Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 21, 2023

Administrator
Regina Senior Living
1175 Nininger Road
Hastings, MN 55033

RE: CCN: 245254
Cycle Start Date: August 22, 2023

Dear Administrator:

On August 30, 2023, we notified you a remedy was imposed. On November 8, 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 November 7, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 8, 2023, did not go into effect. (42 CFR 488.417 (b))

In our letter of August 30, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 6, 2023. 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

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

Electronically delivered

November 21, 2023

Administrator
Regina Senior Living
1175 Nininger Road
Hastings, MN 55033

Re: Reinspection Results
Event ID: UB4412

Dear Administrator:

On November 8, 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 August 22, 2023. At this time these correction orders were found corrected.

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

October 24, 2023

Administrator
Regina Senior Living
1175 Nininger Road
Hastings, MN 55033

RE: CCN: 245254
Cycle Start Date: August 22, 2023

Dear Administrator:

On August 30, 2023, we informed you that we may impose enforcement remedies.

On October 6, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On October 6, 2023, the situation of immediate jeopardy to potential health and safety cited at F686 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 November 8, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 8, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 8, 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 a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Regina Senior Living is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 6, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 February 22, 2024 (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 § 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 24, 2023

Administrator
Regina Senior Living
1175 Nininger Road
Hastings, MN 55033

Re: State Nursing Home Licensing Orders
Event ID: UB4411

Dear Administrator:

The above facility was surveyed on September 29, 2023 through October 6, 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 9/29/23, 10/2/23-10/4/23 & 10/6/23, 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 complaints were reviewed. H52545843C (MN00097114 & MN00097070) with deficiencies issued at F580, F684 & F686. The survey resulted in an Immediate Jeopardy (IJ) at F686 when the facility failed to implement interventions to prevent pressure ulcer development when a resident admitted to the facility without pressure ulcers, developed a pressure ulcer, and the facility failed to provide ongoing comprehensive skin assessments, monitor for signs of infection/deterioration, and notify R1's provider of changes, resulting in R1 being hospitalized. The IJ began on 8/15/23, and the immediacy was removed on 10/6/23. The above findings constituted substandard quality of care, and an extended survey was conducted from 10/4/23 to 10/6/23. 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	F 000		

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

Electronically Signed | 11/01/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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	Continued From page 1 regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically	F 580		11/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 580	Continued From page 2 update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify 2 of 3 (R1 & R2) residents' physician and representative of a significant change in status when R1 developed a pressure ulcer and R2 had an abrasion to his back that required ongoing treatment. Findings include: R1's quarterly Minimum Data Set (MDS) dated 6/20/23 indicated R1 was cognitively intact, required extensive assistance for bed mobility and transfers, and was not ambulatory. The MDS indicated R1 was at risk for pressure ulcers, had diagnoses of Multiple sclerosis, weakness and abnormal posture and required the extensive assistance of one staff for bed mobility, dressing and toileting. A Nurse Practitioner (NP) note dated 7/27/23, indicated R1 had several wounds to bilateral buttocks near coccyx that an in house wound physician (WMD) was following.	F 580	F580 This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. • R1 no longer resides in the facility. Medical Record was reviewed and sent to the Quality Assurance committee for process improvement opportunities. • Abrasion on R2's back is healed, per facility wound nurse, as of 10/05/2023. Nursing continues to monitor and evaluate resident's skin for breakdown, during routine skin checks. • Residents at high risk for pressure ulcers were identified and skin/body audits completed. Residents with current pressure injuries had comprehensive skin	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 580	Continued From page 3 During an interview on 10/2/23, at 1:56 p.m. FM-B stated she didn't know about the pressure ulcer until just prior to R1 going to the hospital on 8/24/23, she recalled that she was told by staff that R1 had some kind of sore because they were going to move her every 2 hours but that was near the end when she was hospitalized. FM-B stated a nurse at the hospital told her that R1 was in septic crises because of the pressure ulcer on her sacrum. During an interview on 10/3/23, at 12:59 p.m. the NP stated she had not been working at this facility long and her first visit with R1 was on 8/1/23 following a urinary tract infection (UTI). The NP stated she did not look at the pressure ulcer then and was not sure that she knew about it at that time. The NP looked at the primary provider notes and stated the physician did not mention a pressure ulcer in her notes either. The NP stated she thought the WMD was involved and did not know about the pressure ulcer worsening until 8/15/23, when she was at the facility and a nurse stated, "you need to see this wound". R2's admission Minimum Data Set (MDS) dated 7/26/23, noted R1 had intact cognition and required extensive assist of one for bed mobility, toileting, and dressing, supervision with transfers and personal hygiene. R2 had diagnoses that included malignant neoplasm of prostate, weakness, and difficulty walking. During an interview on 10/2/23, at 11:34 a.m. licensed practical nurse (LPN)-A stated she had seen R2 along with the wound physician (WMD) for wound rounds on 9/28/23, and new wound care orders were obtained. LPN-A stated she did not see the orders entered into the electronic	F 580	assessments completed, care plan interventions reviewed and updated as necessary. Providers were notified of current status, treatment, and interventions. • Current facility nursing staff, including agency/contract associates will receive education prior to their next shift. Education began on 10/4/2023 and will continue until completed by all associates. Education includes: o Prevention and Treatment of Skin Breakdown Policy o Comprehensive pressure ulcer assessments and care o Interventions for pressure ulcers o Notifying the provider of alterations in skin o Pressure ulcer prevention modalities in accordance with the plan of care • Ongoing audits will be completed twice weekly for six weeks to ensure that changes in skin condition have been reported to the provider per the facility policy. Results of audits will be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 580	Continued From page 4 medical record and that R2 did not receive the ordered dressing changes but was not sure how many dressing changes were missed and that the WMD was not notified of the missed dressing changes. During an interview on 10/2/23, at 1:21 p.m. FM-C stated she is the emergency contact for R2, she was not notified of an open area on his back, not notified that WMD had seen him for the open area or that the area required ongoing treatment. During an interview on 10/2/23, at 1:30 p.m. the WMD stated she saw R2 for an abrasion to his upper back that was a reaction to a patch, the wound was superficial, and she ordered daily wound care. The WMD stated she had not been notified that the daily dressing changes had been missed or that wound care was not provided as ordered. The WMD stated there is a potential for wound deterioration if a dressing is not changed as ordered as some dressings are not meant to be in place for 4-5 days at a time. A facility policy titled Change in Condition effective in 2/19, noted licensed nursing staff should notify the attending provider of a change in condition as well as the resident representative and document the notification.	F 580		
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	F 684		11/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 684	Continued From page 5 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: Based on record review and interview, the facility failed to ensure that a resident received treatment and care when a wound physician ordered daily wound care for 1 of 3 residents (R2) reviewed for quality of care. R2's physician orders were not transcribed into the electronic medical record (EMR) and was not performed. Findings include: R2's admission Minimum Data Set (MDS) dated 7/26/23, noted R1 had intact cognition and required extensive assist of one staff for bed mobility, toileting, and dressing, supervision with transfers and personal hygiene. R2 had diagnoses that included malignant neoplasm of prostate, weakness ad difficulty walking. A progress note dated 9/28/23, indicated R2 was seen on weekly wound rounds with wound nurse (LPN)-A and the wound physician (WMD), R2 had an abrasion noted to his middle back, wound orders were as follows: 1. Cleanse with wound cleanser 2. Skin prep to peri wound 3. Apply xeroform to affected area 4. Cover with island gauze 5. Initial and date dressing. A VOHRA wound evaluation and management summary dated 9/28/23, noted R2 had wound on his right buttock and upper back. The note indicated R2's back wound was not pressure	F 684	F684 " Abrasion on R2□s back is healed, per facility wound nurse, as of 10/05/2023. Nursing continues to monitor and evaluate resident□s skin for breakdown during routine skin checks. " Residents at high risk for pressure ulcers were identified and skin/body audits completed. Residents with current pressure injuries had comprehensive skin assessments completed, care plan interventions reviewed and updated as necessary. Providers were notified of current status, treatment, and interventions. " Current facility nursing staff, including agency/contract associates will receive education prior to their next shift. Education began on 10/4/2023 and will continue until completed by all associates. Education includes: o Prevention and Treatment of Skin Breakdown Policy o Comprehensive pressure ulcer assessments and care o Interventions for pressure ulcers o Notifying the provider of alterations in skin o Pressure ulcer prevention modalities in accordance with the plan of care Order Review Policy " Ongoing audits will be completed twice weekly for six weeks to ensure that treatment orders are entered into the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 684	Continued From page 6 related, measured 5.7 centimeters (cm) Length by 4.5 cm Width and 0.1 cm Depth. The note had a dressing treatment plan of xeroform gauze and gauze island dressing, change daily. R2's treatment administration record (TAR) accessed on 9/29/23, did not reflect the wound care orders to R2's back abrasion. During an interview on 10/2/23, at 11:34 a.m. LPN-A confirmed the order was not entered into R2's TAR and his wound care was not completed. LPN-A stated she was not why sure why the order was not entered and did not know the frequency of the dressing change to R2's back wound. During an interview on 10/2/23, at 1:30 p.m. the WMD noted she saw R2 for an abrasion to his upper back that was a reaction to a patch, the wound was superficial, and she ordered daily wound care. The WMD stated she had not been notified that the daily dressing changes had been missed or that wound care was not provided as ordered. The WMD stated there is a potential for wound deterioration if a dressing is not changed as ordered as some dressings are not meant to be in place for 4-5 days at a time. A facility policy titled Prevention and Treatment of Skin Breakdown effective 9/1/18, noted residents who experience a break in skin integrity or wounds are provided care and service to heal the skin according to professional standards of care.	F 684	facility TAR. Results of audits will be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.	
F 686 SS=J	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.	F 686		11/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 686	Continued From page 7 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 interview and record review, the facility failed to implement interventions to prevent pressure ulcer development for 1 of 1 resident (R1) reviewed for pressure ulcers. R1 admitted to the facility without pressure ulcers, subsequently developed an unstageable pressure ulcer related to necrotic (death of tissue). The facility failed to provide ongoing comprehensive skin assessments, monitor for signs of infection/deterioration, and notify R1's provider of changes, resulting in R1 being hospitalized . The immediate jeopardy began on 8/15/23, when a pressure ulcer was noted to R1's buttocks without proper assessment, physician notification, and documentation of interventions and was identified on 10/4/23. The administrator and director of nursing (DON) were notified of the on 10/4/23 at 4:55 p.m. The immediate jeopardy was removed on 10/6/23 but noncompliance remained at the lower scope and severity level 2, D - isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F 686	F686 • Resident #1 is no longer a resident of the facility. Medical Record was reviewed and sent to the Quality Assurance committee for process improvement opportunities. • All facility residents reviewed to ensure Braden Scale completed within current quarter. • Residents at high risk for pressure ulcers were identified and skin/body audits completed. • Residents with current pressure injuries had comprehensive skin assessments completed, care plan interventions reviewed and updated as necessary. Providers notified of current status, treatment, and interventions. • Prevention and Treatment of Skin Breakdown Policy reviewed for accuracy, and remains current. • Current facility nursing staff, including agency/contract associates will receive education prior to their next shift. Education began on 10/4/2023 and will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 686	Continued From page 8 Findings include: The State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, revision 211, 2-3-23 indicated definitions for stage 3, stage 4, and unstageable pressure ulcers. Stage 3 Pressure Ulcer: Full-thickness skin loss: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable PU/PI. Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer. Slough and/or eschar may be visible 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. Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is	F 686	continue until completed by all associates. Education includes: o Prevention and Treatment of Skin Breakdown Policy o Comprehensive pressure ulcer assessments and care o Interventions for pressure ulcers o Notifying the provider of alterations in skin o Pressure ulcer prevention modalities in accordance with the plan of care • Ongoing audits will be completed three times per week for 4 weeks to ensure that high risk residents and those with pressure injuries have interventions in place to prevent skin breakdown. Results of audits will be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 686	Continued From page 9 obscured by slough or eschar. Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur. R1's admission note to the facility dated 3/24/23, indicated R1 had no skin issues except for bruising on her left arm due to lab draws and a biopsy procedure on her right arm. R1's care plan initiated on 3/27/23, noted she was at risk for skin breakdown and had interventions for turning and reposition program as needed every two hours, barrier cream to dry areas as needed, and wheelchair cushion. These interventions were discontinued on 4/26/23. The discontinue reason was "Scheduled end date." R1's Physician Orders dated 3/27/23, noted skin assessment to be completed on weekly shower day, to be completed even if a shower is refused, all old and new skin abnormalities need to be documented. R1's care plan initiated 4/10/23, noted an intervention for risk for skin alteration; "See eTAR (electronic Treatment Administration Record)." A progress note dated 5/10/23, indicated staff	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 686	Continued From page 10 reported a small sore on R1's coccyx, the nurse noted 1 centimeter (cm) x 1 cm, applied barrier cream, a foam dressing and left the provider a non-urgent voicemail. A progress note dated 5/16/23, noted R1 had a sore on her bottom and was added to wound rounds. A progress note date 5/22/23, noted R1 was seen on wound rounds and had a "pea-sized" pressure ulcer on her coccyx. No specific measurements, staging, description of wound bed, drainage or condition of peri-wound skin were documented. R1's Physician Orders dated 5/22/23, directed to care for the pressure ulcer as follows: cleanse with wound cleanser, skin prep to peri-wound and cover with foam daily. The order was discontinued on 6/23/23. R1's quarterly Minimum Data Set (MDS) dated 6/20/23 indicated R1 was cognitively intact, required extensive assistance of one to two staff for bed mobility and transfers, and was not ambulatory. The MDS indicated R1 was at risk for pressure ulcers, had diagnoses of multiple sclerosis, weakness and abnormal posture and required the extensive assistance of one staff for bed mobility, dressing and toileting. A progress noted dated 6/29/23, indicated R1 was seen on wound rounds for a small blister on her coccyx area, which had healed. The progress note lacked further description. A progress note dated 7/5/23, indicated an "open area" on R1's coccyx was healed.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 686	Continued From page 11	F 686		

A progress note dated 7/9/23, indicated open areas to R1's gluteal area, it was covered with a foam dressing. The noted lacked documentation of wound bed description, drainage, measurements, etiology, or peri wound skin.

A progress note dated 7/17/23, indicated R1 received a shower, new open areas were found, and the wound nurse completed an assessment. The wound nurse documented a progress note that stated R1 had two open areas on her buttocks, the left buttock had visible adipose with full thickness skin loss and the right had partial thickness skin loss with exposed dermis. R1 was added to weekly wound rounds. The note lacked further description of the pressure ulcers.

R1's wound management form dated 7/17/23, noted R1 had an open area on her left buttock that measured 3 cm x 3.5 cm and an open area on her right buttock that measured 2 cm x 1.5 cm, and the healing status was "stable". The wound management form lacked wound bed descriptors, drainage, peri wound skin or staging of the pressure ulcer.

R1's Physician Orders dated 7/17/23 directed to cleanse with wound cleaner, apply skin prep to peri-wound skin, apply a small amount of Medi-honey to the wound bed, cover with foam and change daily.

A progress note dated 7/27/23, indicated R1 was seen on wound rounds, treatment was performed to bilateral buttocks, wound nurse to see weekly.

R1's wound management form dated 7/27/23, noted R1's wound measurements to the left buttock measured 1.5 cm x 2 cm, and the right

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 686	Continued From page 12 buttock open area measured 2 cm x 3 cm. The wound management note lacked further description of the pressure ulcer. R1's care plan dated 7/27/23 identified R1 had skin breakdown on bilateral buttocks. The care plan indicated a Braden score (assessment for risk of skin breakdown) of 19 (indicates no risk for pressure ulcer development). R1's care plan lacked any interventions, indicating only to "See eTAR." R1's July 2023, eTAR did not contain pressure ulcer prevention interventions but contained orders for wound care to R1's pressure ulcer. A progress note dated 8/6/23, noted R1 was pale and tired, dressing changed as ordered to stage 3 & 4 pressure ulcers. Vital signs were temperature 97.7 F, blood pressure 97/60, O2 95% on room air, heart rate 77, and respirations were 16. R1's wound management form dated 8/10/23, noted R1's left buttock measured 3 cm x 4 cm and her right buttock measured 5 cm x 4 cm and healing status was listed as "stable". The note lacked any further descriptions. A progress note dated 8/13/23, noted R1's dressing change was completed, and a foul smell and drainage was noted, R1 would be turned every 2 hours to relieve pressure to buttocks. The note lacked documentation of provider notification. A progress noted dated 8/14/23, indicated R1 had a scheduled shower and that she has open areas to left and right gluteal cleft, eschar (devitalized	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 686	Continued From page 13 tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like) noted on right side, total affected area measured 10.5 cm x 5.5 cm, foul smell and significant drainage noted. Repositioning was offered every 2 hours, and the nurse manager would be notified. The note lacked documentation of provider notification. A progress note dated 8/14/23, indicated the nurse and the wound medical doctor (WMD) would assess the wound on 8/17/23 when onsite for wounds, staff to encourage R1 to reposition every 1-2 hours. R1's care plan initiated on 8/15/23, noted wound MD to eval [sik] and treat. A Nurse Practitioner (NP)-E note dated 8/15/23, noted R1 was seen that day for a worsening decubitus (pressure ulcer) ulcer per request for nursing staff. The NP-E noted R1 had worsening ulcer as noted by staff with necrotic (death of tissue) tissue, odor, and increased amount of drainage. The wound was approximately 10 cm x 5 cm, pink wound base with some necrotic tissue on the right, foul odor, yellow drainage and R1 had pain with dressing changes. The NP-E ordered staff to continue change foam dressing daily and as needed if saturated, to monitor for fever, chills, or increased chills, out of bed for meals only until seen by the WMD. R1's Physician Order dated 8/17/23, noted wound MD to eval [sik] and treat. An Initial Wound Evaluation & Management Summary dated 8/17/23, noted the WMD provided an assessment to R1's wound. R1 had	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 686	Continued From page 14 an unstageable (due to necrosis) pressure ulcer to her sacrum, it measured 11.2 cm x 5.6 cm x 0.2 cm, had an odor, moderate serous drainage, had 80% necrotic tissue and 20% granulation (pink-red moist tissue that fills an open wound) tissue. The WMD ordered Santyl to be applied, covered with a foam dressing daily, off load pressure ulcer, reposition per facility protocol. The WMD performed bedside debridement and as a result the necrotic tissue was removed to a depth of 0.6 cm and decreased the nonviable wound bed from 80% to 40%. R1's wound management form dated 8/17/23, noted left and right buttocks wounds were merged into one wound that measured 11.2 cm x 5.6 cm x 0.2 cm. The wound had a moderate amount of drainage, it was seropurulent (yellow or tan, cloudy and thick), there was a foul and strong odor to the wound, and it was an unstageable (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur) due to 80% of the wound bed being slough and/or eschar, and 20% granulation tissue, the pressure	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 686	Continued From page 15 ulcer had macerated/soft, irregular edges, the peri wound skin had blanchable erythema (redness), and the healing status was "stable". A progress note dated 8/17/23, noted R1 had her dressing changed three times that day due to increased drainage and bleeding after debridement. The note lacked documentation of physician notification, or orders to increase dressing change due to drainage. A progress note dated 8/18/23, indicated R1's dressing was changed due to dressing condition and R1 had pain during the dressing change that was not controlled with as needed Tylenol. R1 was having pain when seated in her chair and with dressing changes. The note indicated an order to increase R1's pain medication was obtained, she had poor appetite eating 5% of her meal and returned to bed after mealtime was over. A progress note dated 8/19/23, noted R1's dressing was changed and the skin on the right side of the pressure ulcer was now a dark gray in color, R1 was repositioned every two hours that shift and was compliant with repositioning. The note lacked documentation that the provider was notified of the change in coloration of the pressure ulcer. A progress note dated 8/20/23, indicated R1 had increased pain related to her pressure ulcer receiving two as needed doses of narcotic pain medication - 2.5 milligrams (mg) of Oxycodone once in the morning and once at bedtime. R1's dressing was changed twice, and she was repositioned frequently due to pressure ulcer discomfort. The note lacked documentation that	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 686	Continued From page 16 the provider was notified of increased pain and discomfort related to the pressure ulcer. A progress note dated 8/21/23, noted R1's dressing was changed, she was wincing and clenching which indicated pain but verbally denied pain, no odor was noted. The note lacked documentation that the provider was notified of increased pain. A progress note dated 8/22/23, indicated the dressing was changed as ordered, it had a foul odor, and the wound base was dark gray in color. The note stated the nurse had the NP-E assess the wound that day. An NP-E note dated 8/22/23, indicated that R1 had a worsening decubitus ulcer with tissue necrosis that underwent bedside debridement by the WMD last week. The NP-E stated that staff was reporting increased odor and drainage, R1 is having increased pain and current dose of Oxycodone was not effective in pain management, R1 was not having fevers. The note described the pressure ulcer as being large ulcer on her coccyx, approximately 10 cm x 5 cm, deeper than previous, with gray colored tissue at wound base with some darker black area, drainage is yellow and there was a foul odor. The note indicated the NP-E discussed the pressure ulcer with the primary physician, the note stated they decided to "forego infection markers" (blood labs to assess for inflammation) as it may not be reliable due to chemotherapy drugs. The NP-E and primary physician noted they would order a CT (computerized x-ray) of her pelvis and lumbosacral spine to rule out osteomyelitis and WBC with diff (blood lab to look at the percentage of white blood cells to help diagnose infection).	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 686	Continued From page 17 The NP-E note indicated she spoke with R1's mother and she agreed with treatment plan, that a palliative care consult was recently canceled to continue with active treatment. The note stated the NP-E discussed R1's poor appetite, low protein stores, anemia, breast cancer, and immobility which increased R1's risk for pressure ulcers, infection, and poor healing. The note stated staff should monitor R1 daily for a fever. A Wound Evaluation & Management Summary note dated 8/24/23, indicated the WMD saw R1 for her pressure ulcer. R1's unstageable (due to necrosis) sacrum pressure ulcer measured 12 cm x 6.8 cm x 2.5 cm, it had moderate serous drainage, the peri wound skin had an odor, maceration (occurs when skin is in contact with moisture too long), and erythema, it was 80% necrotic, 10% granulation. The WMD noted the wound was exacerbated, due to nutritional compromise, infection, and a generalized decline. R1 was sent to the hospital due to the appearance of the pressure ulcer, increased size, depth and tunneling. The WMD recommended transfer to the emergency department (ER) for further evaluation, surgical debridement, and treatment with intravenous antibiotics. R1's wound management form dated 8/24/23, noted R1's unstageable pressure ulcer measured 12 cm x 6.8 cm x 2.5 cm, had moderate seropurulent drainage, a sour odor, and was 80% eschar, 10% granulation tissue, the wound edges were not attached to the base, the peri wound skin was white or gray in color, the wound healing status was declining and R1 was sent to the ER for surgical debridement. A progress note dated 8/24/23, noted R1 was	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 686	Continued From page 18	F 686		

seen on wound rounds by the WMD and was sent to the ER for increased necrotic tissue, inability to tolerate bedside debridement to her unstageable pressure ulcer. R1's family was present and brought her to the ER.

R1's Minnesota Cause of Death Worksheet undated, indicated R1's date of death was 9/15/23. R1's immediate cause of death was due to septic shock as a consequence of parapneumonic pleural effusion (accumulation of fluid with a lung infection, mainly pneumonia typically associated with bacterial infections). Other significant conditions contributing to R1's death included multiple sclerosis, stage 4 sacral ulcer, urinary tract infection, and metastatic breast cancer.

During an interview on 9/29/23, at 12:19 p. m. family member (FM)-A stated the first she knew about the pressure ulcer is when she saw it on 8/17/23, when the WMD was there, she took pictures with her phone of the pressure ulcer on that date as well as a week later when the WMD was there again. FM-A stated she was aghast when she saw the pressure ulcer and since R1 required full care and questioned why the facility did not prevent the pressure ulcer. FM-A stated just prior to R1's hospitalization the facility had started to reposition R1 but by that time, the pressure ulcer was too bad. FM-A stated an intensive care unit (ICU) nurse at the hospital told her that R1 had septic shock and she did not want this to happen to anyone else.

During an interview on 10/2/23, at 11:34 a.m. licensed practical nurse (LPN)-A was also a clinical manager and wound nurse for long term care. LPN-A stated she performed weekly wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 686	Continued From page 19 rounds and confirmed that many of R1's wound management forms were incomplete and lacked detailed descriptions of the pressure ulcer such as wound bed appearance, drainage, per wound status. LPN-A confirmed there was no notification of the provider when R1 had necrotic tissue, odor, increased drainage, pain or when it increased in size. LPN-A stated she would expect a nurse to call the provider with any change in the pressure ulcer. LPN-A stated the interventions to prevent pressure ulcers for R1 included an air loss mattress repositioning every 2 hours, protein supplement and a tilt in space wheelchair, however, confirmed R1's care plan did not reflect those interventions. During an interview on 10/2/23, at 1:30 p.m. the WMD stated she did not know when she was first contacted to see R1, but that it was the same day she saw her. The following week the wound had deteriorated, and she thought R1 needed surgical debridement. During an interview on 10/2/23, at 1:56 p.m. FM-B stated she did not know about the pressure ulcer until just prior to R1 going to the hospital and questioned why the facility did not get the WMD involved before it got so bad. FM-B stated staff at the facility told her that they were going to start repositioning her every 2 hours but noted R1 was frequently not repositioned when she visited, she questioned staff about R1 being up in her wheelchair so long and was told that it was because it was nearly mealtime. FM-B stated another time, R1 was left up in her wheelchair all night long by an agency staff and only knew because R1's roommate told her. FM-B stated a staff member at the hospital told her that R1 was in septic crisis because of the pressure ulcer on	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 686	Continued From page 20 her coccyx. During an interview on 10/3/23, at 11:20 a.m. the director of nursing (DON) stated she expected nurses to complete weekly skin assessments in a progress note. The DON confirmed that R1 did not have full descriptions of her pressure ulcers in the wound management form. The DON stated R1 had pressure ulcer prevention interventions that were on a nursing assistant (NA) group sheet but since R1 was discharged, they do not have saved copies of the group sheet. The DON stated R1 had her own wheelchair cushion, she received an air mattress at the end of June and the facility obtained a tilt in space wheelchair on 8/10/23 to reduce the pressure to her sacrum. During an interview on 10/3/23, at 12:59 p.m. the NP-E stated she had not been working at this facility long and her first visit with R1 was on 8/1/23 following a urinary tract infection (UTI). The NP-E stated she did not look at the pressure ulcer then and was not sure that she knew about it at that time. The NP-E looked at the primary provider notes and stated the physician did not mention a pressure ulcer in her notes either. The NP-E stated she thought the WMD was involved and did not know about the pressure ulcer worsening until 8/15/23, when she was at the facility and a nurse stated, "you need to see this wound". The NP-E stated there was necrotic tissue and yellow drainage, she ordered staff to change the dressing daily and as needed for saturation. The NP-E stated she saw the pressure ulcer again on 8/22/23, following debridement from the WMD and had increased her Oxycodone for pain. The NP-E stated at that visit the pressure ulcer had increased depth and necrotic tissue, she spoke with the primary	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 686	Continued From page 21 physician, and they decided to forego any infection markers but ordered a CT to rule out osteomyelitis. The NP-E stated she also spoke with R1's emergency contact who agreed with the plan, while also trying to explain the decreased likelihood of healing. During an interview on 10/3/23, at 1:34 p.m. NA-A stated she never saw R1's pressure ulcer but remembered that she could smell it, she stated she thought R1 had a bowel movement, but another staff member told her the odor was R1's pressure ulcer. During an interview on 10/3/23, at 1:41 p.m. NA-B stated she was aware of R1's pressure ulcer and had reported it to the nurse during a shower when it was getting bad, it was getting bigger, draining more. During a follow up interview on 10/4/23, at 12:57 p.m. The DON confirmed R1 did not have consistent weekly skin assessments and that those weekly skin checks were supposed to be completed on R1's bath day. The DON expected nurses to describe skin alterations, new and old, she also expected nurses to fully describe skin alterations with location, wound bed descriptions, drainage, peri wound skin and etiology of skin alteration. The DON stated all nurses are responsible for updating care plans and that the nurse that initially discovered R1's pressure ulcer should have updated the care plan with interventions, should have been continually changed with the worsening condition of the pressure ulcer, and that turning and repositioning every 2-3 hours should be in any resident at risk for pressure ulcers care plan. The DON stated she expected all nurses to know signs and	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 686	Continued From page 22 symptoms of infection and to report those signs to a provider immediately, they should not wait, should not just update the DON or wound nurse. A facility policy titled Prevention and Treatment of Skin Breakdown effective 9/1/18, noted documentation of the skin impairment should be completed, staging of pressure injury is completed by trained licensed associates, standing orders are initiated and then notification to the provider. Staff should also notify the provider if the pressure injury has not shown progress in 2 weeks and/or deteriorating unexpectedly and to re-evaluate the care plan. The policy also noted evaluation of the current pressure reduction interventions and revision of the care plan. The immediate jeopardy that began on 8/15/23, was removed on 10/6/23, when the facility assured all residents had a current Braden Scale completed, residents that were at high risk for pressure ulcers were identified and skin/body audits were completed, residents with pressure ulcers had comprehensive skin assessments completed with care plan interventions reviewed and updated, providers were notified of current status, treatment and interventions. The facility reviewed their policy and education on the policy, comprehensive skin assessments, interventions for pressure ulcers, provider notification and pressure ulcer prevention modalities in accordance with plan of care was provided to nursing staff prior to their next scheduled shift, but the noncompliance remained at the lower scope and severity level 2, D - isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 9/29/23, 10/2/23-10/4/23 & 10/6/23, 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(s) (was/were) issued. Please indicate in your electronic plan of	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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	Continued From page 1 correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed. H52545843C (MN00097114 & MN00097070) with licensing orders issued at 0900 & 0265. 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	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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	Continued From page 2 not required at 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		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265		11/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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
2 265	Continued From page 3 D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to notify 2 of 3 (R1 & R2) residents' physician and representative of a significant change in status when R1 developed a pressure ulcer and R2 had an abrasion to his back that required ongoing treatment. Findings include: R1's quarterly Minimum Data Set (MDS) dated 6/20/23 indicated R1 was cognitively intact, required extensive assistance for bed mobility and transfers, and was not ambulatory. The MDS indicated R1 was at risk for pressure ulcers, had diagnoses of Multiple sclerosis, weakness and abnormal posture and required the extensive assistance of one staff for bed mobility, dressing and toileting. A Nurse Practitioner (NP) note dated 7/27/23, indicated R1 had several wounds to bilateral buttocks near coccyx that an in house wound physician (WMD) was following. During an interview on 10/2/23, at 1:56 p.m. FM-B stated she didn't know about the pressure ulcer until just prior to R1 going to the hospital on 8/24/23, she recalled that she was told by staff that R1 had some kind of sore because they were going to move her every 2 hours but that was near the end when she was hospitalized. FM-B	2 265	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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
2 265	Continued From page 4 stated a nurse at the hospital told her that R1 was in septic crises because of the pressure ulcer on her sacrum. During an interview on 10/3/23, at 12:59 p.m. the NP stated she had not been working at this facility long and her first visit with R1 was on 8/1/23 following a urinary tract infection (UTI). The NP stated she did not look at the pressure ulcer then and was not sure that she knew about it at that time. The NP looked at the primary provider notes and stated the physician did not mention a pressure ulcer in her notes either. The NP stated she thought the WMD was involved and did not know about the pressure ulcer worsening until 8/15/23, when she was at the facility and a nurse stated, "you need to see this wound". R2's admission Minimum Data Set (MDS) dated 7/26/23, noted R1 had intact cognition and required extensive assist of one for bed mobility, toileting, and dressing, supervision with transfers and personal hygiene. R2 had diagnoses that included malignant neoplasm of prostate, weakness, and difficulty walking. During an interview on 10/2/23, at 11:34 a.m. licensed practical nurse (LPN)-A stated she had seen R2 along with the wound physician (WMD) for wound rounds on 9/28/23, and new wound care orders were obtained. LPN-A stated she did not see the orders entered into the electronic medical record and that R2 did not receive the ordered dressing changes but was not sure how many dressing changes were missed and that the WMD was not notified of the missed dressing changes. During an interview on 10/2/23, at 1:21 p.m. FM-C stated she is the emergency contact for	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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
2 265	Continued From page 5 R2, she was not notified of an open area on his back, not notified that WMD had seen him for the open area or that the area required ongoing treatment. During an interview on 10/2/23, at 1:30 p.m. the WMD stated she saw R2 for an abrasion to his upper back that was a reaction to a patch, the wound was superficial, and she ordered daily wound care. The WMD stated she had not been notified that the daily dressing changes had been missed or that wound care was not provided as ordered. The WMD stated there is a potential for wound deterioration if a dressing is not changed as ordered as some dressings are not meant to be in place for 4-5 days at a time. A facility policy titled Change in Condition effective in 2/19, noted licensed nursing staff should notify the attending provider of a change in condition as well as the resident representative and document the notification. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 265		
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	2 900		11/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 6 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 interview and record review, the facility failed to implement interventions to prevent pressure ulcer development for 1 of 1 resident (R1) reviewed for pressure ulcers. R1 admitted to the facility without pressure ulcers, subsequently developed an unstageable pressure ulcer related to necrotic (death of tissue). The facility failed to provide ongoing comprehensive skin assessments, monitor for signs of infection/deterioration, and notify R1's provider of changes, resulting in R1 being hospitalized . The immediate jeopardy began on 8/15/23, when a pressure ulcer was noted to R1's buttocks without proper assessment, physician notification, and documentation of interventions and was identified on 10/4/23. The administrator and director of nursing (DON) were notified of the on 10/4/23 at 4:55 p.m. The immediate jeopardy was removed on 10/6/23 but noncompliance remained at the lower scope and severity level 2, D - isolated scope and severity level, which indicated no actual harm with potential for more than	2 900	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 7 minimal harm that is not immediate jeopardy. Findings include: The State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, revision 211, 2-3-23 indicated definitions for stage 3, stage 4, and unstageable pressure ulcers. Stage 3 Pressure Ulcer: Full-thickness skin loss: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable PU/PI. Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer. Slough and/or eschar may be visible 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. Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 8 be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur. R1's admission note to the facility dated 3/24/23, indicated R1 had no skin issues except for bruising on her left arm due to lab draws and a biopsy procedure on her right arm. R1's care plan initiated on 3/27/23, noted she was at risk for skin breakdown and had interventions for turning and reposition program as needed every two hours, barrier cream to dry areas as needed, and wheelchair cushion. These interventions were discontinued on 4/26/23. The discontinue reason was "Scheduled end date." R1's Physician Orders dated 3/27/23, noted skin assessment to be completed on weekly shower day, to be completed even if a shower is refused, all old and new skin abnormalities need to be documented. R1's care plan initiated 4/10/23, noted an intervention for risk for skin alteration; "See eTAR (electronic Treatment Administration Record)." A progress note dated 5/10/23, indicated staff	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 9 reported a small sore on R1's coccyx, the nurse noted 1 centimeter (cm) x 1 cm, applied barrier cream, a foam dressing and left the provider a non-urgent voicemail. A progress note dated 5/16/23, noted R1 had a sore on her bottom and was added to wound rounds. A progress note date 5/22/23, noted R1 was seen on wound rounds and had a "pea-sized" pressure ulcer on her coccyx. No specific measurements, staging, description of wound bed, drainage or condition of peri-wound skin were documented. R1's Physician Orders dated 5/22/23, directed to care for the pressure ulcer as follows: cleanse with wound cleanser, skin prep to peri-wound and cover with foam daily. The order was discontinued on 6/23/23. R1's quarterly Minimum Data Set (MDS) dated 6/20/23 indicated R1 was cognitively intact, required extensive assistance of one to two staff for bed mobility and transfers, and was not ambulatory. The MDS indicated R1 was at risk for pressure ulcers, had diagnoses of multiple sclerosis, weakness and abnormal posture and required the extensive assistance of one staff for bed mobility, dressing and toileting. A progress noted dated 6/29/23, indicated R1 was seen on wound rounds for a small blister on her coccyx area, which had healed. The progress note lacked further description. A progress note dated 7/5/23, indicated an "open area" on R1's coccyx was healed. A progress note dated 7/9/23, indicated open	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 10 areas to R1's gluteal area, it was covered with a foam dressing. The noted lacked documentation of wound bed description, drainage, measurements, etiology, or peri wound skin. A progress note dated 7/17/23, indicated R1 received a shower, new open areas were found, and the wound nurse completed an assessment. The wound nurse documented a progress note that stated R1 had two open areas on her buttocks, the left buttock had visible adipose with full thickness skin loss and the right had partial thickness skin loss with exposed dermis. R1 was added to weekly wound rounds. The note lacked further description of the pressure ulcers. R1's wound management form dated 7/17/23, noted R1 had an open area on her left buttock that measured 3 cm x 3.5 cm and an open area on her right buttock that measured 2 cm x 1.5 cm, and the healing status was "stable". The wound management form lacked wound bed descriptors, drainage, peri wound skin or staging of the pressure ulcer. R1's Physician Orders dated 7/17/23 directed to cleanse with wound cleaner, apply skin prep to peri-wound skin, apply a small amount of Medi-honey to the wound bed, cover with foam and change daily. A progress note dated 7/27/23, indicated R1 was seen on wound rounds, treatment was performed to bilateral buttocks, wound nurse to see weekly. R1's wound management form dated 7/27/23, noted R1's wound measurements to the left buttock measured 1.5 cm x 2 cm, and the right buttock open area measured 2 cm x 3 cm. The wound management note lacked further	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 11 description of the pressure ulcer. R1's care plan dated 7/27/23 identified R1 had skin breakdown on bilateral buttocks. The care plan indicated a Braden score (assessment for risk of skin breakdown) of 19 (indicates no risk for pressure ulcer development). R1's care plan lacked any interventions, indicating only to "See eTAR." R1's July 2023, eTAR did not contain pressure ulcer prevention interventions but contained orders for wound care to R1's pressure ulcer. A progress note dated 8/6/23, noted R1 was pale and tired, dressing changed as ordered to stage 3 & 4 pressure ulcers. Vital signs were temperature 97.7 F, blood pressure 97/60, O2 95% on room air, heart rate 77, and respirations were 16. R1's wound management form dated 8/10/23, noted R1's left buttock measured 3 cm x 4 cm and her right buttock measured 5 cm x 4 cm and healing status was listed as "stable". The note lacked any further descriptions. A progress note dated 8/13/23, noted R1's dressing change was completed, and a foul smell and drainage was noted, R1 would be turned every 2 hours to relieve pressure to buttocks. The note lacked documentation of provider notification. A progress noted dated 8/14/23, indicated R1 had a scheduled shower and that she has open areas to left and right gluteal cleft, eschar (devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like) noted on right side, total affected area measured	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 12 10.5 cm x 5.5 cm, foul smell and significant drainage noted. Repositioning was offered every 2 hours, and the nurse manager would be notified. The note lacked documentation of provider notification. A progress note dated 8/14/23, indicated the nurse and the wound medical doctor (WMD) would assess the wound on 8/17/23 when onsite for wounds, staff to encourage R1 to reposition every 1-2 hours. R1's care plan initiated on 8/15/23, noted wound MD to eval [sik] and treat. A Nurse Practitioner (NP)-E note dated 8/15/23, noted R1 was seen that day for a worsening decubitus (pressure ulcer) ulcer per request for nursing staff. The NP-E noted R1 had worsening ulcer as noted by staff with necrotic (death of tissue) tissue, odor, and increased amount of drainage. The wound was approximately 10 cm x 5 cm, pink wound base with some necrotic tissue on the right, foul odor, yellow drainage and R1 had pain with dressing changes. The NP-E ordered staff to continue change foam dressing daily and as needed if saturated, to monitor for fever, chills, or increased chills, out of bed for meals only until seen by the WMD. R1's Physician Order dated 8/17/23, noted wound MD to eval [sik] and treat. An Initial Wound Evaluation & Management Summary dated 8/17/23, noted the WMD provided an assessment to R1's wound. R1 had an unstageable (due to necrosis) pressure ulcer to her sacrum, it measured 11.2 cm x 5.6 cm x 0.2 cm, had an odor, moderate serous drainage, had 80% necrotic tissue and 20% granulation	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 13 (pink-red moist tissue that fills an open wound) tissue. The WMD ordered Santyl to be applied, covered with a foam dressing daily, off load pressure ulcer, reposition per facility protocol. The WMD performed bedside debridement and as a result the necrotic tissue was removed to a depth of 0.6 cm and decreased the nonviable wound bed from 80% to 40%. R1's wound management form dated 8/17/23, noted left and right buttocks wounds were merged into one wound that measured 11.2 cm x 5.6 cm x 0.2 cm. The wound had a moderate amount of drainage, it was seropurulent (yellow or tan, cloudy and thick), there was a foul and strong odor to the wound, and it was an unstageable (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur) due to 80% of the wound bed being slough and/or eschar, and 20% granulation tissue, the pressure ulcer had macerated/soft, irregular edges, the peri wound skin had blanchable erythema (redness), and the healing status was "stable". A progress note dated 8/17/23, noted R1 had her	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 14 dressing changed three times that day due to increased drainage and bleeding after debridement. The note lacked documentation of physician notification, or orders to increase dressing change due to drainage. A progress note dated 8/18/23, indicated R1's dressing was changed due to dressing condition and R1 had pain during the dressing change that was not controlled with as needed Tylenol. R1 was having pain when seated in her chair and with dressing changes. The note indicated an order to increase R1's pain medication was obtained, she had poor appetite eating 5% of her meal and returned to bed after mealtime was over. A progress note dated 8/19/23, noted R1's dressing was changed and the skin on the right side of the pressure ulcer was now a dark gray in color, R1 was repositioned every two hours that shift and was compliant with repositioning. The note lacked documentation that the provider was notified of the change in coloration of the pressure ulcer. A progress note dated 8/20/23, indicated R1 had increased pain related to her pressure ulcer receiving two as needed doses of narcotic pain medication - 2.5 milligrams (mg) of Oxycodone once in the morning and once at bedtime. R1's dressing was changed twice, and she was repositioned frequently due to pressure ulcer discomfort. The note lacked documentation that the provider was notified of increased pain and discomfort related to the pressure ulcer. A progress note dated 8/21/23, noted R1's dressing was changed, she was wincing and clenching which indicated pain but verbally denied	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 15 pain, no odor was noted. The note lacked documentation that the provider was notified of increased pain. A progress note dated 8/22/23, indicated the dressing was changed as ordered, it had a foul odor, and the wound base was dark gray in color. The note stated the nurse had the NP-E assess the wound that day. An NP-E note dated 8/22/23, indicated that R1 had a worsening decubitus ulcer with tissue necrosis that underwent bedside debridement by the WMD last week. The NP-E stated that staff was reporting increased odor and drainage, R1 is having increased pain and current dose of Oxycodone was not effective in pain management, R1 was not having fevers. The note described the pressure ulcer as being large ulcer on her coccyx, approximately 10 cm x 5 cm, deeper than previous, with gray colored tissue at wound base with some darker black area, drainage is yellow and there was a foul odor. The note indicated the NP-E discussed the pressure ulcer with the primary physician, the note stated they decided to "forego infection markers" (blood labs to assess for inflammation) as it may not be reliable due to chemotherapy drugs. The NP-E and primary physician noted they would order a CT (computerized x-ray) of her pelvis and lumbosacral spine to rule out osteomyelitis and WBC with diff (blood lab to look at the percentage of white blood cells to help diagnose infection). The NP-E note indicated she spoke with R1's mother and she agreed with treatment plan, that a palliative care consult was recently canceled to continue with active treatment. The note stated the NP-E discussed R1's poor appetite, low protein stores, anemia, breast cancer, and immobility which increased R1's risk for pressure	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 16 ulcers, infection, and poor healing. The note stated staff should monitor R1 daily for a fever. A Wound Evaluation & Management Summary note dated 8/24/23, indicated the WMD saw R1 for her pressure ulcer. R1's unstageable (due to necrosis) sacrum pressure ulcer measured 12 cm x 6.8 cm x 2.5 cm, it had moderate serous drainage, the peri wound skin had an odor, maceration (occurs when skin is in contact with moisture too long), and erythema, it was 80% necrotic, 10% granulation. The WMD noted the wound was exacerbated, due to nutritional compromise, infection, and a generalized decline. R1 was sent to the hospital due to the appearance of the pressure ulcer, increased size, depth and tunneling. The WMD recommended transfer to the emergency department (ER) for further evaluation, surgical debridement, and treatment with intravenous antibiotics. R1's wound management form dated 8/24/23, noted R1's unstageable pressure ulcer measured 12 cm x 6.8 cm x 2.5 cm, had moderate seropurulent drainage, a sour odor, and was 80% eschar, 10% granulation tissue, the wound edges were not attached to the base, the peri wound skin was white or gray in color, the wound healing status was declining and R1 was sent to the ER for surgical debridement. A progress note dated 8/24/23, noted R1 was seen on wound rounds by the WMD and was sent to the ER for increased necrotic tissue, inability to tolerate bedside debridement to her unstageable pressure ulcer. R1's family was present and brought her to the ER. R1's Minnesota Cause of Death Worksheet undated, indicated R1's date of death was	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 17 9/15/23. R1's immediate cause of death was due to septic shock as a consequence of parapneumonic pleural effusion (accumulation of fluid with a lung infection, mainly pneumonia typically associated with bacterial infections). Other significant conditions contributing to R1's death included multiple sclerosis, stage 4 sacral ulcer, urinary tract infection, and metastatic breast cancer. During an interview on 9/29/23, at 12:19 p. m. family member (FM)-A stated the first she knew about the pressure ulcer is when she saw it on 8/17/23, when the WMD was there, she took pictures with her phone of the pressure ulcer on that date as well as a week later when the WMD was there again. FM-A stated she was aghast when she saw the pressure ulcer and since R1 required full care and questioned why the facility did not prevent the pressure ulcer. FM-A stated just prior to R1's hospitalization the facility had started to reposition R1 but by that time, the pressure ulcer was too bad. FM-A stated an intensive care unit (ICU) nurse at the hospital told her that R1 had septic shock and she did not want this to happen to anyone else. During an interview on 10/2/23, at 11:34 a.m. licensed practical nurse (LPN)-A was also a clinical manager and wound nurse for long term care. LPN-A stated she performed weekly wound rounds and confirmed that many of R1's wound management forms were incomplete and lacked detailed descriptions of the pressure ulcer such as wound bed appearance, drainage, per wound status. LPN-A confirmed there was no notification of the provider when R1 had necrotic tissue, odor, increased drainage, pain or when it increased in size. LPN-A stated she would expect a nurse to call the provider with any change in the pressure	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 18 ulcer. LPN-A stated the interventions to prevent pressure ulcers for R1 included an air loss mattress repositioning every 2 hours, protein supplement and a tilt in space wheelchair, however, confirmed R1's care plan did not reflect those interventions. During an interview on 10/2/23, at 1:30 p.m. the WMD stated she did not know when she was first contacted to see R1, but that it was the same day she saw her. The following week the wound had deteriorated, and she thought R1 needed surgical debridement. During an interview on 10/2/23, at 1:56 p.m. FM-B stated she did not know about the pressure ulcer until just prior to R1 going to the hospital and questioned why the facility did not get the WMD involved before it got so bad. FM-B stated staff at the facility told her that they were going to start repositioning her every 2 hours but noted R1 was frequently not repositioned when she visited, she questioned staff about R1 being up in her wheelchair so long and was told that it was because it was nearly mealtime. FM-B stated another time, R1 was left up in her wheelchair all night long by an agency staff and only knew because R1's roommate told her. FM-B stated a staff member at the hospital told her that R1 was in septic crisis because of the pressure ulcer on her coccyx. During an interview on 10/3/23, at 11:20 a.m. the director of nursing (DON) stated she expected nurses to complete weekly skin assessments in a progress note. The DON confirmed that R1 did not have full descriptions of her pressure ulcers in the wound management form. The DON stated R1 had pressure ulcer prevention interventions that were on a nursing assistant (NA) group sheet	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 19 but since R1 was discharged, they do not have saved copies of the group sheet. The DON stated R1 had her own wheelchair cushion, she received an air mattress at the end of June and the facility obtained a tilt in space wheelchair on 8/10/23 to reduce the pressure to her sacrum. During an interview on 10/3/23, at 12:59 p.m. the NP-E stated she had not been working at this facility long and her first visit with R1 was on 8/1/23 following a urinary tract infection (UTI). The NP-E stated she did not look at the pressure ulcer then and was not sure that she knew about it at that time. The NP-E looked at the primary provider notes and stated the physician did not mention a pressure ulcer in her notes either. The NP-E stated she thought the WMD was involved and did not know about the pressure ulcer worsening until 8/15/23, when she was at the facility and a nurse stated, "you need to see this wound". The NP-E stated there was necrotic tissue and yellow drainage, she ordered staff to change the dressing daily and as needed for saturation. The NP-E stated she saw the pressure ulcer again on 8/22/23, following debridement from the WMD and had increased her Oxycodone for pain. The NP-E stated at that visit the pressure ulcer had increased depth and necrotic tissue, she spoke with the primary physician, and they decided to forego any infection markers but ordered a CT to rule out osteomyelitis. The NP-E stated she also spoke with R1's emergency contact who agreed with the plan, while also trying to explain the decreased likelihood of healing. During an interview on 10/3/23, at 1:34 p.m. NA-A stated she never saw R1's pressure ulcer but remembered that she could smell it, she stated she thought R1 had a bowel movement, but	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 20 another staff member told her the odor was R1's pressure ulcer. During an interview on 10/3/23, at 1:41 p.m. NA-B stated she was aware of R1's pressure ulcer and had reported it to the nurse during a shower when it was getting bad, it was getting bigger, draining more. During a follow up interview on 10/4/23, at 12:57 p.m. The DON confirmed R1 did not have consistent weekly skin assessments and that those weekly skin checks were supposed to be completed on R1's bath day. The DON expected nurses to describe skin alterations, new and old, she also expected nurses to fully describe skin alterations with location, wound bed descriptions, drainage, peri wound skin and etiology of skin alteration. The DON stated all nurses are responsible for updating care plans and that the nurse that initially discovered R1's pressure ulcer should have updated the care plan with interventions, should have been continually changed with the worsening condition of the pressure ulcer, and that turning and repositioning every 2-3 hours should be in any resident at risk for pressure ulcers care plan. The DON stated she expected all nurses to know signs and symptoms of infection and to report those signs to a provider immediately, they should not wait, should not just update the DON or wound nurse. A facility policy titled Prevention and Treatment of Skin Breakdown effective 9/1/18, noted documentation of the skin impairment should be completed, staging of pressure injury is completed by trained licensed associates, standing orders are initiated and then notification to the provider. Staff should also notify the provider if the pressure injury has not shown	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00100	A. BUILDING: _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 21 progress in 2 weeks and/or deteriorating unexpectedly and to re-evaluate the care plan. The policy also noted evaluation of the current pressure reduction interventions and revision of the care plan. The immediate jeopardy that began on 8/15/23, was removed on 10/6/23, when the facility assured all residents had a current Braden Scale completed, residents that were at high risk for pressure ulcers were identified and skin/body audits were completed, residents with pressure ulcers had comprehensive skin assessments completed with care plan interventions reviewed and updated, providers were notified of current status, treatment and interventions. The facility reviewed their policy and education on the policy, comprehensive skin assessments, interventions for pressure ulcers, provider notification and pressure ulcer prevention modalities in accordance with plan of care was provided to nursing staff prior to their next scheduled shift, but the noncompliance remained at the lower scope and severity level 2, D - isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 900		