as indicated. -Assess skin for redness or pressure related changes with each care encounter. Report any changes immediately. Head-to-toe assessment by licensed nurse performed weekly at minimum (revision date 2/11/22). -Administer medications per MD order. Resident refuses treatment at times. Encourage her to allow treatment (revision date 6/8/22). -Keep resident clean and dry. Use barrier cream after good peri-care. Apply proper incontinent products. Encourage resident to allow staff to assist in cares. Resident has history of refusing due to wanting to remain as independent as possible (inconsistent with MDS dated 5/12/22). Education given on risks of completing own cares as resident does struggle with thoroughness of task (revised on 6/16/22). R3's physician orders included: -Right buttock and left perineal area: apply	2 900			

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2 900	Continued From page 26 mepilex border to area and change every three days and as needed if soiled. Interdry to groin area. Change twice daily every morning and at bedtime (start date 4/19/22). -Nursing to check perineal area for proper wiping/cleaning/document refusal at bedtime (start date 4/22/22). -Nursing to check perineal area every shift and update provider if worsening skin area (start date 6/13/22). R3's record was reviewed between 3/31/22 to 6/16/22. Weekly Skin Reviews were reviewed in conjunction with non-pressure weekly trackers and physician notes. The record identified worsening skin integrity and the development of pressure ulcers after R3 had MASD. The record lacked ongoing weekly comprehensive skin assessments and treatments not completed according to physician orders. -Weekly non-pressure tracker dated 3/31/22, included facility acquired open area on right buttocks MASD increased in size measuring 1.0 cm x 0.5 cm x 0.1 cm was bright red and/or blanches to touch. Physician visit note dated 3/31/22, indicated facility requesting evaluation of right buttock open wound with redness that they have been dressing with border foam to cover. -Weekly non-pressure tracker dated 4/7/22, included an open area on right buttock measuring 0.5 cm x 0.3 cm x 0.1 cm and indicated wound was improving. A facility acquired open area on left perineal area MASD measuring 1.0 cm x 0.3 cm x 0.1 was pink or normal for ethnic group. Physician visit included dated 4/7/22, included nursing reported R3's "periarea is very raw, red, and inflamed in periarea. She does refuse for personal cares to be done frequently." Today, NP assessed the MASD to right buttock area	2 900			

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2 900	Continued From page 27 measuring 0.3 cm x 1cm and left perineal MASD measuring 0.57 cm x 0.3 cm x 0.1 cm. NP discussed new dressing and Nursing was instructed to continue monitoring skin with weekly skin check and update provider of worsening skin area. -Weekly non-pressure tracker dated 4/12/22, indicated an open area on right buttock measuring 0.4 cm x 0.3 cm x 0.1 cm was bright red and/or blanches to touch. Left perineal are MASD measuring 0.9 cm x 0.3 cm x 0.1 cm. -Weekly skin review dated 4/21/22 indicated R3 had a small open area on her perineum; no other information about the area was documented. -Weekly skin review dated 4/28/22 indicated R3 had a small open area on coccyx; no other information about the small open area was documented. R3's record did not include completed skin reviews and/or non-pressure weekly trackers between 4/29/22 and 5/18/22. R3's physician visit dated 5/6/22, indicated right buttock area MASD improving and groin rash has resolved per nursing. No further physician visits were provided that addressed R3's wounds. -Weekly skin review dated 5/19/22, indicated R3 had an area on left labia which is currently being treated. R3's record did not include completed skin reviews and/or non-pressure weekly trackers between 5/20/22 and 6/5/22. -R3's weekly skin review dated 6/6/22, included	2 900			

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2 900	Continued From page 28 open excoriated areas on mons pubis and labia from scratching. Raw, reddened skin on right buttock measuring 4.5 cm x 6.0 cm with smaller open area in the middle measuring 1.5 cm x 1.0 cm. The corresponding non-pressure weekly tracker dated 6/6/22 was inconsistent with the weekly tracker; the non-pressure tracker only identified open area on right buttock measuring 1.5 cm x 1.0 cm x 0.1 cm. The next skin tracker that was completed on 6/16/22. The weekly skin review and the non-pressure tracker were inconsistent. The non-pressure weekly tracker dated 6/16/22, included an open area on right buttock measuring 0.9 cm x 0.5 cm x 0.1 cm. Whereas the weekly skin review dated 6/16/22 included, right and left buttock with open areas of concern to coccyx and right/left buttock. R3's record lacked comprehensive wound assessments for all the areas identified on the tracking forms. In addition, the record lacked identification of potential causal factors and/or modifiable risk factors contributing the deterioration of R3's that could otherwise be removed to ensure healing, reduce the risk of deterioration, and new ulcer development. Review of R3's TAR identified the physician orders and also indicated several occasions when R3 was not provided skin treatments per physician orders. - Right buttock and left perineal area: Apply Medi-honey to right buttock and left perineal and cover with 2x2 foam dressing. Once daily and as needed. Update provider if worsening to be completed every dayshift. Not completed on the following dates: 4/9/22, 4/10/22, 4/15/22, 4/18/22, 4/19/22, and 5/2/22.	2 900			

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2 900	Continued From page 29 -Right buttock and left perineal area: Apply Mepilex border to area and change every three days and as needed if soiled on dayshift. Not completed on the following dates: 4/20/22, 4/23/22, 4/26/22, 4/29/22, 5/2/22, 6/3/22, and 6/9/22. -Interdry to groin area. Change twice daily every morning and at bedtime. Not completed on 4/20/22, 5/19/22, 6/2/22, 6/6/22, 6/7/22, 6/8/22, and 6/9/22. -Nursing to check perineal area for proper wiping/cleaning at bedtime. Document refusal. Not completed on 6/3/22 and 6/9/22. During an interview on 6/14/22, at 2:19 p.m. NA-C stated R3 currently had multiple sores on her buttocks and thigh area that staff are cleaning twice a shift. NA-C stated there were no dressings ordered to be applied to open wounds. During an observation on 6/15/22, at 8:31 a.m. R3 observed sitting in grey recliner in corner of room with breakfast tray. Surveyor could smell stale, foul urine from the doorway of R3's room. During an observation and interview on 6/15/22, at 10:08 a.m. R3 laid in bed, RN-B at bedside to change R3's dressings. R3 did not have prescribed bordered foam dressing to open sores on right and left buttocks, bilateral mons pubis area, nor interdry in groin folds. RN-B indicated R3 had two open sores to right buttocks (one circular and the other a large, long rectangular shaped slit), one open sore to left buttocks, one open sore on left mons pubis perineal area, and one open sore on right mons pubis perineal area. RN-B stated the area was very reddened to almost darkened purplish colored and moist. RN-B stated she measured all wounds which included pressure and non-pressure sores; but	2 900			

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2 900	Continued From page 30 was uncertain how often this task gets completed. RN-B applied one 4x4 mepilex to two right buttocks stage 2 PUs and one mepliex applied to left stage 1 PU on left buttocks. RN-B stated facility did not apply dressing to open areas to mons pubis perineal area. RN-B stated R3 is very active during the day and transfers independently so is not on a repositioning schedule. During an observation and interview on 6/16/22, at 10:30 a.m. R3 observed walking with NA-B to go to third floor whirlpool tub for bath. NA-B assisted R3 to remove her clothing; physician ordered dressings were not in place on her buttocks nor interdry in her abdominal folds. Surveyor observed R3 with two open areas on right buttocks, one small open area on left buttocks, and bilateral openings on mons pubis perineal area. At 10:57 a.m. LPN-E completed dressing changes to R3's bottom. LPN-E indicated the small circular opening on left buttocks and right long rectangular shaped opening on right are new wounds since 6/10/22 when she had last worked. During an interview on 6/15/22, at 8:46 a.m. RN-B stated R3 has sores on her buttocks, lower extremities from eczema, redness in bilateral groin folds and abdominal folds that require interdry placed in folds. RN-B stated R3 was incontinent of bladder frequently and wore a brief. During an interview on 6/15/22, at 9:00 a.m. R3 stated she did not have any current open sores on her skin. R3 stated she used to have sores on her buttocks, but facility staff bandaged them up and they healed up right away. R3 stated she was continent of bowel and bladder and was independent with transfers and locomotion. R3	2 900			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 900	Continued From page 31 had some notable forgetfulness during interview as R3 was unsure why she wore an incontinence brief. During an interview on 6/15/22, at 4:20 p.m. NA-D stated R3 was alert, oriented, and independent with all cares. NA-D stated R3 wore an incontinence brief as she had some episodes of incontinence. NA-D stated R3 wanted to remain independent. During an interview on 6/15/22, at 4:05 p.m. RN-C stated R3 has had open areas on her buttocks and perineum, but they have since healed up and closed even though according to NAs R3 had open areas on 6/14/22 and the surveyor's observation earlier that day. RN-C stated NAs should be checking on R3 every two hours or as needed. RN-C stated if R3 refuses, aides should be redirecting resident or checking back with her shortly. RN-C stated R3 is incontinent of bladder at all times and R3's dementia is quite "off" sometimes and speaks about a past doctor who she takes recommendations from. During an interview on 6/16/22, at 8:09 a.m. NA-B stated R3 was alert, but often very forgetful due to her dementia. NA-B stated R3 listens to a MD from years past so they often redirect R3 informing her the MD is okay with cares. NA-B stated R3 has multiple open areas on buttocks and mons pubis perineal area and stated these were open on her shift on 6/12/22. NA-B stated R3 has reddened groin folds, underneath bilateral breasts, and on perineal area. NA-B stated these were "very enflamed, swollen, sore, and painful" for R3. NA-B stated aides are to be checking on R3's incontinence brief two to three times per shift and checking and changing as appropriate.	2 900			

Minnesota Department of Health

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2 900	Continued From page 32 NA-B stated she believed this was not part of the aide tasks on EHR; however, the information is passed along in verbal shift report. During an interview on 6/16/22, at 8:29 a.m. LPN-E stated R3 had an order to dress open areas on right and left buttocks with mepilex every three days or as needed for soiling. LPN-E stated R3 will refuse; however she would respond easily with redirection or reapproach. LPN-E stated NA's should be alerting nurses if they need assistance for redirection. LPN-E stated there were only certain NAs who were aware of correct cares and completed them well. LPN-E stated R3 was incontinent of bladder all the time and wears an incontinence brief. During an interview on 6/16/22, at 11:35 a.m. RN-A stated R3's buttocks opened up in March. RN-A confirmed R3's skin wound measurements were not completed the weeks of 5/26/22 and 6/2/22. RN-A stated her concern would be failure to track and trend progression or healing of the wounds if there are no weekly skin measurements completed. RN-A stated R3 has dementia and is quite forgetful following a TBI. RN-A stated R3's dressing should be in place per physician orders at all times. RN-A verified R3 there was not a task list or care plan for NAs to know R3 should have a dressing in place at all times. RN-A stated she had fallen behind on completing these timely. RN-A stated weekly skin trackers are to be completed by her every seven days on residents with pressure and non-pressure related wounds. RN-A stated she was not keeping up on weekly wound measurements and completing management duties as she was pulled to work the floor as a nurse. RN-A stated wounds and PUs were reviewed during their IDT meetings which	2 900			

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2 900	Continued From page 33 included updating the plans of care and interventions for residents; however, was uncertain if these were getting completed timely as DON primarily updated care plans. During an interview on 6/16/22, at 1:09 p.m. DON stated expectation for pressure and non-pressure wounds to be documented and measured weekly on all residents, turned and repositioned according to orders, and checked and changed as ordered, reminding and reapproaching residents on importance of repositioning, and following doctor prescribed wound care as ordered. DON indicated risk factors that may lead to worsening or new development of PUs which included, not repositioning timely, following physician orders, range of motion, and debility. DON stated an awareness of wound supply shortages. DON stated facility does IDT or "weekly at risk" (WAR) meetings every Wednesday to discuss new admissions, falls, skin concerns, new behaviors, service intensive families, new antibiotics in the past week, nutritional needs and weights, and any other concerns or issues identified with all residents. DON stated care plans and interventions were updated after IDT meetings by herself, MDS nurse, or RN-A. DON indicated if care plans were not updated; then residents were not receiving the best possible care and staff would not complete what needs to be done. During a returned telephone interview on 6/21/22 at 1:17 p.m. NP expressed concern of not being able to find facility staff to assist with wound measurements and dressing changes when at facility which could have affected R1's care he received. NP stated she initiated a wound care protocol for DON to give her a list of all residents with current wounds every Friday at 9:00 a.m. for	2 900			

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2 900	Continued From page 34 physician rounds so they were able to properly assess and measure all PU's and non-pressure ulcer wounds. NP stated R3 has dementia with significant cognitive impairment. NP stated she thought R3's worsening skin conditions including MASD were related to R3 not receiving good perineal care following incontinence episodes. The facility policy titled Pressure and Non-pressure Injuries dated 8/2/21, indicated this center will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measures intended to achieve the goal of prevention of pressure injuries in our residents. For those residents admitted with, or who subsequently developed a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity. -A head-to-toe body evaluation will be completed on every resident upon admission/readmission and will be documented on the Admission/Readmission Evaluation UDA. -Initiate the Pressure Injury Weekly Tracker UDA - one per wound. -Ensure primary care physician (PCP) is aware of wounds/location of wounds and current treatment orders. -Ensure appropriate treatment orders for each wound area, as needed. -Ensure resident/responsible party is aware of wounds and current treatment plan. -Initiate the baseline plan of care related to current skin status and skin risk level. -Complete a head-to-toe skin check and document findings on the Skin Review - Weekly NSHC UDA.	2 900			

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2 900	Continued From page 35 -Assess current wounds at least every seven days, or more frequently as needed (e.g., decline in wound, presence of infection, wound healed). If a wound fails to show some evidence of progress toward healing within 2-4 weeks, the area and the resident's overall clinical condition should be reassessed. Re-evaluation of the treatment plan includes determining whether to continue or modify the current interventions. Results may vary depending on the resident's overall condition and interventions/treatments used. The complexity of the resident's condition may limit responsiveness to treatment or tolerance for certain treatment modalities. The clinicians, if deciding to retain the current regimen, should document the rationale for continuing the present treatment to explain why some, or all, of the plan's interventions remain relevant despite little or no apparent healing SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring.	2 900			

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2 900	Continued From page 36 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 29, 2022

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

Re: State Nursing Home Licensing Orders
Event ID: MEV711

Dear Administrator:

The above facility was surveyed on June 14, 2022 through June 16, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

Rochester East Health Services

June 29, 2022

Page 2

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/16/2022
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F 000	INITIAL COMMENTS On 6/14/22, through 6/16/22, a standard abbreviated survey was conducted at your facility. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H51842025C (MN83975) at F684 and F686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684			7/11/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/01/2022

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.

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F 684	Continued From page 1 Based on observation, interview, and document review, the facility failed to comprehensively assess, monitor, follow physician ordered treatments and care plan for 1 of 4 residents (R2) who developed and had ongoing painful moisture associated skin damage (MASD) Findings include: R2's admission record identified an admit date of 1/20/20, with diagnoses that included: type 2 diabetes mellitus (DM), congestive heart failure (CHF), atrial fibrillation, chronic kidney disease, peripheral venous disease (PVD), and morbid obesity. R2's annual Minimum Data Set (MDS) assessment dated 4/8/22, indicated R3 had moderate cognitive impairment, did not have behaviors or rejection of care, required limited one person assist with locomotion, extensive assistance with most activities of daily living (ADL's) other than eating. R2 noted to be frequently incontinent of bladder and occasionally incontinent of bowel. The MDS identified R2 was at risk for pressure ulcer development and did not identify moisture associated skin damage (MASD). Skin care interventions included pressure reducing device for chair and bed, application of nonsurgical dressings other than to feet, and applications of ointments/medications other than to feet. R2's skin care plan dated 6/7/22, indicated R2 was at risk for skin integrity conditions and pressure sores related to impaired mobility and incontinence. Interventions included: -Assess skin for redness or pressure related changes with each care encounter. Report any	F 684	F 684 R2 is not currently at the facility. Needs will be reassessed upon R2's return. Residents with MASD with orders for treatment have the potential to be impacted by this practice. Residents reviewed for current MASD issues, assessed by licensed nurses, and orders validated if indicated. Education will be provided by the Director of Nursing or designee to nurses on completing treatments as ordered, following MD orders, and completing medication error reports for missed treatments. Education included completion of weekly skin assessments and updates to wound reports if indicated. The Director of Nursing or designee will complete monitor the facility dashboard to identify any missed treatments Monday-Friday and follow up with nurses on any missed treatments or missed skin assessment and monitoring. Missed treatments or missed documentation will be addressed following the center process for educational or disciplinary action. This will be an ongoing change of practice.		

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F 684	Continued From page 2 changes immediately. -Conduct pressure injury skin assessments (i.e. Braden scale) as indicated. -Frequent repositioning in bed and chair. -Head-to-toe assessment by licensed nurse performed weekly at minimum. -No wipes, only wash cloths with water, and hypoallergenic soap. R2's bowel/bladder care plan dated 1/21/22, R2 had alteration in bowel and bladder incontinence related to impaired mobility, mood/behavioral issues, and medication. Interventions included keeping R2 clean and dry, use barrier cream after good peri-care, apply incontinent products as needed. A revised intervention dated 6/9/22, indicated scheduled toileting program every two to three hours and as needed while awake. R2's physician note dated 5/12/22, indicated R2 was frustrated due to the quality of care she is receiving at the facility, skin is being "rubbed" with scented wipes as she has noted significant irritation with the product, the care she receives overnight, and not being properly dressed with pants as staff are unable to assist. R2 had pain located in her inner thighs due to "urine burns" related to poor skin care and the products used. Bilateral inner proximal thighs incontinence associated dermatitis with open skin areas. R2 noted with significant erythema, non-blanchable with several small about 1 centimeter (cm) size open skin areas on both proximal inner thighs close to the groin area. No erythema noted underneath her breasts or abdominal pannus/folds. Physician orders included "DO NOT USE WIPES" - only use a wash cloth, water, and hypoallergenic soap to clean her three times per day and as needed if she is soiled, clean the	F 684			

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F 684	Continued From page 3 region with soap and water allowing to dry completely. "PAT DRY, DO NOT RUB." Apply barrier cream (zinc oxide). Notify if area affected worsens. R2's physician note dated 5/17/22, indicated R2 stated caregivers have been grumbling and wanting to use regular soap on her skin. Licensed practical nurse (LPN)-A placed several notices in R2's room and bathroom stating not to use regular soap and wipes on R2's skin any longer. Current skin management seems to be helping as no rash nor open areas were noted today. Orders placed to use hypoallergenic briefs and registered nurse (RN)-A notified and will order incontinence products. Physician skin care orders included: -Cleanse groin and intergluteal areas with warm washcloth, pat dry, and apply Clotrimazole cream two times a day until resolved. Once resolved then continue as needed (start date 2/22/22). -Do not use wipes, only use a wash cloth, water, hypoallergenic soap every shift, apply zinc oxide cream 13% topically three times a day for rash and as needed to bilateral proximal inner thighs (start date 5/12/22). R2's record lacked evidence that the order for hypoallergenic briefs from the 5/17/22, visit was transcribed into the medical chart. R2's Treatment Administration Record (TAR) identified R2's prescribed treatments and treatments were not completed per physician orders: -Cleanse groin and intergluteal area with warm washcloth, pat dry and apply Clotrimazole cream two times a day until resolved. Not completed on	F 684			

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F 684	Continued From page 4 5/4/22, 5/6/22, 5/20/22, and 6/9/22. -Peri area and buttocks open to air while in bed. Not completed on 5/4/22, 5/6/22, 5/20/22, and 6/9/22. R2's record was reviewed from 5/1/22 to 6/16/22, although the record identified R2's Weekly skin Reviews were completed, there was a lack of a completed comprehensive assessment. R2's skin reviews are as follows: -On 5/16/22, redness in groin and down inner thighs which is currently being treated. -On 5/23/22, no current skin conditions as R2 refused shower and skin check. -On 5/30/22, no current skin conditions. -On 6/4/22, redness in groin from MASD and open area on back/front of right leg. -On 6/7/22, documented blisters, redness, and open area to right lower leg. During an observation and interview on 6/15/22, at 11:52 a.m. LPN-A and NA-F were observed changing R2's saturated incontinent brief. Buttocks, bilateral groins, and abdominal folds observed moist, yeasty, very inflamed, fire engine red, and raw. R2 screamed out in pain as facility staff wiped her buttocks. R2 informed LPN-A and NA-F that some NAs were still using wet-wipes on her skin despite current physician orders and the NAs on nightshift would not even cleanse skin prior to putting on a dry brief. NAs put a new brief back on R2. LPN-A stated R2 was incontinent of bowel and bladder. LPN-A stated they use hypoallergenic incontinence briefs on R2, however, the facility had not ordered yet so not available. An opened package of Cardinal Health Personal Cleaning Cloths - Scented were found in R2's room on top of the dresser. LPN-A took opened package of wet-wipes and placed it on	F 684			

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F 684	Continued From page 5 second floor East wing treatment cart. LPN-A stated since R2 had a lot of urinary incontinence staff could not leave her peri area and bottom open to air. During an observation and interview on 6/16/22, at 7:52 a.m. R2 observed sitting on edge of bed with bedside table in front of her. R2 stated she remains in a wet brief until 20 to 30 minutes prior to the end of night shift every night without getting changed. R2 stated she is frequently incontinent and does not always know when the brief is wet. R2 stated her incontinence brief was last changed at 5:30 a.m. During an observation and interview on 6/16/22, at 8:54 a.m. R2 observed sitting on edge of bedside eating breakfast. R2 had not been toileted or changed since 5:30 a.m. During an observation on 6/16/22, at 9:15 a.m. R2's call light observed on. At 9:21 a.m., NA-G answered R2's call light. R2 wanted to use the bedpan to have a bowel movement, NA-G pulled down R2's brief that was saturated with urine and assisted R2 on the bedpan. At 9:37 a.m., NA-G assisted R2 off of bed pan and cleansed R2's skin using wet washcloths and applied DermaCerin barrier cream (moisturizing cream petroleum based, R2 did not have a physician order for this type of cream). NA-G stated she alternates barrier creams every other time with PeriGuard ointment (contains zinc 3.8%). NA-G stated R2 is on a toileting schedule every two to three hours and needs assistance to reposition. NA-G confirmed R2 had not been toileted or her incontinence brief since 5:30 a.m. as she had not assisted R2 yet this morning. NA-G stated she saw wet-wipes in R2's room two weeks ago	F 684			

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F 684	Continued From page 6 despite having a physician order not to use them. NA-G stated facility was not using hypoallergenic incontinence briefs yet either. NA-G stated R2 allows staff to properly wash her skin and stated she has never seen a residents buttocks look that reddened and inflamed before. During an interview on 6/14/22, at 2:19 p.m. NA-C stated R2 was a dependent resident with no skin conditions; however, stated R2 required the use of dry tissues, wet washcloths, barrier cream, and could not use wet wipes on skin for cleansing. NA-C did not articulate and/or mention the intervention of R2's peri area and buttocks were to be open to air while in bed. During an interview on 6/14/22, at 3:09 p.m. NA-E stated R2's buttocks were extremely red and sometimes had open areas involved. NA-E stated aides apply different barrier creams to buttocks and nurses will apply dressings to open areas. NA-E stated R2 was on a turning, repositioning, and toileting schedule was every two to three hours and as needed. NA-E stated R2 required the use of wet wash cloths and no wet-wipes were to be used on R2's skin due to allergies. NA-E did not articulate and/or mention the intervention of R2's peri area and buttocks were to be open to air while in bed. During an interview on 6/15/22, at 8:46 a.m. RN-B stated R2 had a very painful, reddened, and inflamed buttocks. RN-B stated R2 required physician orders to cleanse skin with wet washcloth, soap, and water and could not use wet-wipes as it worsened R2's MASD. During an interview on 6/15/22, at 3:28 p.m. NA-A stated R2 was on a toileting and repositioning	F 684			

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F 684	Continued From page 7 schedule up to five times per shift. NA-A stated NAs should be assisting R2 to the bedpan a couple times per day. NA-A stated R2 occasionally refuses; however, does well with redirection and reapproach. NA-A stated NA's document refusals and informed nurse each time. NA-A stated R2 could not use wet-wipes due to a skin allergy and was cleansed with soap and water. NA-A stated R2 had MASD and there were signs posted in R2's room and bathroom to alert staff to not use wet-wipes. NA-A did not articulate and/or mention the intervention of R2's peri area and buttocks were to be open to air while in bed. During an interview on 6/15/22, at 12:09 p.m. R2 stated her buttocks "burned like hell." R2 stated the night shift NAs do not clean her up well after an incontinence episode; which also occasionally happens on day shift as well. R2 stated staff take off wet brief, do not dry her skin or wash her skin, and re-apply a dry clean brief. R2 stated nurses remove wet-wipes from her room, but then they reappear after they have been removed. R2 stated RN-A completed wound care measurements today; however, was not getting completed every week. During an interview on 6/16/22, at 8:09 a.m. NA-B stated R2's entire buttocks and groin folds were very reddened and moist. NA-B stated facility transitioned from using wet-wipes to using a damp wash cloth or toilet paper and applying barrier cream as needed. NA-B stated R2 will put on call light when she needs to be toileted. NA-B stated she was uncertain if R2 was on a turning, repositioning, or toileting schedule. NA-B stated R2 does not always know when she is incontinent and wet.	F 684			

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F 684	Continued From page 8 During an interview on 6/16/22, at 8:29 a.m. LPN-E stated NAs should be following toileting and repositioning schedules every two hours as ordered so all residents skin remained dry and intact. LPN-E stated NAs and nursing staff must follow physician prescribed orders if wet-wipes are not allowed for a resident. LPN-E stated if she found a NA not following orders, she would attempt to re-educate the aide, speak to the unit manager, and possibly the director of nursing (DON) if needed. LPN-E stated concern for further skin breakdown and skin sores that could worsen developing into pressure ulcers (PUs) which could lead to infections and sepsis. During an interview on 6/16/22, at 11:16 a.m. LPN-A stated R2's bowel and bladder functioning has declined since she started at facility in February. LPN-A stated R2 is frequently incontinent most of the time. LPN-A stated R2 was on a toileting schedule every two hours; however, was not certain if NAs complete this task as she stated R2 will let staff know when she's incontinent. LPN-A stated NAs do not need to check R2's incontinence brief for dryness. LPN-A stated she had not seen wet-wipes in R2's room in the past two weeks so the package that was found in R2's room on 6/15/22 was recently used on resident. LPN-A stated concern for possible further skin breakdown as R2 is allergic to the wet-wipes that are perfumed. During an interview on 6/16/22, at 11:35 a.m. RN-A stated she thought R2 was not necessarily on a toileting or repositioning schedule. RN-A stated R2 had morning and bedtime cares only or if R2 had an incontinent episode. RN-A stated she asked the staff member who is responsible for ordering supplies to order hypoallergenic	F 684			

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F 684	Continued From page 9 briefs one month ago; but has not followed-up to see if R2 received the supplies. RN-A stated facility does not have hypoallergenic soap as they use the "total bath and body wash" which is orange colored. RN-A stated she would have to follow-up on the soap. RN-A stated R2 did not have MASD or skin sensitivity redness a few months ago and R2's skin has worsened. RN-A stated she would need to re-educate nursing staff on following physician orders to not use wet-wipes on R2's skin despite efforts LPN-A had utilized with posting signs on R2's room and bathroom. RN-A stated her concern of staff using wipes and applying dry brief over non-cleansed soiled skin could lead to further skin breakdown and possible infection. RN-A stated that weekly skin assessments are to be completed on bath days. Facility has bath sheets that the aide fills out and gives to the floor nurse to be signed and reviewed; then turned in to RN-A for final review. RN-A stated these were not completed by floor nurses and was not certain if skin conditions had been addressed. RN-A stated she had fallen behind on completing these timely. RN-A stated weekly skin trackers are to be completed by her every seven days on residents with pressure and non-pressure related wounds. RN-A admitted she was not keeping up on weekly wound measurements and completing management duties as she was pulled to work the floor as a nurse. RN-A stated wounds and PUs were reviewed during their IDT meetings which included updating the plans of care and interventions for residents; however, was uncertain if these were getting completed timely as DON primarily updated care plans During an interview on 6/16/22, at 1:09 p.m. DON stated expectation for pressure and non-pressure	F 684			

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F 684	Continued From page 10 wounds to be documented and measured weekly on all residents, turned and repositioned according to orders, and checked and changed as ordered, reminding and reapproaching residents on importance of repositioning, and following doctor prescribed wound care as ordered. DON indicated risk factors that may lead to worsening or new development of PUs which included, not repositioning timely, following physician orders, range of motion, and debility. DON stated an awareness of wound supply shortages. DON stated facility does IDT or "weekly at risk" (WAR) meetings every Wednesday to discuss new admissions, falls, skin concerns, new behaviors, service intensive families, new antibiotics in the past week, nutritional needs and weights, and any other concerns or issues identified with all residents. DON stated care plans and interventions were updated after IDT meetings by herself, MDS nurse, or RN-A. DON indicated if care plans were not updated; then residents were not receiving the best possible care and staff would not complete what needs to be done. DON stated her expectation for nursing staff to assist R2 with toileting, check and change her incontinence brief, and reposition her so the MASD does not cause further skin breakdown. DON stated facility has been unable to locate any hypoallergenic incontinence briefs for R2. The facility policy titled, Pressure and Non-pressure Injuries dated 8/2/21, indicated this center will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measures intended to achieve the goal of prevention of pressure injuries in our residents. For those residents admitted with, or who	F 684			

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F 684	Continued From page 11 subsequently developed a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity. -A head-to-toe body evaluation will be completed on every resident upon admission/readmission and will be documented on the Admission/Readmission Evaluation UDA. -Initiate the Pressure Injury Weekly Tracker UDA - one per wound. -Ensure primary care physician (PCP) is aware of wounds/location of wounds and current treatment orders. -Ensure resident/responsible party is aware of wounds and current treatment plan. -Ensure appropriate treatment orders for each wound area, as needed. -Initiate the baseline plan of care related to current skin status and skin risk level. -Complete a head-to-toe skin check and document findings on the Skin Review - Weekly NSHC UDA. -Assess current wounds at least every seven days, or more frequently as needed (e.g., decline in wound, presence of infection, wound healed). If a wound fails to show some evidence of progress toward healing within 2-4 weeks, the area and the resident's overall clinical condition should be reassessed. Re-evaluation of the treatment plan includes determining whether to continue or modify the current interventions. Results may vary depending on the resident's overall condition and interventions/treatments used. The complexity of the resident's condition may limit responsiveness to treatment or tolerance for certain treatment modalities. The clinicians, if deciding to retain the current regimen, should	F 684			

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F 684	Continued From page 12	F 684			
F 686 SS=G	document the rationale for continuing the present treatment to explain why some, or all, of the plan's interventions remain relevant despite little or no apparent healing. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) 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 (ii) 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to prevent pressure ulcers development or deterioration and promote healing by failing to follow physician ordered treatments, follow the care plan, and ensure comprehensive assessments and monitoring for 2 of 4 residents (R1 and R3) reviewed for pressure ulcers. The facility's failures resulted in actual harm for 2 of 4 residents (R1, R3) when new ulcers developed and/or worsened. The deficient practice has the potential to effect all residents in the facility that are at risk for pressure ulcers. Findings include:	F 686	F 686 R1 no longer resides at the facility. R3 reviewed for weekly monitoring and measuring needs, assessments, treatments, and care planning by Director of Nursing and/or Designee by 07/11/22. Center residents to have full body skin assessments completed and if skin impairments present reviewed for weekly and measuring needs, comprehensive wound assessments, treatments, and		7/11/22

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F 686	Continued From page 13 Pressure Ulcer/Injury (PU/PI) is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. The appearance will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Stage 2 Pressure Ulcer: Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. Stage 3 Pressure Ulcer: Full-thickness of the skin may extend into the subcutaneous tissue layer; granulation tissue and epibole (rolled wound edges) are often present. At this stage, there may be undermining and/or tunneling that makes the wound much larger than it may seem on the surface. R1's hospital discharge summary dated 3/1/22, indicated R1 had new dermatitis in gluteal cleft associated with incontinence that developed on			F 686	care planning by Director of Nursing and/or Designee by 07/11/2022. Wound Discovery Checklist/Packet initiated by 07/11/2022 that allows staff to utilize a checklist approach to ensure proper actions are taken for residents upon discovery of a new wound. Wound team members identified for weekly wound round duties. Nursing Staff re-educated by Director of Nursing and/or Designee skin/wound protocols to include; identification, documentation, comprehensive wound assessment, intervention implementation and care planning by 07/11/2022. The Director of Nursing or designee will monitor the facility dashboard to identify any missed skin assessments or wound monitoring Monday-Friday and follow up with nurses on any missed assessments and monitoring following the center process for educational or disciplinary action. This will be an ongoing change of practice. Additionally, the director of nursing and/ or designee will complete audits of compliance with comprehensive skin assessments for five residents weekly for four weeks, then for four residents weekly for four weeks, then one resident weekly for four weeks. The Director of Nursing or designee will audit weekly comprehensive wound assessment for five wounds weekly for		

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F 686	Continued From page 14 2/18/22. R1's admission record identified an admit date of 3/1/22, with diagnoses that included: Parkinson's disease, dementia without behavioral disturbance, peripheral vascular disease (PVD), and chronic obstructive pulmonary disease (COPD). R1's Minimum Data Set (MDS) assessment dated 4/5/22, indicated R1 had moderately impaired cognition, no behaviors or rejection of care, required supervision with eating, and extensive two-person assistance with all other activities of daily living (ADL's) and used a wheelchair for mobility. MDS identified R1 was frequently incontinent of bowel and bladder. The MDS also identified R1 was at risk for pressure ulcers and did not have pressure ulcers or other impaired skin integrity (the MDS did not identify R1's impaired skin integrity according to the record); associated interventions included pressure reducing device for chair and bed, application of nonsurgical dressings other than to feet, and applications of ointments/medications other than to feet. R1's admission physician note dated 3/4/22, indicated R1 was negative for any skin integrity conditions including wounds. On 3/10/22, physician note indicated R1 was negative for wounds R1's care plan dated 3/10/22, indicated urinary incontinence and bowel related to impaired mobility and will be free from skin breakdown and be maintained in as clean and dry, dignified state as possible. Care plan indicated R1 had actual skin integrity break and/or pressure sore(s) - see	F 686	four weeks, four wounds weekly for four weeks, then weekly for four weeks as well as observation of completion of wound treatments three times weekly for four weeks, twice weekly for four weeks, then weekly for four weeks. Results of audits will be submitted to the QAPI committee for review and recommendations.		

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F 686	Continued From page 15 wound assessment pressure sore, skin tear - bilateral legs, elbows, underlying PVD, upper extremity fractures, and COPD. On 3/23/22, revised interventions included: -Assess and measure all skin integrity areas per policy. -Follow pressure ulcer prevention guidelines to prevent additional skin problems, promote health, and prevent complications. -Initiate skin monitoring forms per facility policy. -Initiate treatment per physician order. -Monitor and report any new open areas, draining, increased drainage or pain to nurse immediately. -Provide treatment to wound(s) per current treatment order. Assess wound(s) for signs and symptoms (s/s) of infection with each dressing change/treatment. Report findings of redness, warmth, swelling, increased drainage or increased pain to physician immediately. -Report wound progress or decline to medical doctor (MD) with any changes or lack of response to treatment per facility guidelines. R1's record was reviewed between 3/1/22 to 5/31/22. The record identified R1 was admitted to the facility with moisture associated skin damage and within two weeks of admission developed a stage 2 PU that continued to deteriorate to a stage 3. R1's record identified the physician had been following R1's wounds after notification and provided new treatment orders as the wound changed. However, in review of R1's treatment administration record and interviews, the treatments were not always completed per physician orders. The record also identified the facility was not completing comprehensive weekly skin assessments that would identify or determine potential causal factors and modifiable	F 686			

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F 686	Continued From page 16 risk factors for appropriate care plan interventions that would reduce the risk of worsening and/or new pressure ulcer development. R1's progress note dated 3/6/22, indicated R1 had developed pressure areas on his coccyx and elbow. R1's record lacked a comprehensive assessment and physician notification. R1's progress note dated 3/9/22, indicated R1 now had a red open area on his coccyx and the physician was notified. A Non-pressure Weekly Tracker form was completed on 3/10/22, with wound measurements and description which included open area on sacrum which was pink and blanchable. The center has an open area that measures 1.4 cm x 1.1 cm x 0.1 cm. Skin is pink, no drainage, no odor, and no tunneling or undermining. R1's record lacked a comprehensive assessment for causal factors. R1's physician visit dated 3/15/22, identified "open area at sacrum measuring 1.4 centimeters (cm) x 1.1 cm x 0.1 cm. Skin around area is pink". Wound continued to heal with pink skin area, no worsening open area or drainage. Nursing to continue to keep it clean and covered with a bordered foam dressing. Nursing was instructed to offload/turn resident at least three times daily to prevent further skin break. Nursing to continue monitoring skin with weekly skin check and update physician if worsening skin area." R1's wound tracker dated 3/17/22, included open area on sacrum measuring 1.4 cm x 0.7 cm x 0.1 cm and indicated wound was improving. R1's physician visit dated 3/23/22, indicated given	F 686			

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F 686	Continued From page 17 the onset of coccygeal wound, he is getting closer to being appropriate for hospice. R1's Wound Tracker dated 3/24/22, indicated open area on sacrum measuring 1.7 cm x 1.0 cm x 0.5 cm and indicated wound was worsening and notified nurse practitioner on 3/22/22. R1's physician visit dated 3/30/22, indicated registered nurse (RN)-A reported coccyx is healing well without redness, drainage, or signs of infection. R1 enrolled with hospice on 3/30/22 per family consent R1's physician visit dated 4/1/22, indicated moisture associated open skin damage measuring 1.5 cm x 0.8 cm x 0.3 cm. R1's record included subsequent weekly Wound Trackers completed on 3/31/22, 4/7/22, 4/14/22, 4/21/22, 4/27/22. The wound trackers indicated the wound measurements remained relatively consistent in size and depth, however, continued to lack a comprehensive assessment to identify and remove potential causal factors. R1's physician visit dated 5/2/22, indicated R1's sacrum PU stage 3 and measured 1.5cm x 0.5 cm x 0.3 cm. R1's record identified weekly Wound Trackers were not completed after 4/27/22 through 5/19/22. R1's weekly Wound Tracker dated 5/19/22 included open area on sacrum measuring 1.5 cm x 0.6 cm x 0.4 cm. On 5/26/22, RN-A documented open area on	F 686			

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F 686	Continued From page 18 sacrum measuring 2.2 cm x 1.0 cm x 0.4 cm and peri-wound tissue pink or normal for ethnic group; but indicated wound was worsening with larger open area measurements. When interviewed on 6/15/22, at 12:36 p.m. hospice registered nurse stated R1 was admitted to hospice on 3/31/22, with diagnoses of Parkinson's dementia and an unstageable PU on coccyx. Hospice RN stated she did not visualize the coccyx wound upon admission as facility LPN-B stated the wound was currently stable. Hospice nurse coordinated with LPN-B to be able to assess and change coccyx dressing on the second visit on 4/7/22; however, when hospice nurse called facility on 4/7/22, at 8:40 a.m. LPN-B stated she had already completed wound care for R1. LPN-B stated coccyx wound was stable, appeared smaller, and facility was continuing on with current treatment orders of acidic acid soaks and mepilex dressing. On 4/28/22, hospice RN had a conversation with RN-A who stated the coccyx PU length and width were staying the same and the dimensions were getting shallower with acidic acid gauze. Hospice RN stated she was uncertain if facility was staging PU at this time. On 4/28/22, hospice nurse stated R1's coccyx wound was upgraded to a stage 2 PU with scant drainage and measured 1.6 cm x 0.5 cm x 0.4 cm with undermining and slough present and she completed dressing change and measurements with RN-A. On 4/29/22, hospice physician wound care orders were faxed to the facility for wound care coccyx pressure area: cleanse with wound cleanser (i.e. Skintegrity) and gauze, allow to dry. Apply skin protectant (i.e. Sure-prep wipe) to intact peri-wound skin, let dry. Apply bordered gauze dressing. Perform wound care every three days and as needed for soiling	F 686			

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F 686	Continued From page 19 and loosening. Routine wound care was to be performed by facility staff per these orders. Hospice nurse stated she faxed over the new wound care orders. Hospice nurse stated she then started noticing there was a pattern with R1 not being provided wound care per physician orders. There was a total of three to four visits made by the hospice RN when there was no dressing in place on R1's coccyx wound. Hospice nurse stated she brought this to the attention of RN-A; RN-A stated the facility had supply issues and there were no bordered dressings to cover the wound. Hospice RN stated it became pattern for facility to not have supplies for R1 so she brought supplies with her and gave facility supplies to use. On 5/24/22, hospice RN stated R1 was found with bowel incontinence in his brief and no dressing found on coccyx wound. Hospice RN stated wound was upgraded to stage 3 PU with undermining, surrounding skin tissue erythema, scant drainage, and measured 1.5 cm x 0.6 cm x 0.5 cm. Hospice RN was unable to locate RN-A at this time to notify her of worsening PU; but notified the floor nurse. On 5/26/22 at 12:10 p.m., hospice nurse called RN-A discussing her concerns with R1 repeatedly found without proper physician prescribed dressings in place for his coccyx PU. On 5/31/22, hospice nurse completed last visit with R1 prior to him discharging to hospice house. R1 was found in bed without coccyx dressing in place with a worsening Stage 3 Coccyx PU which then measured 2.0 cm x 1.2 cm x 0.5 cm with undermining and erythema on surrounding skin. R1 was showing some signs of terminal decline, more swallowing decline, and hospice believed he was already transitioning at that time. R1's treatment administration record (TAR)	F 686			

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F 686	Continued From page 20 identified physician orders which included apply in house barrier cream and cover open area with large mepilex 4x4 to coccyx once every day-shift and to update physician if worsening skin area starting on 3/12/22. On 3/24/22, the order was changed to apply acetic acid solution-soaked gauze twice daily and as needed and cover with mepilex dressing. Treatment was not completed on 3/26/22, 4/1/22, 4/9/22, 4/11/22, 4/15/22, 4/18/22, 4/20/22, 4/24/22, 4/25/22, 4/26/22, 4/27/22, and 4/29/22. On 5/3/22, order indicated to cleanse wound with wound cleanser and gauze and allow to dry. Apply skin protectant (i.e. Sure-prep wipe) to intact peri-wound skin, let dry. Apply bordered gauze dressing. Perform wound care every three days and as needed for soiling or loosening. Notify hospice if worsening, has increased drainage, size redness, warmth, pain. Treatment was not completed on 5/3/22 and 5/12/22. When interviewed on 6/15/22, at 3:28 p.m. nursing assistant (NA)-A stated R1 was incontinent of bowel frequently and required frequent checks and changes. NA-A stated aides would get floor nurse to change R1's coccyx dressing if soiled or if it fell off. NA-A stated R1 was repositioned every 2 hours and was unable to sit up in his wheelchair towards the end due to increased pain in coccyx area. When interviewed on 6/16/22, at 8:09 a.m. NA-B stated R1 had a stageable PU on his coccyx that was deep and worsened over time since his admission to facility. NA-B stated she found R1 without coccyx dressing in place usually in the mornings after night shift would say R1 was incontinent of bowel. NA-B stated aides were to notify nurses if dressing was soiled so a new one	F 686			

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F 686	Continued From page 21 could be applied. NA-B stated R1 would grimace in pain if bowel movement in the wound and staff had to clean it out and when the nurses had to measure the depth of the wound. When interviewed on 6/16/22, at 11:35 a.m. RN-A stated a comprehensive head-to-toe assessment is completed on every resident upon admission, quarterly, and at change of condition which included: skin and bowel assessments. RN-A stated that weekly skin assessments are to be completed on bath days. Facility has bath sheets that the aide fills out and gives to the floor nurse to be signed and reviewed; then turned in to RN-A for final review. RN-A admitted these were not completed by floor nurses, RN-A had found them not signed and dated by floor nurses, so she was uncertain if the skin conditions had been addressed. RN-A stated she had fallen behind on completing these timely. RN-A stated weekly skin trackers are to be completed by her every seven days on residents with pressure and non-pressure related wounds. RN-A stated R1 developed a stage 1 PU on his coccyx after his admission to facility. RN-A stated she completed R1's admission comprehensive assessment; however, failed to complete a thorough skin assessment which included looking at R1's buttocks. RN-A stated she found R1's open area on coccyx and moisture associated skin damage (MASD) two weeks after admission to facility. RN-A stated she was aware R1 was found numerous times without proper wound care dressings to his PU and floor nurses would report to her that "oh, I was just going to put that on now." RN-A stated R1 was frequently incontinent of stool and the coccyx dressing needed to be replaced; however, was not completed often because of some staff completely disregarded	F 686			

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F 686	Continued From page 22 R1's need. RN-A stated the aides would get R1 cleaned up well but citric acid was not used by nursing staff to cleanse the inside of R1's wound during incontinence episodes as it should have been. RN-A stated R1 was on a turning and repositioning schedule every two hours; but thought this was not getting completed by aides timely. RN-A admitted she was not keeping up on weekly wound measurements and completing management duties as she was pulled to work the floor as a nurse. RN-A stated facility completes weekly interdisciplinary team (IDT) meetings on Wednesdays which included: Administrator, DON, RN unit manager, MDS nurse, and dietician. RN-A stated she was unable to go to these meetings in May as she was working as a floor nurse primarily. RN-A stated wounds and PUs were reviewed during their IDT meetings which included updating the plans of care and interventions for residents; however, was uncertain if these were getting completed timely as DON primarily updated care plans. During a returned call telephone interview on 6/21/22, at 1:17 p.m. NP stated R1 was admitted to facility without a PU. NP stated physician was notified approximately two weeks after admission that R1 developed an open area on his coccyx. NP expressed concern of not being able to find facility staff to assist with wound measurements and dressing changes when at facility which could have affected R1's care he received. NP stated she initiated a wound care protocol for DON to give her a list of all residents with current wounds every Friday at 9:00 a.m. for physician rounds so they were able to properly assess and measure all PUs and non-pressure ulcer wounds.	F 686			

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F 686	Continued From page 23 R3's admission record identified diagnoses that included: dementia with behavioral disturbance, type 2 diabetes mellitus (DM), anxiety, and eczema. R3's quarterly MDS assessment dated 5/12/22, indicated R3 was cognitively intact, displayed no behaviors or rejection of cares, required setup help for most ADL's, however required limited one-person assist for dressing and personal hygiene. The MDS identified R3 had occasional incontinence of bladder. R3's MDS indicated R3 was at risk for pressure ulcer development, did not have pressure ulcers, however, did have MASD, skin care interventions included pressure reducing device for chair and bed and application of ointments/medications other than to feet. R3's care plan dated 8/13/18, indicated R3 was at risk for bowel and bladder incontinence as evidenced by the resident needing some assistance with toileting as needed due to dementia, anxiety, weakness, and use of diuretic. Provide incontinence care/perineal care after each incontinent episode and use barrier cream each time. R3 was at risk for skin integrity related to dementia, weakness, dermatitis/eczema, sleeps in recliner per resident choice, MASD to chest area/under breasts/groin/right buttocks with interventions that included: -Conduct pressure injury skin assessments (i.e. Braden scale) as indicated. -Assess skin for redness or pressure related changes with each care encounter. Report any changes immediately. Head-to-toe assessment by licensed nurse performed weekly at minimum (revision date 2/11/22). -Administer medications per MD order. Resident refuses treatment at times. Encourage her to	F 686			

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F 686	Continued From page 24 allow treatment (revision date 6/8/22). -Keep resident clean and dry. Use barrier cream after good peri-care. Apply proper incontinent products. Encourage resident to allow staff to assist in cares. Resident has history of refusing due to wanting to remain as independent as possible (inconsistent with MDS dated 5/12/22). Education given on risks of completing own cares as resident does struggle with thoroughness of task (revised on 6/16/22). R3's physician orders included: -Right buttock and left perineal area: apply mepilex border to area and change every three days and as needed if soiled. Interdry to groin area. Change twice daily every morning and at bedtime (start date 4/19/22). -Nursing to check perineal area for proper wiping/cleaning/document refusal at bedtime (start date 4/22/22). -Nursing to check perineal area every shift and update provider if worsening skin area (start date 6/13/22). R3's record was reviewed between 3/31/22 to 6/16/22. Weekly Skin Reviews were reviewed in conjunction with non-pressure weekly trackers and physician notes. The record identified worsening skin integrity and the development of pressure ulcers after R3 had MASD. The record lacked ongoing weekly comprehensive skin assessments and treatments not completed according to physician orders. -Weekly non-pressure tracker dated 3/31/22, included facility acquired open area on right buttocks MASD increased in size measuring 1.0 cm x 0.5 cm x 0.1 cm was bright red and/or blanches to touch. Physician visit note dated 3/31/22, indicated facility requesting evaluation of	F 686			

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F 686	Continued From page 25 right buttock open wound with redness that they have been dressing with border foam to cover. -Weekly non-pressure tracker dated 4/7/22, included an open area on right buttock measuring 0.5 cm x 0.3 cm x 0.1 cm and indicated wound was improving. A facility acquired open area on left perineal area MASD measuring 1.0 cm x 0.3 cm x 0.1 was pink or normal for ethnic group. Physician visit included dated 4/7/22, included nursing reported R3's "periaarea is very raw, red, and inflamed in periaarea. She does refuse for personal cares to be done frequently." Today, NP assessed the MASD to right buttock area measuring 0.3 cm x 1cm and left perineal MASD measuring 0.57 cm x 0.3 cm x 0.1 cm. NP discussed new dressing and Nursing was instructed to continue monitoring skin with weekly skin check and update provider of worsening skin area. -Weekly non-pressure tracker dated 4/12/22, indicated an open area on right buttock measuring 0.4 cm x 0.3 cm x 0.1 cm was bright red and/or blanches to touch. Left perineal are MASD measuring 0.9 cm x 0.3 cm x 0.1 cm. -Weekly skin review dated 4/21/22 indicated R3 had a small open area on her perineum; no other information about the area was documented. -Weekly skin review dated 4/28/22 indicated R3 had a small open area on coccyx; no other information about the small open area was documented. R3's record did not include completed skin reviews and/or non-pressure weekly trackers between 4/29/22 and 5/18/22.	F 686			

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F 686	Continued From page 26 R3's physician visit dated 5/6/22, indicated right buttock area MASD improving and groin rash has resolved per nursing. No further physician visits were provided that addressed R3's wounds. -Weekly skin review dated 5/19/22, indicated R3 had an area on left labia which is currently being treated. R3's record did not include completed skin reviews and/or non-pressure weekly trackers between 5/20/22 and 6/5/22. -R3's weekly skin review dated 6/6/22, included open excoriated areas on mons pubis and labia from scratching. Raw, reddened skin on right buttock measuring 4.5 cm x 6.0 cm with smaller open are in the middle measuring 1.5 cm x 1.0 cm. The corresponding non-pressure weekly tracker dated 6/6/22 was inconsistent with the weekly tracker; the non-pressure tracker only identified open area on right buttock measuring 1.5 cm x 1.0 cm x 0.1 cm. The next skin tracker that was completed on 6/16/22. The weekly skin review and the non-pressure tracker were inconsistent. The non-pressure weekly tracker dated 6/16/22, included an open area on right buttock measuring 0.9 cm x 0.5 cm x 0.1 cm. Whereas the weekly skin review dated 6/16/22 included, right and left buttock with open areas of concern to coccyx and right/left buttock. R3's record lacked comprehensive wound assessments for all the areas identified on the tracking forms. In addition, the record lacked identification of potential causal factors and/or	F 686			

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F 686	Continued From page 27 modifiable risk factors contributing the deterioration of R3's that could otherwise be removed to ensure healing, reduce the risk of deterioration, and new ulcer development. Review of R3's TAR identified the physician orders and also indicated several occasions when R3 was not provided skin treatments per physician orders. - Right buttock and left perineal area: Apply Medi-honey to right buttock and left perineal and cover with 2x2 foam dressing. Once daily and as needed. Update provider if worsening to be completed every dayshift. Not completed on the following dates: 4/9/22, 4/10/22, 4/15/22, 4/18/22, 4/19/22, and 5/2/22. -Right buttock and left perineal area: Apply Mepilex border to area and change every three days and as needed if soiled on dayshift. Not completed on the following dates: 4/20/22, 4/23/22, 4/26/22, 4/29/22, 5/2/22, 6/3/22, and 6/9/22. -Interdry to groin area. Change twice daily every morning and at bedtime. Not completed on 4/20/22, 5/19/22, 6/2/22, 6/6/22, 6/7/22, 6/8/22, and 6/9/22. -Nursing to check perineal area for proper wiping/cleaning at bedtime. Document refusal. Not completed on 6/3/22 and 6/9/22. During an interview on 6/14/22, at 2:19 p.m. NA-C stated R3 currently had multiple sores on her buttocks and thigh area that staff are cleaning twice a shift. NA-C stated there were no dressings ordered to be applied to open wounds. During an observation on 6/15/22, at 8:31 a.m. R3 observed sitting in grey recliner in corner of room with breakfast tray. Surveyor could smell	F 686			

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F 686	Continued From page 28 stale, foul urine from the doorway of R3's room. During an observation and interview on 6/15/22, at 10:08 a.m. R3 laid in bed, RN-B at bedside to change R3's dressings. R3 did not have prescribed bordered foam dressing to open sores on right and left buttocks, bilateral mons pubis area, nor interdry in groin folds. RN-B indicated R3 had two open sores to right buttocks (one circular and the other a large, long rectangular shaped slit), one open sore to left buttocks, one open sore on left mons pubis perineal area, and one open sore on right mons pubis perineal area. RN-B stated the area was very reddened to almost darkened purplish colored and moist. RN-B stated she measured all wounds which included pressure and non-pressure sores; but was uncertain how often this task gets completed. RN-B applied one 4x4 mepilex to two right buttocks stage 2 PUs and one meplix applied to left stage 1 PU on left buttocks. RN-B stated facility did not apply dressing to open areas to mons pubis perineal area. RN-B stated R3 is very active during the day and transfers independently so is not on a repositioning schedule. During an observation and interview on 6/16/22, at 10:30 a.m. R3 observed walking with NA-B to go to third floor whirlpool tub for bath. NA-B assisted R3 to remove her clothing; physician ordered dressings were not in place on her buttocks nor interdry in her abdominal folds. Surveyor observed R3 with two open areas on right buttocks, one small open area on left buttocks, and bilateral openings on mons pubis perineal area. At 10:57 a.m. LPN-E completed dressing changes to R3's bottom. LPN-E indicated the small circular opening on left	F 686			

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F 686	Continued From page 29 buttocks and right long rectangular shaped opening on right are new wounds since 6/10/22 when she had last worked. During an interview on 6/15/22, at 8:46 a.m. RN-B stated R3 has sores on her buttocks, lower extremities from eczema, redness in bilateral groin folds and abdominal folds that require interdry placed in folds. RN-B stated R3 was incontinent of bladder frequently and wore a brief. During an interview on 6/15/22, at 9:00 a.m. R3 stated she did not have any current open sores on her skin. R3 stated she used to have sores on her buttocks, but facility staff bandaged them up and they healed up right away. R3 stated she was continent of bowel and bladder and was independent with transfers and locomotion. R3 had some notable forgetfulness during interview as R3 was unsure why she wore an incontinence brief. During an interview on 6/15/22, at 4:20 p.m. NA-D stated R3 was alert, oriented, and independent with all cares. NA-D stated R3 wore an incontinence brief as she had some episodes of incontinence. NA-D stated R3 wanted to remain independent. During an interview on 6/15/22, at 4:05 p.m. RN-C stated R3 has had open areas on her buttocks and perineum, but they have since healed up and closed even though according to NAs R3 had open areas on 6/14/22 and the surveyor's observation earlier that day. RN-C stated NAs should be checking on R3 every two hours or as needed. RN-C stated if R3 refuses, aides should be redirecting resident or checking back with her shortly. RN-C stated R3 is	F 686			

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F 686	Continued From page 30 incontinent of bladder at all times and R3's dementia is quite "off" sometimes and speaks about a past doctor who she takes recommendations from. During an interview on 6/16/22, at 8:09 a.m. NA-B stated R3 was alert, but often very forgetful due to her dementia. NA-B stated R3 listens to a MD from years past so they often redirect R3 informing her the MD is okay with cares. NA-B stated R3 has multiple open areas on buttocks and mons pubis perineal area and stated these were open on her shift on 6/12/22. NA-B stated R3 has reddened groin folds, underneath bilateral breasts, and on perineal area. NA-B stated these were "very enflamed, swollen, sore, and painful" for R3. NA-B stated aides are to be checking on R3's incontinence brief two to three times per shift and checking and changing as appropriate. NA-B stated she believed this was not part of the aide tasks on EHR; however, the information is passed along in verbal shift report. During an interview on 6/16/22, at 8:29 a.m. LPN-E stated R3 had an order to dress open areas on right and left buttocks with mepilex every three days or as needed for soiling. LPN-E stated R3 will refuse; however she would respond easily with redirection or reapproach. LPN-E stated NA's should be alerting nurses if they need assistance for redirection. LPN-E stated there were only certain NAs who were aware of correct cares and completed them well. LPN-E stated R3 was incontinent of bladder all the time and wears an incontinence brief. During an interview on 6/16/22, at 11:35 a.m. RN-A stated R3's buttocks opened up in March. RN-A confirmed R3's skin wound measurements	F 686			

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F 686	Continued From page 31 were not completed the weeks of 5/26/22 and 6/2/22. RN-A stated her concern would be failure to track and trend progression or healing of the wounds if there are no weekly skin measurements completed. RN-A stated R3 has dementia and is quite forgetful following a TBI. RN-A stated R3's dressing should be in place per physician orders at all times. RN-A verified R3 there was not a task list or care plan for NAs to know R3 should have a dressing in place at all times. RN-A stated she had fallen behind on completing these timely. RN-A stated weekly skin trackers are to be completed by her every seven days on residents with pressure and non-pressure related wounds. RN-A stated she was not keeping up on weekly wound measurements and completing management duties as she was pulled to work the floor as a nurse. RN-A stated wounds and PUs were reviewed during their IDT meetings which included updating the plans of care and interventions for residents; however, was uncertain if these were getting completed timely as DON primarily updated care plans. During an interview on 6/16/22, at 1:09 p.m. DON stated expectation for pressure and non-pressure wounds to be documented and measured weekly on all residents, turned and repositioned according to orders, and checked and changed as ordered, reminding and reapproaching residents on importance of repositioning, and following doctor prescribed wound care as ordered. DON indicated risk factors that may lead to worsening or new development of PUs which included, not repositioning timely, following physician orders, range of motion, and debility. DON stated an awareness of wound supply shortages. DON stated facility does IDT or	F 686			

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F 686	Continued From page 32 "weekly at risk" (WAR) meetings every Wednesday to discuss new admissions, falls, skin concerns, new behaviors, service intensive families, new antibiotics in the past week, nutritional needs and weights, and any other concerns or issues identified with all residents. DON stated care plans and interventions were updated after IDT meetings by herself, MDS nurse, or RN-A. DON indicated if care plans were not updated; then residents were not receiving the best possible care and staff would not complete what needs to be done. During a returned telephone interview on 6/21/22 at 1:17 p.m. NP expressed concern of not being able to find facility staff to assist with wound measurements and dressing changes when at facility which could have affected R1's care he received. NP stated she initiated a wound care protocol for DON to give her a list of all residents with current wounds every Friday at 9:00 a.m. for physician rounds so they were able to properly assess and measure all PU's and non-pressure ulcer wounds. NP stated R3 has dementia with significant cognitive impairment. NP stated she thought R3's worsening skin conditions including MASD were related to R3 not receiving good perineal care following incontinence episodes. The facility policy titled Pressure and Non-pressure Injuries dated 8/2/21, indicated this center will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measures intended to achieve the goal of prevention of pressure injuries in our residents. For those residents admitted with, or who subsequently developed a pressure injury or impaired skin integrity, they will receive care,	F 686			

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F 686	Continued From page 33 treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity. -A head-to-toe body evaluation will be completed on every resident upon admission/readmission and will be documented on the Admission/Readmission Evaluation UDA. -Initiate the Pressure Injury Weekly Tracker UDA - one per wound. -Ensure primary care physician (PCP) is aware of wounds/location of wounds and current treatment orders. -Ensure appropriate treatment orders for each wound area, as needed. -Ensure resident/responsible party is aware of wounds and current treatment plan. -Initiate the baseline plan of care related to current skin status and skin risk level. -Complete a head-to-toe skin check and document findings on the Skin Review - Weekly NSHC UDA. -Assess current wounds at least every seven days, or more frequently as needed (e.g., decline in wound, presence of infection, wound healed). If a wound fails to show some evidence of progress toward healing within 2-4 weeks, the area and the resident's overall clinical condition should be reassessed. Re-evaluation of the treatment plan includes determining whether to continue or modify the current interventions. Results may vary depending on the resident's overall condition and interventions/treatments used. The complexity of the resident's condition may limit responsiveness to treatment or tolerance for certain treatment modalities. The clinicians, if deciding to retain the current regimen, should document the rationale for continuing the present treatment to explain why some, or all, of the	F 686			

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F 686	Continued From page 34 plan's interventions remain relevant despite little or no apparent healing	F 686			