Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 25, 2023

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

RE: CCN: 245184
Cycle Start Date: July 18, 2023

Dear Administrator:

On August 1, 2023, we notified you a remedy was imposed. On August 24, 2023, 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 August 15, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 16, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 1, 2023, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 16, 2023, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 15, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, 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.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 25, 2023

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

Re: Reinspection Results
Event ID: 6Y4I12

Dear Administrator:

On August 24, 2023, 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 survey completed on July 18, 2023. At this time these correction orders were found corrected.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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August 1, 2023

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

RE: CCN: 245184
Cycle Start Date: July 18, 2023

Dear Administrator:

On July 18, 2023, a survey was completed at your facility by the Minnesota Department of Healthto determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 18, 2023.

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 18, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 18, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 18, 2023.

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.

This Department is also recommending that CMS impose:

- 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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 18, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Rochester East Health Services will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 18, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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.

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
Office (507) 206-2728

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 January 18, 2024 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / 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 electronic 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

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.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	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) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/17/23 and 7/18/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint weas reviewed. H51843575C (MN00095261, MN00095241), with a deficiencies issued at F686 and F773 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 686 SS=G	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	F 686		8/15/23

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

Electronically Signed | 08/11/2023

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 686	Continued From page 1 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 ensure accuracy of comprehensive skin assessments and failed to follow physician orders for pressure ulcer management and treatment for 2 of 3 residents (R1 and R3). The facility's failures resulted in actual harm for R1 when ongoing wound mismanagement caused closed sacral surgical incision to deteriorate back to open stage 4 pressure ulcer, infection, and discontinuation of wound vac management. Findings include: Negative Pressure Wound Therapy (NWPT) also known as a wound vac helps to heal wounds by providing a moist environment, promote new tissue formation, and removing excess fluid and infection. The negative pressure or vacuum suction is provided by a pump that is connect to your wound. A foam dressing is placed in the wound and covered with an occlusive dressing. The fluid that is removed is collected in a canister on the pump. Stage 4 PU: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the wound bed, it is an unstageable PU/PI.	F 686	This Plan of Correction is submitted solely as required under Federal and State regulation and statutes applicable to long term care providers. The submission of the plan does not constitute an agreement by the facility that the allegations of noncompliance or conclusions are accurate, that the allegations constitute noncompliance, or that the scope or severity regarding any of the deficiencies cited are correctly applied. The submission of this required Plan of Correction does not constitute an admission or acknowledgement of noncompliance or liability on the part of the facility, and any such noncompliance or liability is hereby specifically denied.¿¿ ¿ R1 Wound vac discontinued on July 12, 2023 by wound care provider. New orders received by nursing and order implemented on July 12, 2023. RN reviewed plan of care with resident and established her preferences for times for dressing changes. R1 continues to follow with wound clinic off site and receives wound care and monitoring as ordered at the facility. R3 dressing orders were updated on 07/17/2023 by Provider, care plan was reviewed and updated by RN on August 8, 2023. R3 receives wound care onsite with nursing and medical provider.	

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F 686	Continued From page 2 R1's face sheet identified R1 was admitted to the facility on 04/19/23, with diagnoses that included osteomyelitis of vertebra sacral and sacrococcygeal region (a rare spine infection that's often caused by bacteria), bone density disorder of multiple sites, and pressure ulcer of sacral region stage 4. A vulnerable adult maltreatment report submitted to the state agency (SA) on 7/12/23 at 5:18 p.m., indicated the facility incorrectly followed wound care orders which caused worsening of R1's stage 4 sacral (a bone located at the base of your spine) ulcer and an additional wound from the misplacement of the wound vac dressing. A second vulnerable adult maltreatment report submitted to the SA on 7/13/23 at 6:48 p.m., noted concerns regarding the facilities' ability to manage R1's stage 4 sacral ulcer and wound vac stating concerns of wound vac dressing not being changed after being placed on 6/28/23 till removed at the wound clinic on 7/12/23. R1's admission Minimum Data Set (MDS) dated 4/26/23, indicated staff assessed R1 to have moderate cognitive impairment; R1's activities of daily living assessment identified R1 required extensive assistance with bed mobility, transferring, dressing, toileting, personal hygiene and locomotion. R1 was occasionally incontinent of bladder and always continent of bowel. R1 was a risk for pressure ulcers and had a stage 4 pressure ulcer that indicated would be addressed in the care plan. R1's care plan dated 4/19/23, identified R1 had osteomyelitis of vertebra, sacral and sacrococcygeal region, interventions included	F 686	Facility in house residents with pressure injuries have the potential to be impacted. Wound documentation, consultant documentation and TARs were reviewed for like residents to validate care and services were provided as ordered. Care plans and treatment plans were reviewed and updated if indicated by Registered Nurse or designee. Guidelines for documentation and wound care were reviewed and no changes were required. A quick reference guide was obtained from Genadyne and is accessible to nurses on troubleshooting and application of the wound vac. Train the trainer education on the Genadyne wound vac was provided by Amy Friedman with Genadyne on July 24, 2023 to nursing leadership and to nurses on July 26 and July 27, 2023. Education will be presented by Director of Nursing or designee to licensed nurses prior to next scheduled shift. Education was initiated on 07/13/2023 to licensed nurses on wound management and documentation. Education will be completed by August 15, 2023 or by the next scheduled shift for PRN or LOA employees. The Unit Manager and Director of Nursing were educated by the RN/Vice President of Success on their role in monitoring physician notes, wound care, documentation, and missed or delayed treatments including need to clarify orders and verify treatments completed per MD order. Dressing change competencies were initiated with nurses beginning July 17, 2023 and will	

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F 686	Continued From page 3 administer medications as ordered, encourage resident to use good clean hygiene techniques to avoid cross contamination. Monitor for side effects from antibiotic therapy and report to physician if present. Monitor lab work as ordered and report results to physician. Additionally, the care plan identified R1 had stage 4 pressure area. Interventions included, report evidence of infection to MD as needed dated (dated 4/19/23) follow treatments per MD orders (dated 4/19/23), Obtain labs as ordered (dated 4/30/23), Specialty air mattress (dated 4/19/23 revised on 7/14/23), use pillows and or repositioning devices as needed (dated 4/30/23). R1's Weekly Pressure Injury Daily Trackers were reviewed in conjunction with the wound clinic's evaluations. The record identified facility skin assessments that had not been consistent with the wound clinic's assessment of the wound status. R1's medical record lacked a comprehensive skin assessment of the sacral incision upon admission on 4/19/23. R1's wound clinic office visit summary dated 4/26/23, identified R1's wound as a sacral incision with Prolene sutures (non-absorbable, sterile surgical sutures.) The sutures and wound was intact and incisional line was nonblanching (discoloration of the skin that does not turn white when pressed) periwound erythema (superficial skin redness), slough (a specific type of nonviable tissue that occurs as a byproduct of the inflammatory process) midline, no dehiscence (when a closed incision re-opens). R1's wound clinic office visit summary dated	F 686	continue to be completed with licensed nurses. Competencies are completed by Director of Nursing or designee. Audits of dressing changes including verification of order accuracy and proper documentation were initiated by nurse leadership on July 14, 2023 and will be completed three times weekly for eight weeks then once weekly for four weeks with results submitted to Quality Assurance Committee for review and recommendations. No wound vacs are noted in house currently. Direct oversight and observations of wound vacs when ordered will be completed three times weekly by the Director of Nursing or designee.	

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F 686	Continued From page 4 5/2/23, identified R1's wound as sacral incision with Prolene sutures that were intact with minimal nonblanching periwound erythema, slough midline, no dehiscence, right gluteal Jackson-Pratt (JP) drain (a closed suction device, meaning that the fluids are collected within a closed system, without the need for an outside suction machine) with minimal serosanguinous (a thin and watery fluid that is pink in color due to the presence of small amounts of red blood cells). R1's record did not include a wound assessment for the sacral incision until 5/9/23. The Weekly Pressure Injury Tracker dated 5/09/23, identified the sacral wound. R1 had a wound flap procedure over a stage 4 pressure ulcer prior to admission and was on 2 intravenous (IV) antibiotics. R1 was followed by the wound clinic with an appointment today (5/9/23) for remaining suture removal. The sacral wound measurements included length 4.2 centimeters (c.m.) x width 1.4 c.m. x depth 0.0 c.m. Surface area area was between 4.1 cm and 8.0 cm2. The assessment indicated R1 did not have pain, periwound was bright red and/or blaches to touch, no inflammation or signs of infection. Further indicated the flap of skin was in place, red/pink in color with a small open area near top left, no drainage and surrounding tissue looked healthy. The assessment indicated the wound as improving despite documentation that identified the wound had a "small open area." R1's wound clinic office visit summary dated 5/09/23. indicated R1's wound as a pressure injury that was down to muscle with some granulation, slough, and fibrinous material with circumferential undermining present (presence of undermining was not identified on the facility	F 686		

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F 686	Continued From page 5 wound evaluation). Proximal and distal sutures intact with central area of dehiscence, central tissue parameters with new pressure injury to flaps, infected. Pre debridement measurements Length 9.0 cm, width 3.0 cm, depth 2.3 cm total 27 cm ^2 Post debridement measurements Length 9.0 cm, width 3.0 cm, depth 2.5 cm total 27 cm^2 New orders given . -perform the following twice a day: 1)carefully remove all prior wraps dressings 2) rinse sacral wound with saline 3) 2 or 3 inch Kling wet with Dakin's ¼ strength twice daily 4) barrier cream 5) if dressing becomes soiled, saturated, or displaced, please remove the dressing and replace as above. 100% nonweightbearing to the sacrum Significant deterioration noted today during wound visit from pressure and loose stools, tissue culture obtained and increase protein intake Return to wound clinic in 1-2 weeks-plan for negative pressure wound therapy. R1's Weekly Pressure Injury Tracker dated 5/16/23, indicated wound measurements of : Length 4.1 c.m. x width 1.7 c.m. x depth 20 c.m. Further identified no tunneling and wound was unchanged. R1's wound clinic visit note dated, 5/23/23, indicated R1 had incisional dehiscence after sitting in stool for prolonged periods of time which led to flap necrosis along the incision and dehiscence down to the muscle fascia, R1 reported her dressings were not being changed consistently to wound clinic orders. The visit note	F 686		

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F 686	Continued From page 6	F 686		

indicated the wound had worsened.
Pre debridement measurements Length 4.5 cm, width 2.0 cm, depth 2.5 cm total 9.0 cm ^2
Post debridement measurements Length 4.5cm, width 2.0 cm, depth 2.8 cm total 9.0 cm^2

R1's wound clinic visit note dated, 5/30/23, indicated R1 had concerns about her wound care, stated when she uses the restroom packing falls out and is not reapplied correctly, resident stated she was not receiving the Dakin's gauze and is often not getting packing at all or barrier cream. Wound description included pressure injury to muscle increased granulation, increased slough, intact proximal and distal incision, left lateral flap with stable subcutaneous necrosis, infected. Wound culture was taken.
Pre debridement measurements Length 3.2 cm, width 2 cm, depth 2.5 cm total 6.4 cm ^2
Post debridement measurements Length 3.2cm, width 2 cm, depth 2.8 cm total 6.4 cm^2

R1's Weekly Pressure Injury Tracker dated 5/30/23, measurements were consistent with the wound clinic.Identified wound was unchanged. Assessment did not identify the wound was necrotic nor that it was infected.

R1's Weekly Pressure Injury Tracker dated 6/5/23, describes wound as Measurements: Length 4.0 c.m. x width 2.0 c.m. x depth 2.4 c.m. The assessment indicated the wound did not have tunneling, periwound tissue was normal, and wound progress was unchanged.

R1's wound clinic visit note dated 6/6/23, indicated R1's wound had a polymicrobial infection (Pseudomonas and Enterococcus Faecalis-bacteriums) and new orders for Cipro

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F 686	Continued From page 7 and Augmentin (antibiotics) were given. Pressure wound down to muscle with increased granulation, decreased slough, intact proximal and distal incision, periwound dermatitis, tunneling at 5:00 approximately 6.2cm (tunneling not identified on facility assessment). Identified the wound was overall slightly improved. Pre debridement measurements Length 4.0 cm, width 2 cm, depth 2.4 cm total 8.0 cm ^2 Post debridement measurements Length 4.0 cm, width 2 cm, depth 2.8 cm total 8.0 cm^2 Dressing change orders were changed to twice daily, acetic acid soaked gauze ensure packing to undermining, and application of Calmoseptine to periwound skin followed by nystatin powder. R1's Weekly Pressure Injury Tracker dated 6/13/23 and 6/20/23, included measurements, indicated no undermining or tunneling, no signs/symptoms of infection, and wound was unchanged. R1's Weekly Pressure Injury Tracker dated 6/26/23, described wound as Measurements: Length 3.8 c.m. x width 2.0 c.m. x depth 1.8 c.m. No tunneling, no undermining, no inflammation or infection. Wound was improving. R1's wound clinic visit note dated, 6/28/23, indicated residents dressings continued to not be changed as ordered and wound was not being packed and was often being left uncovered. Resident continues to be interested in wound vac therapy when she can safely use. Wound described as pressure injury sacrum down to muscle, periwound dermatitis, tunneling at 5:00 approximately 4.4 cm, increased granulation tissue, resolved malodor (unpleasant smell), minimal slough, overall slight improvement.	F 686		

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F 686	Continued From page 8 Pre debridement measurements Length 3.8. cm, width 2 cm, depth 1.7 cm total 7.6 cm ^2 Post debridement measurements Length 3.8 cm, width 2 cm, depth 1.8 cm total 7.6 cm^2 The visit note included new orders for wound vac dressing change for three times a week. R1's June's 2023 treatment administration record (TAR) identified between 6/1/23 through 6/6/23, documentation identified a chart code of '9' indicating the dressing was not completed or the box was left blank on 5 of 12 occurrences where the dressing was supposed to be changed. Documentation between 6/7/23 through 6/29/23 identified the acetic acid packing at 5 o'clock position was left blank or a chart code of '9', for 10 of 22 possible changes. Physician order for sacral wound treatments with a start date of 6/30/23 (end date 7/23/23) included the following: 1) Remove old dressing. Rinse all open ares with saline 2) Aceitc acid 0.25% 2 or 3 inch kling gauze allow to soak for 10-15 minutes (in wound) and then rinse with saline 3) Black foam negative pressure wound therpay system at 125 mmHg continuous making sure to avoid any pressure points to the sacrum (use bridge dressing. change dressing if it becomes spoiled, saturated, or displaced.) Every Monday, Wednesday, and Friday. R1's June and July 2023 TAR included the physician order for wound vac dressing changes to be completed on Monday, Wednesday, and Friday. The TAR indicated on 6/30/23, 7/3/23, 7/5/23, 7/7/23, and 7/10/23 the sacral dressing was supposed to be changed however a chart	F 686		

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F 686	Continued From page 9 code of '9' was recorded which indicated the dressing was not completed and directed to see progress notes. The box for 7/12/23 was left blank. Corresponding progress did not identify reason why dressing was not changed. Additionally, R1's care plan was not revised to include wound vac therapy, and R1's record did not include ongoing monitoring for signs/symptoms of infection, amount of drainage, R1's tolerance or associated pain related to wound vac, wound improvement/deterioration, and wound vac function and efficacy. R1's Weekly Pressure Injury Tracker dated 7/03/23, indicated a wound assessment had been completed even though the TAR identified the dressing was not changed. The assessment identified wound measurements of: Length 4.0 c.m. x width 2.0 c.m. x depth 2.5 c.m. Tissue described as 100% granulation tissue, moderate serosanguinous drainage, no tunneling or undermining, and no inflammation or infection. Wound was improving. R1's wound clinic visit note dated, 7/12/23, indicated when resident presented, she stated wound VAC had been left on from June 29th till July 6th. Patient also requested that the VAC be removed as it was painful and uncomfortable and stated she had requested it to be removed at the facility had not been acknowledged. Wound VAC was noted to be on healthy skin and not in the correct location or incorporating the wound. Resident indicated she was in much more discomfort than she had in the past even after undergoing surgery. Wound description: pressure injury sacrum down to muscle, new area of tissue breakdown to fat layer at 2:00 circumferential to periwound dermatitis, increased wound bed	F 686		

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slough, malodor, deteriorated.
Pre debridement measurements Length 3.2. cm, width 3.5 cm, depth 2.0 cm total 11.2 cm ^2
Post debridement measurements Length 3.2 cm, width 3.5 cm, depth 2.4 cm total 11.2 cm^2
Assessment/Plan: New wound orders obtained without wound VAC, R1 indicated significant wound care concerns and wound care orders not being followed. The current wound is a result of a surgical wound dehiscence that was healing postoperatively and resulted after patient was sitting in her own stool for hours. The wound VAC had been left on too long and resulted in significant wound deterioration.

R1's Weekly Pressure Injury Tracker dated 7/13/23, described wound as Measurements: Length 3.5 c.m. x width 2.8 c.m. x depth 2.5 c.m. no tunneling or undermining, peri-wound skin is bright red and irritated about 1cm wide in circumferential redness/irritation. Resident describes pain and stated area has felt sore for a couple days. Wound is worsening.

During an observation on 7/18/23, at 11:01 a.m. licensed practical nurse (LPN)-A entered R1's room to complete the coccyx dressing change. LPN-A obtained two towels, applied soap and water to one and left the other one dry. As she carried the towels over to R1, she dropped the dry towel on the floor twice and picked it back up. LPN-A then cleaned the wound with the soapy towel then used the towel that had been on the floor to dry the wound. LPN-A packed the gauze into the wound. LPN-A stated she had soaked the gauze in acetic acid before it was packed.

During an interview on 7/17/23 at 4:41 p.m. R1 indicated she had admitted to the facility with a

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wound. During her weekly wound clinic appointments she had been informed the wound was not healing the way it should be and the dressing did not appear to be getting done correctly. R1 explained at the beginning of wound there had been discussion about a wound vac but had to wait until the infection in the wound cleared up. The wound vac was put on 6/29/23. R1 indicated after the wound vac was put on she had asked multiple nurses when it was supposed to be changed. Nobody was changing it, the nurses would put tape over it. Finally on July 9th R1 recalled the machine was beeping, one of the nurses came in, and applied tape over the dressing. The nurse did eventually change the dressing after I had informed her, I was seeing the wound doctor on 7/12/23." She had waited 11 days for the dressing to be changed. On 7/12/23, the wound clinic took it off and could tell the facility hadn't been changing it.

During an interview on 7/18/23, at 10:41 a.m. LPN-A stated she had put on R1's wound vac but was unable to recall the date she had done so. LPN-A explained she was not comfortable with wound vacs because she had not had any training. LPN-A stated she did not tell anyone she was not competent or asked anyone questions. LPN-A stated she was going to change it one time but R1 had told her someone had changed it on the previous night. LPN-A documented R1 refused without further verifying with the record and/ or other nurses.

During an interview on 7/18/23, at 12:49 registered nurse (RN)-B stated she had worked with R1 and thought she was reliable historian. RN-B stated she had not ever completed a wound vac change in the facility and stated R1

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F 686	Continued From page 12 had told her the wound vac changes were being completed in the wound clinic. RN-B had not changed a wound vac since 2005 or 2006, had not had any wound vac education since, and would not feel comfortable changing it. RN-B stated if a "9" was marked on the TAR that meant the order/task was not completed; nurses were supposed to write a progress note explaining why it was not done. During an interview on 7/18/23 at 12:59 p.m. RN-A stated she had not taken care of R1's wound vac. RN-A reported she had worked for the facility for several years and never received any training related to wound vac dressings or cares. During an interview on 7/18/23 at 1:54 p.m. with clinical manager (CM)-A stated R1 is alert and oriented but can occasionally be forgetful. CM-A had not completed R1's dressing changes. CM-A indicated the findings of the facility's investigation identified floor nurses admitted to not changing R1's wound vac. CM-A explained no training on wound vacs had been offered at the facility and it was her belief the reason why it was not completed by nurses. During an interview on 7/18/23, at 1:24 p.m. wound clinic wound nurse (WN) stated, she had been following R1 since 4/26/23 after her surgery. WN stated R1 had sutures and a JP drain The plan was to keep pressure off the wound and bacitracin on suture line and Xeroform and Mepilex around the tube of the drain to prevent further injury. The wound clinic was monitoring it weekly. The end of April, beginning of May we had not seen R1, when we did see her the wound started opening and by 5/23/23, it had completely	F 686		

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F 686	Continued From page 13 opened. We felt the biggest issues were that the dressings were not being done as ordered. The wound continued to worsen, and she ended up with another infection which caused the wound vac treatments to be pushed back. The wound vac was supposed to be started on 6/28/23. We did not receive any calls or questions at the wound clinic from the facility. When WN saw R1 on 7/12/23, the wound vac had been placed incorrectly and the wound appeared worse. The facility was contacted, and the orders were changed back to stop the wound vac because of the infection and improper placement. R1 had told us the facility had not changed the dressing since 6/29/23. During an interview on 7/18/2023 at 8:33 a.m. wound clinic doctor (MD)-A stated every visit R1 came in there were issues. R1 had reported to the wound clinic staff there were times she would sit in stool for hours before getting help. Her wound opened up. We found the facility was not completing the dressings as ordered. When R1 came into the clinic with the vac on, R1 reported the facility was not changing the vac dressing; we found the dressing had been applied wrong. The facility had put the sponge on normal viable skin which created a bigger problem of a new wound and no granulation tissue, the wound had deteriorated and became bigger. MD-A explained if a wound vac dressing was left on too long, it could cause infection, which happened to R1. We had to resect to the bone and put R1 back on antibiotics. MD-A further explained since the facility could not follow the basic dressings orders, it was decided to stop the wound vac. MD-A stated "the wound should be healed already. MD reported no staff at the facility informed the clinic they didn't know how to	F 686		

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F 686	Continued From page 14 manage the wound vac or called with questions. R3's quarterly Minimum Data Set (MDS) dated 5/5/23, indicated R3 had moderate cognitive impairment; R3's activities of daily living assessment identified R3 required extensive assistance of two people with bed mobility, transferring, dressing, toileting, personal hygiene needed one person physical assistance and locomotion was supervision of one person. Walking had not occurred during assessment period. R3 was frequently incontinent of bladder and bowel. R3 was a risk for pressure ulcers and had a stage 2 pressure ulcer. R3's care plan dated 3/20/23, indicated, R3 had diagnoses that included, diabetes mellitus, diabetic neuropathy, and pressure ulcer stage 2. R3's skin care plan identified R3 had diabetic ulcers to toes left foot and pressure ulcer to ankle. Interventions included enhanced barrier precautions related to wound care (dated 11/22/22), Inspect skin during cares for redness, open areas and report (revised 7/5/22) and Treatments as ordered monitor for effectiveness. R3's physician orders signed included: Left malleolus (ankle) Cleanse ulcer base with normal saline or wound cleanser. Pat dry and then cover with gauze and secure in place with Kerlix.Change daily and as needed (ordered 6/2/23, started 6/3/23) Avoid wearing shoe until left malleous (ankle) is completely healed, document refusals every shift (11/2/22) During an observation on 7/17/23 at 12:23 p.m. R3 had a sign on his door that directed R3 required contact precautions (personal protective	F 686		

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equipment). R3 had both shoes on his feet even though physician order directed to keep the left shoe off. R3 stated his dressings were not being done daily; R3's ankle dressing was not dated to show how long the dressing had been on. Nurse practitioner (NP) was prepping for R3's left ankle dressing change, NP did not have a gown on in accordance with the sign on R3's door. NP stated R3 was not supposed to have his left shoe on, it was supposed to be off till his wounds were completely healed. NP removed left ankle dressing with gloves on, then cleaned the wound without changing her gloves. After NP cleaned the wound she removed gloves and she washed her hands and put on new gloves. The NP applied Xeroform gauze over the wound, which was not consistent with the physician order dated 6/2/23. NP explained she had previously wrote the dressing change order directing Xeroform usage and was not sure when the order was changed that excluded the Xeroform.

Physician order for left ankle with start date of 7/18/23, included xeroform cut to fit wound bed cover with soft gauze and secure with kerlix change daily and as needed (PRN) every day shift.

During an observation on 7/18/23 at 9:33a.m. LPN-A was completing a dressing change on R3. LPN-A had gown and gloves on. LPN-A wet a towel and wash cloth in the bathroom. While walking back to R3 from the bathroom a towel dropped on the floor. LPN-A cleaned the wound and dried it with the towel that had dropped on the floor. LPN applied barrier cream to foot with same gloved hands and removed soiled gloves, washed hands and put on clean gloves. LPN-A cut the Xeroform and applied it to the whole

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F 686	Continued From page 16 malleolus going outside the wound edges (instead of fitting to wound bed according to physcian orders) and applied Mepilex. During an interview on 7/18/23, at 2:10 p.m. Regional Registered Nurse Consultant (RNC) stated she was notified on 7/13/23 with a call of concern from the wound clinic. The wound clinic stated the wound vac had only been changed once since 6/29/23 by LPN-A and LPN-B. RNC stated she had interviewed the nurses and LPN-A and LPN-C had indicated when they read the wound vac order they thought the dressing was only to be changed on Monday, Wednesday, and Friday if the dressing was soiled and needed to be changed. They both also mentioned they had not been comfortable changing a wound vac. RNC stated she had since checked all orders to make sure they have clear timelines and had separated PRN orders from scheduled orders. RNC stated training had been initiated on 7/13/23 and continued 7/14/23. Wound vac dressings and complicated dressings have been suspended until nurses can be trained. RNC also stated she had also talked to the floor nurse managers about holding floor nurses accountable for missed treatments and now missed treatments are now showing up first during the daily record reviews. Facility policy, Clean Dressing Change, Dated 7/20/22, indicated, the policy of the facility to provide wound care in a manor to decrease potential for infection and or cross-contamination. Physician's orders will specify type of dressing and frequency of changes.	F 686		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii)	F 773		8/15/23

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F 773	Continued From page 17 §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on document review and interview the facility failed to ensure laboratory tests were completed according to the physician orders for 1 of 1 (R1) residents reviewed. Findings include: R1's face sheet identified R1 was admitted to the facility on 04/19/23, with diagnoses that included osteomyelitis of vertebra sacral and sacrococcygeal region (a rare spine infection that's often caused by bacteria), bone density disorder of multiple sites, and pressure ulcer of sacral region stage 4. R1's wound clinic progress note dated 5/9/23, indicated resident had numerous loose stools and had an inability to keep her incision out of her stool since her last visit. Wound was described as infected. R1's physician order dated 6/16/23 included Lab-C.Diff (lab that tests for clostridium difficile which causes that causes diarrhea and colitis.	F 773	This Plan of Correction is submitted solely as required under Federal and State regulation and statutes applicable to long term care providers. The submission of the plan does not constitute an agreement by the facility that the allegations of noncompliance or conclusions are accurate, that the allegations constitute noncompliance, or that the scope or severity regarding any of the deficiencies cited are correctly applied. The submission of this required Plan of Correction does not constitute an admission or acknowledgement of noncompliance or liability on the part of the facility, and any such noncompliance or liability is hereby specifically denied. R1 lab order had been discontinued on July 14, 2023 as her symptoms no longer indicated the lab was needed. Residents who currently reside in the facility have the potential to be impacted	

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F 773	Continued From page 18 R1's June 2023 treatment administration records (TAR) identified the lab order and directed staff to obtain a stool sample and discontinue order once obtained with a start date of 6/17/23 and end date of 6/29/23. From 6/17/23 through 6/29/23, the chart code of '9' was recorded indicating the specimen was not collected, see progress notes. Corresponding progress notes did not consistently identify why the specimen was not collected as ordered. R1's progress note dated 6/17/23, indicated the sample was collected however contaminated. R1's progress note dated 6/26/23, at 7:24 p.m. indicated stool sample was obtained at 3:20 p.m. and was in the fridge waiting to be sent to lab. R1's progress note dated 6/27/23 indicated the sample was collected on the evening shift on 6/27/23. In review of R1's record it was not evident the specimen was sent to the lab for processing. R1's progress note dated 6/28/23, indicated a sample was not able to be obtained. R1's physician order dated 6/29/23 included, Please obtain a liquid stool if sample for C-difficile toxin due to her recent antibiotic use. R1's June/July TAR identified the lab order dated 6/29/23, from 6/29/23 through 7/14/23, the chart code '9' was recorded indicating the specimen was not collected. During an interview on 7/17/23, at 3:09 p.m.	F 773	by the alleged practice. Orders were reviewed on July 18, 2023 to validate there were no outstanding lab orders. Orders are reviewed as part of the morning clinical meeting to ensure labs are completed. A lab tracking form was created on August 9, 2023 and will be reviewed with nurses on August 10 and 11, 2023 and implemented on August 14, 2023. Nurse managers will review lab tracking prior to morning clinical meetings to validate that lab was obtained. The Director of Nursing or designee provided education to licensed nurses beginning August 10, 2023 on the lab tracking process and the need to collect ordered labs timely. The information was presented in small groups and one to one education. The Director of Nursing or designee will audit lab orders and completion of labs twice weekly for eight weeks and then weekly for four weeks. Results of audits will be submitted to the quality assurance committee for review and recommendations.	

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	245184	A. BUILDING _____ B. WING _____	C 07/18/2023

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F 773	Continued From page 19 Regional Registered Nurse Consultant (RNC) stated when the provider writes an order for a stool specimen with labs it is expected to be collected at the next loose stool and to notify the provider with in 48 hours if the resident has no loose stools so the order can be discontinued. RNC confirmed the labs were not obtained but should have been completed timely. A policy related to following physician's orders was requested but not provided by the end of the survey.	F 773		

Electronically delivered

August 1, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 6Y4I11

Dear Administrator:

The above facility was surveyed on July 17, 2023, through July 18, 2023 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 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 contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

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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 7/17/23 and 7/18/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued 0900. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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

Electronically Signed | 08/11/23

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaint weas reviewed. H51843575C (MN00095261, MN00095241) 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 the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 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		
2 900	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 ensure accuracy of comprehensive skin assessments and failed to follow physician orders for pressure ulcer management and treatment for 2 of 3 residents (R1 and R3). The facility's failures resulted in actual harm for R1 when ongoing wound mismanagement caused closed sacral surgical incision to deteriorate back to open stage 4 pressure ulcer, infection, and discontinuation of	2 900	Completed	8/15/23

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2 900	Continued From page 3 wound vac management. Findings include: Negative Pressure Wound Therapy (NWPT) also known as a wound vac helps to heal wounds by providing a moist environment, promote new tissue formation, and removing excess fluid and infection. The negative pressure or vacuum suction is provided by a pump that is connect to your wound. A foam dressing is placed in the wound and covered with an occlusive dressing. The fluid that is removed is collected in a canister on the pump. Stage 4 PU: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the wound bed, it is an unstageable PU/PI. R1's face sheet identified R1 was admitted to the facility on 04/19/23, with diagnoses that included osteomyelitis of vertebra sacral and sacrococcygeal region (a rare spine infection that's often caused by bacteria), bone density disorder of multiple sites, and pressure ulcer of sacral region stage 4. A vulnerable adult maltreatment report submitted to the state agency (SA) on 7/12/23 at 5:18 p.m., indicated the facility incorrectly followed wound care orders which caused worsening of R1's stage 4 sacral (a bone located at the base of your spine) ulcer and an additional wound from the misplacement of the wound vac dressing.	2 900		

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2 900	Continued From page 4 A second vulnerable adult maltreatment report submitted to the SA on 7/13/23 at 6:48 p.m., noted concerns regarding the facilities' ability to manage R1's stage 4 sacral ulcer and wound vac stating concerns of wound vac dressing not being changed after being placed on 6/28/23 till removed at the wound clinic on 7/12/23. R1's admission Minimum Data Set (MDS) dated 4/26/23, indicated staff assessed R1 to have moderate cognitive impairment; R1's activities of daily living assessment identified R1 required extensive assistance with bed mobility, transferring, dressing, toileting, personal hygiene and locomotion. R1 was occasionally incontinent of bladder and always continent of bowel. R1 was a risk for pressure ulcers and had a stage 4 pressure ulcer that indicated would be addressed in the care plan. R1's care plan dated 4/19/23, identified R1 had osteomyelitis of vertebra, sacral and sacrococcygeal region, interventions included administer medications as ordered, encourage resident to use good clean hygiene techniques to avoid cross contamination. Monitor for side effects from antibiotic therapy and report to physician if present. Monitor lab work as ordered and report results to physician. Additionally, the care plan identified R1 had stage 4 pressure area. Interventions included, report evidence of infection to MD as needed dated (dated 4/19/23) follow treatments per MD orders (dated 4/19/23), Obtain labs as ordered (dated 4/30/23), Specialty air mattress (dated 4/19/23 revised on 7/14/23), use pillows and or repositioning devices as needed (dated 4/30/23). R1's Weekly Pressure Injury Daily Trackers were	2 900		

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2 900	Continued From page 5 reviewed in conjunction with the wound clinic's evaluations. The record identified facility skin assessments that had not been consistent with the wound clinic's assessment of the wound status. R1's medical record lacked a comprehensive skin assessment of the sacral incision upon admission on 4/19/23. R1's wound clinic office visit summary dated 4/26/23, identified R1's wound as a sacral incision with Prolene sutures (non-absorbable, sterile surgical sutures.) The sutures and wound was intact and incisional line was nonblanching (discoloration of the skin that does not turn white when pressed) periwound erythema (superficial skin redness), slough (a specific type of nonviable tissue that occurs as a byproduct of the inflammatory process) midline, no dehiscence (when a closed incision re-opens). R1's wound clinic office visit summary dated 5/2/23, identified R1's wound as sacral incision with Prolene sutures that were intact with minimal nonblanching periwound erythema, slough midline, no dehiscence, right gluteal Jackson-Pratt (JP) drain (a closed suction device, meaning that the fluids are collected within a closed system, without the need for an outside suction machine) with minimal serosanguinous (a thin and watery fluid that is pink in color due to the presence of small amounts of red blood cells). R1's record did not include a wound assessment for the sacral incision until 5/9/23. The Weekly Pressure Injury Tracker dated 5/09/23, identified the sacral wound. R1 had a wound flap procedure over a stage 4 pressure ulcer prior to admission	2 900		

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2 900	Continued From page 6 and was on 2 intravenous (IV) antibiotics. R1 was followed by the wound clinic with an appointment today (5/9/23) for remaining suture removal. The sacral wound measurements included length 4.2 centimeters (c.m.) x width 1.4 c.m. x depth 0.0 c.m. Surface area area was between 4.1 cm and 8.0 cm2. The assessment indicated R1 did not have pain, periwound was bright red and/or blaches to touch, no inflammation or signs of infection. Further indicated the flap of skin was in place, red/pink in color with a small open area near top left, no drainage and surrounding tissue looked healthy. The assessment indicated the wound as improving despite documentation that identified the wound had a "small open area." R1's wound clinic office visit summary dated 5/09/23. indicated R1's wound as a pressure injury that was down to muscle with some granulation, slough, and fibrinous material with circumferential undermining present (presence of undermining was not identified on the facility wound evaluation). Proximal and distal sutures intact with central area of dehiscence, central tissue parameters with new pressure injury to flaps, infected. Pre debridement measurements Length 9.0 cm, width 3.0 cm, depth 2.3 cm total 27 cm ^2 Post debridement measurements Length 9.0 cm, width 3.0 cm, depth 2.5 cm total 27 cm^2 New orders given . -perform the following twice a day: 1)carefully remove all prior wraps dressings 2) rinse sacral wound with saline 3) 2 or 3 inch Kling wet with Dakin's ¼ strength twice daily 4) barrier cream 5) if dressing becomes soiled, saturated, or displaced, please remove the dressing and replace as above.	2 900		

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2 900	Continued From page 7 100% nonweightbearing to the sacrum Significant deterioration noted today during wound visit from pressure and loose stools, tissue culture obtained and increase protein intake Return to wound clinic in 1-2 weeks-plan for negative pressure wound therapy. R1's Weekly Pressure Injury Tracker dated 5/16/23, indicated wound measurements of : Length 4.1 c.m. x width 1.7 c.m. x depth 20 c.m. Further identified no tunneling and wound was unchanged. R1's wound clinic visit note dated, 5/23/23, indicated R1 had incisional dehiscence after sitting in stool for prolonged periods of time which led to flap necrosis along the incision and dehiscence down to the muscle fascia, R1 reported her dressings were not being changed consistently to wound clinic orders. The visit note indicated the wound had worsened. Pre debridement measurements Length 4.5 cm, width 2.0 cm, depth 2.5 cm total 9.0 cm ^2 Post debridement measurements Length 4.5cm, width 2.0 cm, depth 2.8 cm total 9.0 cm^2 R1's wound clinic visit note dated, 5/30/23, indicated R1 had concerns about her wound care, stated when she uses the restroom packing falls out and is not reapplied correctly, resident stated she was not receiving the Dakin's gauze and is often not getting packing at all or barrier cream. Wound description included pressure injury to muscle increased granulation, increased slough, intact proximal and distal incision, left lateral flap with stable subcutaneous necrosis, infected. Wound culture was taken. Pre debridement measurements Length 3.2 cm, width 2 cm, depth 2.5 cm total 6.4 cm ^2	2 900		

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2 900	Continued From page 8 Post debridement measurements Length 3.2cm, width 2 cm, depth 2.8 cm total 6.4 cm^2 R1's Weekly Pressure Injury Tracker dated 5/30/23, measurements were consistent with the wound clinic.Identified wound was unchanged. Assessment did not identify the wound was necrotic nor that it was infected. R1's Weekly Pressure Injury Tracker dated 6/5/23, describes wound as Measurements: Length 4.0 c.m. x width 2.0 c.m. x depth 2.4 c.m. The assessment indicated the wound did not have tunneling, periwound tissue was normal, and wound progress was unchanged. R1's wound clinic visit note dated 6/6/23, indicated R1's wound had a polymicrobial infection (Pseudomonas and Enterococcus Faecalis-bacteriums) and new orders for Cipro and Augmentin (antibiotics) were given. Pressure wound down to muscle with increased granulation, decreased slough, intact proximal and distal incision, periwound dermatitis, tunneling at 5:00 approximately 6.2cm (tunneling not identified on facility assessment). Identified the wound was overall slightly improved. Pre debridement measurements Length 4.0 cm, width 2 cm, depth 2.4 cm total 8.0 cm ^2 Post debridement measurements Length 4.0 cm, width 2 cm, depth 2.8 cm total 8.0 cm^2 Dressing change orders were changed to twice daily, acetic acid soaked gauze ensure packing to undermining, and application of Calmoseptine to periwound skin followed by nystatin powder. R1's Weekly Pressure Injury Tracker dated 6/13/23 and 6/20/23, included measurements, indicated no undermining or tunneling, no signs/symptoms of infection, and wound was	2 900		

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2 900	Continued From page 9 unchanged. R1's Weekly Pressure Injury Tracker dated 6/26/23, described wound as Measurements: Length 3.8 c.m. x width 2.0 c.m. x depth 1.8 c.m. No tunneling, no undermining, no inflammation or infection. Wound was improving. R1's wound clinic visit note dated, 6/28/23, indicated residents dressings continued to not be changed as ordered and wound was not being packed and was often being left uncovered. Resident continues to be interested in wound vac therapy when she can safely use. Wound described as pressure injury sacrum down to muscle, periwound dermatitis, tunneling at 5:00 approximately 4.4 cm, increased granulation tissue, resolved malodor (unpleasant smell), minimal slough, overall slight improvement. Pre debridement measurements Length 3.8. cm, width 2 cm, depth 1.7 cm total 7.6 cm ^2 Post debridement measurements Length 3.8 cm, width 2 cm, depth 1.8 cm total 7.6 cm^2 The visit note included new orders for wound vac dressing change for three times a week. R1's June's 2023 treatment administration record (TAR) identified between 6/1/23 through 6/6/23, documentation identified a chart code of '9' indicating the dressing was not completed or the box was left blank on 5 of 12 occurrences where the dressing was supposed to be changed. Documentation between 6/7/23 through 6/29/23 identified the acetic acid packing at 5 o'clock position was left blank or a chart code of '9', for 10 of 22 possible changes. Physician order for sacral wound treatments with a start date of 6/30/23 (end date 7/23/23) included the following:	2 900		

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2 900	Continued From page 10 1) Remove old dressing. Rinse all open ares with saline 2) Aceitc acid 0.25% 2 or 3 inch kling gauze allow to soak for 10-15 minutes (in wound) and then rinse with saline 3) Black foam negative pressure wound therpay system at 125 mmHg continuous making sure to avoid any pressure points to the sacrum (use bridge dressing. change dressing if it becomes spoiled, saturated, or displaced.) Every Monday, Wednesday, and Friday. R1's June and July 2023 TAR included the physician order for wound vac dressing changes to be completed on Monday, Wednesday, and Friday. The TAR indicated on 6/30/23, 7/3/23, 7/5/23, 7/7/23, and 7/10/23 the sacral dressing was supposed to be changed however a chart code of '9' was recorded which indicated the dressing was not completed and directed to see progress notes. The box for 7/12/23 was left blank. Corresponding progress did not identify reason why dressing was not changed. Additionally, R1's care plan was not revised to include wound vac therapy, and R1's record did not include ongoing monitoring for signs/symptoms of infection, amount of drainage, R1's tolerance or associated pain related to wound vac, wound improvement/deterioration, and wound vac function and efficacy. R1's Weekly Pressure Injury Tracker dated 7/03/23, indicated a wound assessment had been completed even though the TAR identified the dressing was not changed. The assessment identified wound measurements of: Length 4.0 c.m. x width 2.0 c.m. x depth 2.5 c.m. Tissue described as 100% granulation tissue, moderate serosanguinous drainage, no tunneling or undermining, and no inflammation or infection.	2 900		

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2 900	Continued From page 11 Wound was improving. R1's wound clinic visit note dated, 7/12/23, indicated when resident presented, she stated wound VAC had been left on from June 29th till July 6th. Patient also requested that the VAC be removed as it was painful and uncomfortable and stated she had requested it to be removed at the facility had not been acknowledged. Wound VAC was noted to be on healthy skin and not in the correct location or incorporating the wound. Resident indicated she was in much more discomfort than she had in the past even after undergoing surgery. Wound description: pressure injury sacrum down to muscle, new area of tissue breakdown to fat layer at 2:00 circumferential to periwound dermatitis, increased wound bed slough, malodor, deteriorated. Pre debridement measurements Length 3.2. cm, width 3.5 cm, depth 2.0 cm total 11.2 cm ^2 Post debridement measurements Length 3.2 cm, width 3.5 cm, depth 2.4 cm total 11.2 cm^2 Assessment/Plan: New wound orders obtained without wound VAC, R1 indicated significant wound care concerns and wound care orders not being followed. The current wound is a result of a surgical wound dehiscence that was healing postoperatively and resulted after patient was sitting in her own stool for hours. The wound VAC had been left on too long and resulted in significant wound deterioration. R1's Weekly Pressure Injury Tracker dated 7/13/23, described wound as Measurements: Length 3.5 c.m. x width 2.8 c.m. x depth 2.5 c.m. no tunneling or undermining, peri-wound skin is bright red and irritated about 1cm wide in circumferential redness/irritation. Resident describes pain and stated area has felt sore for a couple days. Wound is worsening.	2 900		

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2 900	Continued From page 12 During an observation on 7/18/23, at 11:01 a.m. licensed practical nurse (LPN)-A entered R1's room to complete the coccyx dressing change. LPN-A obtained two towels, applied soap and water to one and left the other one dry. As she carried the towels over to R1, she dropped the dry towel on the floor twice and picked it back up. LPN-A then cleaned the wound with the soapy towel then used the towel that had been on the floor to dry the wound. LPN-A packed the gauze into the wound. LPN-A stated she had soaked the gauze in acetic acid before it was packed. During an interview on 7/17/23 at 4:41 p.m. R1 indicated she had admitted to the facility with a wound. During her weekly wound clinic appointments she had been informed the wound was not healing the way it should be and the dressing did not appear to be getting done correctly. R1 explained at the beginning of wound there had been discussion about a wound vac but had to wait until the infection in the wound cleared up. The wound vac was put on 6/29/23. R1 indicated after the wound vac was put on she had asked multiple nurses when it was supposed to be changed. Nobody was changing it, the nurses would put tape over it. Finally on July 9th R1 recalled the machine was beeping, one of the nurses came in, and applied tape over the dressing. The nurse did eventually change the dressing after I had informed her, I was seeing the wound doctor on 7/12/23." She had waited 11 days for the dressing to be changed. On 7/12/23, the wound clinic took it off and could tell the facility hadn't been changing it. During an interview on 7/18/23, at 10:41 a.m. LPN-A stated she had put on R1's wound vac but was unable to recall the date she had done so.	2 900		

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2 900	Continued From page 13 LPN-A explained she was not comfortable with wound vacs because she had not had any training. LPN-A stated she did not tell anyone she was not competent or asked anyone questions. LPN-A stated she was going to change it one time but R1 had told her someone had changed it on the previous night. LPN-A documented R1 refused without further verifying with the record and/ or other nurses. During an interview on 7/18/23, at 12:49 registered nurse (RN)-B stated she had worked with R1 and thought she was reliable historian. RN-B stated she had not ever completed a wound vac change in the facility and stated R1 had told her the wound vac changes were being completed in the wound clinic. RN-B had not changed a wound vac since 2005 or 2006, had not had any wound vac education since, and would not feel comfortable changing it. RN-B stated if a "9" was marked on the TAR that meant the order/task was not completed; nurses were supposed to write a progress note explaining why it was not done. During an interview on 7/18/23 at 12:59 p.m. RN-A stated she had not taken care of R1's wound vac. RN-A reported she had worked for the facility for several years and never received any training related to wound vac dressings or cares. During an interview on 7/18/23 at 1:54 p.m. with clinical manager (CM)-A stated R1 is alert and oriented but can occasionally be forgetful. CM-A had not completed R1's dressing changes. CM-A indicated the findings of the facility's investigation identified floor nurses admitted to not changing R1's wound vac. CM-A explained no training on wound vacs had been offered at the facility and it	2 900		

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2 900	Continued From page 14 was her belief the reason why it was not completed by nurses. During an interview on 7/18/23, at 1:24 p.m. wound clinic wound nurse (WN) stated, she had been following R1 since 4/26/23 after her surgery. WN stated R1 had sutures and a JP drain The plan was to keep pressure off the wound and bacitracin on suture line and Xeroform and Mepilex around the tube of the drain to prevent further injury. The wound clinic was monitoring it weekly. The end of April, beginning of May we had not seen R1, when we did see her the wound started opening and by 5/23/23, it had completely opened. We felt the biggest issues were that the dressings were not being done as ordered. The wound continued to worsen, and she ended up with another infection which caused the wound vac treatments to be pushed back. The wound vac was supposed to be started on 6/28/23. We did not receive any calls or questions at the wound clinic from the facility. When WN saw R1 on 7/12/23, the wound vac had been placed incorrectly and the wound appeared worse. The facility was contacted, and the orders were changed back to stop the wound vac because of the infection and improper placement. R1 had told us the facility had not changed the dressing since 6/29/23. During an interview on 7/18/2023 at 8:33 a.m. wound clinic doctor (MD)-A stated every visit R1 came in there were issues. R1 had reported to the wound clinic staff there were times she would sit in stool for hours before getting help. Her wound opened up. We found the facility was not completing the dressings as ordered. When R1 came into the clinic with the vac on, R1 reported the facility was not changing the vac dressing; we found the dressing had been applied wrong. The	2 900		

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2 900	Continued From page 15 facility had put the sponge on normal viable skin which created a bigger problem of a new wound and no granulation tissue, the wound had deteriorated and became bigger. MD-A explained if a wound vac dressing was left on too long, it could cause infection, which happened to R1. We had to resect to the bone and put R1 back on antibiotics. MD-A further explained since the facility could not follow the basic dressings orders, it was decided to stop the wound vac. MD-A stated "the wound should be healed already. MD reported no staff at the facility informed the clinic they didn't know how to manage the wound vac or called with questions. R3's quarterly Minimum Data Set (MDS) dated 5/5/23, indicated R3 had moderate cognitive impairment; R3's activities of daily living assessment identified R3 required extensive assistance of two people with bed mobility, transferring, dressing, toileting, personal hygiene needed one person physical assistance and locomotion was supervision of one person. Walking had not occurred during assessment period. R3 was frequently incontinent of bladder and bowel. R3 was a risk for pressure ulcers and had a stage 2 pressure ulcer. R3's care plan dated 3/20/23, indicated, R3 had diagnoses that included, diabetes mellitus, diabetic neuropathy, and pressure ulcer stage 2. R3's skin care plan identified R3 had diabetic ulcers to toes left foot and pressure ulcer to ankle. Interventions included enhanced barrier precautions related to wound care (dated 11/22/22), Inspect skin during cares for redness, open areas and report (revised 7/5/22) and Treatments as ordered monitor for effectiveness. R3's physician orders signed included:	2 900		

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2 900	Continued From page 16 Left malleolus (ankle) Cleanse ulcer base with normal saline or wound cleanser. Pat dry and then cover with gauze and secure in place with Kerlix.Change daily and as needed (ordered 6/2/23, started 6/3/23) Avoid wearing shoe until left malleous (ankle) is completely healed, document refusals every shift (11/2/22) During an observation on 7/17/23 at 12:23 p.m. R3 had a sign on his door that directed R3 required contact precautions (personal protective equipment). R3 had both shoes on his feet even though physician order directed to keep the left shoe off. R3 stated his dressings were not being done daily; R3's ankle dressing was not dated to show how long the dressing had been on. Nurse practitioner (NP) was prepping for R3's left ankle dressing change, NP did not have a gown on in accordance with the sign on R3's door. NP stated R3 was not supposed to have his left shoe on, it was supposed to be off till his wounds were completely healed. NP removed left ankle dressing with gloves on, then cleaned the wound without changing her gloves. After NP cleaned the wound she removed gloves and she washed her hands and put on new gloves. The NP applied Xeroform gauze over the wound, which was not consistent with the physician order dated 6/2/23. NP explained she had previously wrote the dressing change order directing Xeroform usage and was not sure when the order was changed that excluded the Xeroform. Physician order for left ankle with start date of 7/18/23, included xeroform cut to fit wound bed cover with soft gauze and secure with kerlix change daily and as needed (PRN) every day shift.	2 900		

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2 900	Continued From page 17 During an observation on 7/18/23 at 9:33a.m. LPN-A was completing a dressing change on R3. LPN-A had gown and gloves on. LPN-A wet a towel and wash cloth in the bathroom. While walking back to R3 from the bathroom a towel dropped on the floor. LPN-A cleaned the wound and dried it with the towel that had dropped on the floor. LPN applied barrier cream to foot with same gloved hands and removed soiled gloves, washed hands and put on clean gloves. LPN-A cut the Xeroform and applied it to the whole malleolus going outside the wound edges (instead of fitting to wound bed according to physcian orders) and applied Mepilex. During an interview on 7/18/23, at 2:10 p.m. Regional Registered Nurse Consultant (RNC) stated she was notified on 7/13/23 with a call of concern from the wound clinic. The wound clinic stated the wound vac had only been changed once since 6/29/23 by LPN-A and LPN-B. RNC stated she had interviewed the nurses and LPN-A and LPN-C had indicated when they read the wound vac order they thought the dressing was only to be changed on Monday, Wednesday, and Friday if the dressing was soiled and needed to be changed. They both also mentioned they had not been comfortable changing a wound vac. RNC stated she had since checked all orders to make sure they have clear timelines and had separated PRN orders from scheduled orders. RNC stated training had been initiated on 7/13/23 and continued 7/14/23. Wound vac dressings and complicated dressings have been suspended until nurses can be trained. RNC also stated she had also talked to the floor nurse managers about holding floor nurses accountable for missed treatments and now missed treatments are now showing up first during the daily record reviews.	2 900		

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2 900	Continued From page 18 Facility policy, Clean Dressing Change, Dated 7/20/22, indicated, the policy of the facility to provide wound care in a manor to decrease potential for infection and or cross-contamination. Physician's orders will specify type of dressing and frequency of changes. 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, this includes but is not limited to training in speciallized wound cares such as negative pressure therapy (wound vac). 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. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		