



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 15, 2024

Administrator
Olivia Restorative Care Center
1003 West Maple Avenue
Olivia, MN 56277

RE: CCN: 245290
Cycle Start Date: March 13, 2024

Dear Administrator:

On April 10, 2024, we notified you a remedy was imposed. On April 29, 2024 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 April 15, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 13, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 10, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 13, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 15, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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



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Electronically delivered

May 15, 2024

Administrator
Olivia Restorative Care Center
1003 West Maple Avenue
Olivia, MN 56277

Re: Reinspection Results
Event ID: E6HE11

Dear Administrator:

On April 18, 2024 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 March 13, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink that reads '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

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March 26, 2024

Administrator
Olivia Restorative Care Center
1003 West Maple Avenue
Olivia, MN 56277

RE: CCN: 245290
Cycle Start Date: March 13, 2024

Dear Administrator:

On March 13, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

Olivia Restorative Care Center

March 26, 2024

Page 2

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 13, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 13, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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/lrc_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.

Olivia Restorative Care Center

March 26, 2024

Page 4

Sincerely,

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

Kamala Fiske-Downing

Minnesota Department of Health

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
March 26, 2024

Administrator
Olivia Restorative Care Center
1003 West Maple Avenue
Olivia, MN 56277

Re: State Nursing Home Licensing Orders
Event ID: E6HE11

Dear Administrator:

The above facility was surveyed on March 13, 2024 through March 13, 2024 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.

Olivia Restorative Care Center

March 26, 2024

Page 2

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,



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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00939	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/13/2024
NAME OF PROVIDER OR SUPPLIER OLIVIA RESTORATIVE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE AVENUE OLIVIA, MN 56277		
(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 3/13/24, 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. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

04/01/24

Minnesota Department of Health

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2 000	Continued From page 1 The following complaints were reviewed. H52901761C (MN00101484) with a licensing order issued at (0900). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE	2 000			

Minnesota Department of Health

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2 000	Continued From page 2	2 000			
2 900	FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow physician ordered wound treatments and failed to ensure appropriate infection control practices during wound care including hand hygiene to prevent or mitigate the risk of wound deterioration and/or infection for 2 of 2 residents (R2, R3) reviewed for pressure ulcers. Findings include:	2 900	Corrected	4/1/24	

Minnesota Department of Health

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2 900	Continued From page 3 R2's admission Minimum Data Set dated 1/9/24, indicated R2 had moderate cognitive impairment, with diagnoses of peripheral vascular disease or peripheral artery disease. R2 required substantial assist with all activities of daily living (ADLs) except for oral hygiene. R2 had no pressure ulcers, arterial, venous ulcers, or other skin problems. R2 had pressure relieving devices on bed and chair and received nutrition or hydration interventions to manage skin problems. R2's skin integrity care plan dated 1/9/24, indicated R2 had potential/actual impairment to skin integrity, with the following interventions: -Barrier cream (dated 1/9/24), -The resident needs pressure relieving/reducing cushion to protect the skin while up in chair (dated 2/5/24). -The resident needs pressure relieving/reducing mattress to protect skin while in bed (2/5/24). R2's physician orders indicated the following orders: -Weekly skin checks and complete assessment every Sunday day shift for monitoring (dated 1/2/24). -Wound care: right knee- cleanse with wound cleanser, pat dry, paint with Betadine daily. Avoid pressure or trauma (dated 2/22/24). -Wound Care right heel pressure wound: 1) cleanse area with wound cleanser and pat dry. 2) Apply skin prep and allow to dry. 3) Apply collagen powder. 4) Cover with a foam heel dressing and wrap with Kerlix. 5) change every 3 days and PRN. Notify provider and wound nurse with any concerns or sings and symptoms/ of infections (Dated 3/2/24). -Monitor right shin abrasion, clean with wound cleanser, pat dry, apply triple antibiotic ointment, cover with band aid, twice daily and as needed.	2 900			

Minnesota Department of Health

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2 900	Continued From page 4 Avoid pressure or trauma (Dated 3/7/24). -Monitor skin tears to left arm daily, apply dressing as needed until healed (Dated 3/12/24). During an observation on 3/13/24 at 10:04 a.m., registered nurse (RN)-C entered R2's room with a wound kit that contained various wound supplies and set it on top of R2's bed side table without first placing a barrier. RN-C completed R2's dressing changes as follows: RN-C explained to R2 what he was doing and assisted R2 to remove his right tennis shoe and light green gripper sock. RN-C applied gloves and removed the large band aid to R2's right lower inner shin, there was a small amount of yellow drainage noted on the old band aid. RN-C indicated he needed to go get more band aides and left the room without performing hand hygiene. RN-C returned to the room and applied gloves. RN-C then reached into the wound kit and removed 4x4's and the wound cleanser. RN-C sprayed the 4x4 with wound cleanser on a 4x4, laying the wound cleanser on a folding chair, without a barrier, RN-C then wiped the right lower shin wound with the 4x4. RN-C, with the same gloves on reached into the wound kit and took out the triple antibiotic ointment. RN-C took off his gloves, applied new gloves without performing hand hygiene, put ointment on his gloved finger, and applied it to R2's wound. RN-C then recapped the ointment and placed it back into the wound kit. With the same gloves on RN-C applied large band aide to R2's wound, removed his gloves, and marked the date and initials on R2's dressing. RN-C left the room to obtain more gloves and returned to the room. R2 stated he was having some pain in right heel area as RN-C removed the dressing to the back of right heel, with the same gloves on. The right heel wound was about 3.5 cm diameter of peeling periphery skin around a 1.5 cm open area white	2 900			

Minnesota Department of Health

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2 900	Continued From page 5 in color moist looking in the center. RN-C used the wound cleanser that was sitting on the chair beside him, sprayed a 4x4 with the wound cleanser, and cleansed the wound with the 4x4, laid the wound cleanser on R2's bed without a barrier present. RN-C cleansed the wound again and with the same gloves on, RN-C reached into the wound kit and obtained one betadine swab packet. Applied the swab to the outside edge of the wound and worked his way to the center of the wound. Threw the swab into the garbage can. RN-C reached again into the wound kit, with the same gloves on and obtained a second betadine swab package. RN-C repeated the process with a second swab, from the outside edge to the center of the wound. RN-C then left the wound open to air. RN-C removed his gloves. RN-C then without gloves on and without performing hand hygiene, applied the light green gripper sock and shoe and did not cover the left heel wound with a dressing according to physician's orders. R2 asked RN-C about his left arm where there were gauze wraps to his forearm and elbow area. RN-C stated that there was not a dressing change order for those areas and did not address. RN-C put all materials back into the general wound kit and put the cover on. RN-C left R2's room, walked to the nurses' station and placed the general kit back into a cupboard without disinfecting the outside of the kit. During an interview on 3/13/24 at 11:35 a.m., RN-C stated he looked at the wound care orders on the computer at the nurses' station, wrote them on a piece of paper and then went to the resident's room with the wound kit to do dressing change. RN-C reviewed R2's dressing change orders and stated he only completed the right shin and heel dressing and had not followed the dressing change orders and identified he had not	2 900			

Minnesota Department of Health

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2 900	Continued From page 6 performed appropriate hand hygiene. R3's significant change MDS dated 12/17/23, had diagnoses of stroke, deep vein thrombosis, and diabetes. R3 was at risk for pressure ulcers, but did not have pressure ulcers, arterial, venous ulcers or any skin concerns noted. R3 did have pressure reducing devices for bed and chair, was on a turning and reposition schedule, and received nutrition or hydration interventions to manage skin problems. R3 had range of motion impairment on one side of her body, used a wheelchair, was dependent with all transfers, toileting hygiene, shower/bathing and putting on her footwear. R3 required extensive assistance with dressing and personal hygiene. R3 did not walk. R3's skin care plan 10/6/23 included: R3 has diabetic ulcer of the right foot related to diabetes, lack of sensation to affected area, and vascular insufficiency. Interventions included but was not limited to, -Monitor pressure areas for color, sensation and temperature, dated 10/6/23 -monitor, document wound size, depth, margins peri wound skin, sinus, undermining, exudates edema, granulation, infection, necrosis, eschar gangrene. Document progress in wound healing on an ongoing basis. Notify MD as indicated, dated 10/6/23, -Weekly treatment documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observation, dated 10/6/23. R3's physician orders included: -Ted socks (elastic compression socks) on in AM off at bedtime, dated 10/13/23,	2 900			

Minnesota Department of Health

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2 900	Continued From page 7 -Wash and dry feet and apply lotion twice daily. Do not apply lotion between toes. Notify wound nurse with skin issues or concerns, dated 12/24/23, -Weekly skin checks and complete assessment, every Tuesday evening shift, dated 9/29/23, -Wound care: bottom of right foot. Cleanse with wound cleanser apply alginate (a special dressing to promote healing), apply boarded foam dressing. If worsens, notify wound nurse. Change daily and as needed, dated 2/11/24. During an observation on 3/13/24 at 11:12 a.m., RN-C enter R3's room. R3 was sitting in her recliner by the window. RN-C set the wound kit and two packages of Maxsorb (an alginate dressing material) on the bedside stand next to R3 without a barrier between them. RN-C applied gloves and then removed R3's red right gripper sock and pulled her open toe TEDS (compression stocking) up to mid foot. RN-C removed the tan Mepilex dressing from R3's right bunion area. There was bright red blood noted on dressing. RN-C stated he could not see where the blood coming from. RN-C grabbed the wound cleanser and 4x4's from the wound kit without changing his gloves. He sprayed the cleanser on the 4x4 and set the wound cleanser on the floor, with no barrier between. RN-C grabbed more 4 x 4's from the wound kit, sprayed the 4 x 4's and the wound area, and then set the wound cleanser on the floor again. RN-C changed his gloves, cut a piece of Maxsorb placed it on the wound, then placed a new Mepilex (boarder foam dressing) over the wound. RN-C then picked up the wound cleanser from the floor and put it back into the wound kit. He then put the lid on the kit, removed his gloves, grabbed the garbage bag and left the room.	2 900			

Minnesota Department of Health

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2 900	Continued From page 8 During an interview on 3/13/24 at 12:19 p.m., RN-B stated with the facilities own staff she provided infection control training, but RN-C was temporary agency staff and was not aware of specific training he had. RN-B stated there should be a barrier between the kit/supplies and the surface they were setting them on as because it prevents cross contamination. RN-B explained wounds were cleaned from the inside of the wound to the outside to prevent contamination of the wound bed. RN-B stated that the nurses working the floor were to look at the wound/dressing orders before they perform the treatments and follow the physician orders. During interview on 3/13/24 at 2:25 p.m., Wound Ostomy Consultant Nurse Practitioner (WOC)-A stated the use of betadine was to clean and dry out wounds. WOC-A did not think the use of it on R2's right heel would have harmed the wound but it was the wrong treatment. With it being the wrong treatment, it could slow down the healing process of this already chronic wound. WOC-A stated a barrier between supplies and the surface important to prevent cross contamination. WOC-A explained the proper way to clean wounds was from the inside (middle) of wound toward the outside, to prevent contamination of the wound. It was her expectation orders for wounds are followed as written. During interview on 3/13/23, at director of nursing (DON) stated it was her expectation the staff carried out the physician orders as written and per the facilities dressing protocol for infection control purposes. Review of facility policy titles Wound Care dated October 2010, indicated in the steps in the procedure:	2 900			

Minnesota Department of Health

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2 900	Continued From page 9 1. Use disposable cloth (paper towel is adequate) to establish a clean field on resident's over bed table. Place all items to be used during procedure on the clean field. Arrange supplies so that they can be easily reached. 2. Wash and dry your hands thoroughly. 3. Position resident. Place disposable cloth next to resident (under the wound) to serve as a barrier to protect bed linen and other body site. 4. Put on exam gloves. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptable. Wash and dry your hands thoroughly. 6. Put on gloves. Gowns wil only be necessary if soiling of your skin or clothing with blood, urine, feces or other body fluids is likely..... 7. Use no touch technique by using tongue blades and applicators to remove ointments and creams frm their containers. 9.Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound. 10. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. 15. Discard the disposable item into the designated container. Discard all soiled laundry, linen, towel and washcloths into the soiled laundry container. Remove disposable gloves and discard into designated container. Wash and dry your hand thoroughly 20. Wipe reusable supplies with alcohol as indicated (i.e., outside of the containers that were touched by unclean hands, scissor blades, etc.). Return reusable supplies to resident's drawer in treatment cart. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee,	2 900			

Minnesota Department of Health

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2 900	Continued From page 10 should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900			

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F 000	INITIAL COMMENTS On 3/13/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H52901761C (MN00101484) with a deficiency cited at F686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to	F 686			4/12/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/01/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 686	Continued From page 1 promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow physician ordered wound treatments and failed to ensure appropriate infection control practices during wound care including hand hygiene to prevent or mitigate the risk of wound deterioration and/or infection for 2 of 2 residents (R2, R3) reviewed for pressure ulcers. Findings include: R2's admission Minimum Data Set dated 1/9/24, indicated R2 had moderate cognitive impairment, with diagnoses of peripheral vascular disease or peripheral artery disease. R2 required substantial assist with all activities of daily living (ADLs) except for oral hygiene. R2 had no pressure ulcers, arterial, venous ulcers, or other skin problems. R2 had pressure relieving devices on bed and chair and received nutrition or hydration interventions to manage skin problems. R2's skin integrity care plan dated 1/9/24, indicated R2 had potential/actual impairment to skin integrity, with the following interventions: -Barrier cream (dated 1/9/24), -The resident needs pressure relieving/reducing cushion to protect the skin while up in chair (dated 2/5/24). -The resident needs pressure relieving/reducing mattress to protect skin while in bed (2/5/24). R2's physician orders indicated the following orders: -Weekly skin checks and complete assessment	F 686	F686 – §483.25(b) Skin Integrity 1.It is the best practice at Olivia Restorative Therapy and Nursing that Based on the comprehensive assessment of a resident, the facility must ensure that— A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. 2.All residents have the potential to be affected in this area. 3.All licensed nursing staff were re-educated on policies and procedures related to wound care and dressing changes on 3/14/2024 (including but not limited to, verifying physicians order, reviewing residents care plan to assess any special needs for the resident, and infection control.) All licensed nurses were also encouraged to have a laptop on the treatment cart, to verify orders, room-side. 4.On 4/8/2024 audit was revised. An audit titled “F686 Wound Care/ Dressing Changes” was updated to clearly reflect purpose of audit. The purpose of the audit is to ensure wound care orders are being followed as directed by the physician. Additionally, that dressing changes are being followed as noted by the facilities		

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F 686	Continued From page 2 every Sunday day shift for monitoring (dated 1/2/24). -Wound care: right knee- cleanse with wound cleanser, pat dry, paint with Betadine daily. Avoid pressure or trauma (dated 2/22/24). -Wound Care right heel pressure wound: 1) cleanse area with wound cleanser and pat dry. 2) Apply skin prep and allow to dry. 3) Apply collagen powder. 4) Cover with a foam heel dressing and wrap with Kerlix. 5) change every 3 days and PRN. Notify provider and wound nurse with any concerns or sings and symptoms/ of infections (Dated 3/2/24). -Monitor right shin abrasion, clean with wound cleanser, pat dry, apply triple antibiotic ointment, cover with band aid, twice daily and as needed. Avoid pressure or trauma (Dated 3/7/24). -Monitor skin tears to left arm daily, apply dressing as needed until healed (Dated 3/12/24). During an observation on 3/13/24 at 10:04 a.m., registered nurse (RN)-C entered R2's room with a wound kit that contained various wound supplies and set it on top of R2's bed side table without first placing a barrier. RN-C completed R2's dressing changes as follows: RN-C explained to R2 what he was doing and assisted R2 to remove his right tennis shoe and light green gripper sock. RN-C applied gloves and removed the large band aid to R2's right lower inner shin, there was a small amount of yellow drainage noted on the old band aid. RN-C indicated he needed to go get more band aides and left the room without performing hand hygiene. RN-C returned to the room and applied gloves. RN-C then reached into the wound kit and removed 4x4's and the wound cleanser. RN-C sprayed the 4x4 with wound cleanser on a 4x4, laying the wound cleanser on a folding chair, without a barrier, RN-C then wiped	F 686	policy and procedure including steps related to infection control i.e. ensuring appropriate handwashing and a clean field is established. This audit started the week of 3/18/2024, audit will be completed weekly until the week of 6/17/2024. Each weekly audit will include an audit of x2 residents needing wound care/dressing changes to ensure the nurse performing the cares complies with the facility's policy and procedures related to wound care and dressing changes. 5.Education and audits will be brought to QAPI for further recommendations. Education will be provided to staff immediately if required upon completion of each audit to ensure compliance. F686 – §483.25(b)(1) Pressure ulcers. 1.It is the best practice at Olivia Restorative Therapy and Nursing that Based on the comprehensive assessment of a resident, the facility must ensure that— 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. 2.All residents have the potential to be affected in this area. 3.All licensed nursing staff were re-educated on the professional standards of practice to promote healing and prevent		

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F 686	Continued From page 3 the right lower shin wound with the 4x4. RN-C, with the same gloves on reached into the wound kit and took out the triple antibiotic ointment. RN-C took off his gloves, applied new gloves without performing hand hygiene, put ointment on his gloved finger, and applied it to R2's wound. RN-C then recapped the ointment and placed it back into the wound kit. With the same gloves on RN-C applied large band aide to R2's wound, removed his gloves, and marked the date and initials on R2's dressing. RN-C left the room to obtain more gloves and returned to the room. R2 stated he was having some pain in right heel area as RN-C removed the dressing to the back of right heel, with the same gloves on. The right heel wound was about 3.5 cm diameter of peeling periphery skin around a 1.5 cm open area white in color moist looking in the center. RN-C used the wound cleanser that was sitting on the chair beside him, sprayed a 4x4 with the wound cleanser, and cleansed the wound with the 4x4, laid the wound cleanser on R2's bed without a barrier present. RN-C cleansed the wound again and with the same gloves on, RN-C reached into the wound kit and obtained one betadine swab packet. Applied the swab to the outside edge of the wound and worked his way to the center of the wound. Threw the swab into the garbage can. RN-C reached again into the wound kit, with the same gloves on and obtained a second betadine swab package. RN-C repeated the process with a second swab, from the outside edge to the center of the wound. RN-C then left the wound open to air. RN-C removed his gloves. RN-C then without gloves on and without performing hand hygiene, applied the light green gripper sock and shoe and did not cover the left heel wound with a dressing according to physician's orders. R2 asked RN-C about his left arm where there were gauze wraps			F 686	infection on 3/14/2024.) 4.On 4/8/2024 audit was revised. An audit titled "F686 Wound Care/ Dressing Changes" was updated to clearly reflect purpose of audit. The purpose of the audit is to ensure wound care orders are being followed as directed by the physician. Additionally, that dressing changes are being followed as noted by the facilities policy and procedure including steps related to infection control i.e. ensuring appropriate handwashing and a clean field is established. This audit started the week of 3/18/2024, audit will be completed weekly until the week of 6/17/2024. Each weekly audit will include an audit of x2 residents needing wound care/dressing changes to ensure the nurse performing the cares complies with the facility's policy and procedures related to wound care and dressing changes. Revision: on 4/8/2024 audit was revised. An audit titled "F686 Skin Check" was updated to clearly reflect the purpose of this audit. The purpose of this audit is ensure that all residents receive skin checks to assess residents' skin for pressure ulcers/skin breakdown, weekly. An audit will be completed once weekly, on all current residents. Audit began on the week of 3/18/2024 and will end on the week of 6/17/2024. 5.Education and audits will be brought to QAPI for further recommendations. Education will be provided to staff immediately if required upon completion		

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F 686	Continued From page 4 to his forearm and elbow area. RN-C stated that there was not a dressing change order for those areas and did not address. RN-C put all materials back into the general wound kit and put the cover on. RN-C left R2's room, walked to the nurses' station and placed the general kit back into a cupboard without disinfecting the outside of the kit. During an interview on 3/13/24 at 11:35 a.m., RN-C stated he looked at the wound care orders on the computer at the nurses' station, wrote them on a piece of paper and then went to the resident's room with the wound kit to do dressing change. RN-C reviewed R2's dressing change orders and stated he only completed the right shin and heel dressing and had not followed the dressing change orders and identified he had not performed appropriate hand hygiene. R3's significant change MDS dated 12/17/23, had diagnoses of stroke, deep vein thrombosis, and diabetes. R3 was at risk for pressure ulcers, but did not have pressure ulcers, arterial, venous ulcers or any skin concerns noted. R3 did have pressure reducing devices for bed and chair, was on a turning and reposition schedule, and received nutrition or hydration interventions to manage skin problems. R3 had range of motion impairment on one side of her body, used a wheelchair, was dependent with all transfers, toileting hygiene, shower/bathing and putting on her footwear. R3 required extensive assistance with dressing and personal hygiene. R3 did not walk. R3's skin care plan 10/6/23 included: R3 has diabetic ulcer of the right foot related to diabetes, lack of sensation to affected area, and vascular			F 686	of each audit to ensure compliance.		

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F 686	Continued From page 5 insufficiency. Interventions included but was not limited to, -Monitor pressure areas for color, sensation and temperature, dated 10/6/23 -monitor, document wound size, depth, margins peri wound skin, sinus, undermining, exudates edema, granulation, infection, necrosis, eschar gangrene. Document progress in wound healing on an ongoing basis. Notify MD as indicated, dated 10/6/23, -Weekly treatment documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observation, dated 10/6/23. R3's physician orders included: -Ted socks (elastic compression socks) on in AM off at bedtime, dated 10/13/23, -Wash and dry feet and apply lotion twice daily. Do not apply lotion between toes. Notify wound nurse with skin issues or concerns, dated 12/24/23, -Weekly skin checks and complete assessment, every Tuesday evening shift, dated 9/29/23, -Wound care: bottom of right foot. Cleanse with wound cleanser apply alginate (a special dressing to promote healing), apply boarded foam dressing. If worsens, notify wound nurse. Change daily and as needed, dated 2/11/24. During an observation on 3/13/24 at 11:12 a.m., RN-C enter R3's room. R3 was sitting in her recliner by the window. RN-C set the wound kit and two packages of Maxsorb (an alginate dressing material) on the bedside stand next to R3 without a barrier between them. RN-C applied gloves and then removed R3's red right gripper sock and pulled her open toe TEDS	F 686			

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F 686	Continued From page 6 (compression stocking) up to mid foot. RN-C removed the tan Mepilex dressing from R3's right bunion area. There was bright red blood noted on dressing. RN-C stated he could not see where the blood coming from. RN-C grabbed the wound cleanser and 4x4's from the wound kit without changing his gloves. He sprayed the cleanser on the 4x4 and set the wound cleanser on the floor, with no barrier between. RN-C grabbed more 4 x 4's from the wound kit, sprayed the 4 x 4's and the wound area, and then set the wound cleanser on the floor again. RN-C changed his gloves, cut a piece of Maxsorb placed it on the wound, then placed a new Mepilex (boarder foam dressing) over the wound. RN-C then picked up the wound cleanser from the floor and put it back into the wound kit. He then put the lid on the kit, removed his gloves, grabbed the garbage bag and left the room. During an interview on 3/13/24 at 12:19 p.m., RN-B stated with the facilities own staff she provided infection control training, but RN-C was temporary agency staff and was not aware of specific training he had. RN-B stated there should be a barrier between the kit/supplies and the surface they were setting them on as because it prevents cross contamination. RN-B explained wounds were cleaned from the inside of the wound to the outside to prevent contamination of the wound bed. RN-B stated that the nurses working the floor were to look at the wound/dressing orders before they perform the treatments and follow the physician orders. During interview on 3/13/24 at 2:25 p.m., Wound Ostomy Consultant Nurse Practitioner (WOC)-A stated the use of betadine was to clean and dry out wounds. WOC-A did not think the use of it on	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245290		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2024	
NAME OF PROVIDER OR SUPPLIER OLIVIA RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1003 WEST MAPLE AVENUE OLIVIA, MN 56277			
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F 686	Continued From page 7 R2's right heel would have harmed the wound but it was the wrong treatment. With it being the wrong treatment, it could slow down the healing process of this already chronic wound. WOC-A stated a barrier between supplies and the surface important to prevent cross contamination. WOC-A explained the proper way to clean wounds was from the inside (middle) of wound toward the outside, to prevent contamination of the wound. It was her expectation orders for wounds are followed as written. During interview on 3/13/23, at director of nursing (DON) stated it was her expectation the staff carried out the physician orders as written and per the facilities dressing protocol for infection control purposes. Review of facility policy titles Wound Care dated October 2010, indicated in the steps in the procedure: 1. Use disposable cloth (paper towel is adequate) to establish a clean field on resident's over bed table. Place all items to be used during procedure on the clean field. Arrange supplies so that they can be easily reached. 2. Wash and dry your hands thoroughly. 3. Position resident. Place disposable cloth next to resident (under the wound) to serve as a barrier to protect bed linen and other body site. 4. Put on exam gloves. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptable. Wash and dry your hands thoroughy. 6. Put on gloves. Gowns wil only be necessary if soiling of your skin or clothing with blood, urine, feces or other body fluids is likely..... 7. Use no touch technique by using tongue			F 686			

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

PRINTED: 04/18/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2024
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F 686	Continued From page 8 blades and applicators to remove ointments and creams frm their containers. 9.Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound. 10. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. 15. Discard the disposable item into the designated container. Discard all soiled laundry, linen, towel and washcloths into the soiled laundry container. Remove disposable gloves and discard into designated container. Wash and dry your hand thoroughly 20. Wipe reusable supplies with alcohol as indicated (i.e., outside of the containers that were touched by unclean hands, scissor blades, etc.). Return reusable supplies to resident's drawer in treatment cart.	F 686			

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/13/24, 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. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

04/01/24

Minnesota Department of Health

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2 000	Continued From page 1 The following complaints were reviewed. H52901761C (MN00101484) with a licensing order issued at (0900). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE	2 000			

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2 000	Continued From page 2	2 000			
	FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.				
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow physician ordered wound treatments and failed to ensure appropriate infection control practices during wound care including hand hygiene to prevent or mitigate the risk of wound deterioration and/or infection for 2 of 2 residents (R2, R3) reviewed for pressure ulcers. Findings include:	2 900	Corrected	4/1/24	

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2 900	Continued From page 3 R2's admission Minimum Data Set dated 1/9/24, indicated R2 had moderate cognitive impairment, with diagnoses of peripheral vascular disease or peripheral artery disease. R2 required substantial assist with all activities of daily living (ADLs) except for oral hygiene. R2 had no pressure ulcers, arterial, venous ulcers, or other skin problems. R2 had pressure relieving devices on bed and chair and received nutrition or hydration interventions to manage skin problems. R2's skin integrity care plan dated 1/9/24, indicated R2 had potential/actual impairment to skin integrity, with the following interventions: -Barrier cream (dated 1/9/24), -The resident needs pressure relieving/reducing cushion to protect the skin while up in chair (dated 2/5/24). -The resident needs pressure relieving/reducing mattress to protect skin while in bed (2/5/24). R2's physician orders indicated the following orders: -Weekly skin checks and complete assessment every Sunday day shift for monitoring (dated 1/2/24). -Wound care: right knee- cleanse with wound cleanser, pat dry, paint with Betadine daily. Avoid pressure or trauma (dated 2/22/24). -Wound Care right heel pressure wound: 1) cleanse area with wound cleanser and pat dry. 2) Apply skin prep and allow to dry. 3) Apply collagen powder. 4) Cover with a foam heel dressing and wrap with Kerlix. 5) change every 3 days and PRN. Notify provider and wound nurse with any concerns or sings and symptoms/ of infections (Dated 3/2/24). -Monitor right shin abrasion, clean with wound cleanser, pat dry, apply triple antibiotic ointment, cover with band aid, twice daily and as needed.	2 900			

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2 900	Continued From page 4 Avoid pressure or trauma (Dated 3/7/24). -Monitor skin tears to left arm daily, apply dressing as needed until healed (Dated 3/12/24). During an observation on 3/13/24 at 10:04 a.m., registered nurse (RN)-C entered R2's room with a wound kit that contained various wound supplies and set it on top of R2's bed side table without first placing a barrier. RN-C completed R2's dressing changes as follows: RN-C explained to R2 what he was doing and assisted R2 to remove his right tennis shoe and light green gripper sock. RN-C applied gloves and removed the large band aid to R2's right lower inner shin, there was a small amount of yellow drainage noted on the old band aid. RN-C indicated he needed to go get more band aides and left the room without performing hand hygiene. RN-C returned to the room and applied gloves. RN-C then reached into the wound kit and removed 4x4's and the wound cleanser. RN-C sprayed the 4x4 with wound cleanser on a 4x4, laying the wound cleanser on a folding chair, without a barrier, RN-C then wiped the right lower shin wound with the 4x4. RN-C, with the same gloves on reached into the wound kit and took out the triple antibiotic ointment. RN-C took off his gloves, applied new gloves without performing hand hygiene, put ointment on his gloved finger, and applied it to R2's wound. RN-C then recapped the ointment and placed it back into the wound kit. With the same gloves on RN-C applied large band aide to R2's wound, removed his gloves, and marked the date and initials on R2's dressing. RN-C left the room to obtain more gloves and returned to the room. R2 stated he was having some pain in right heel area as RN-C removed the dressing to the back of right heel, with the same gloves on. The right heel wound was about 3.5 cm diameter of peeling periphery skin around a 1.5 cm open area white	2 900			

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2 900	Continued From page 5 in color moist looking in the center. RN-C used the wound cleanser that was sitting on the chair beside him, sprayed a 4x4 with the wound cleanser, and cleansed the wound with the 4x4, laid the wound cleanser on R2's bed without a barrier present. RN-C cleansed the wound again and with the same gloves on, RN-C reached into the wound kit and obtained one betadine swab packet. Applied the swab to the outside edge of the wound and worked his way to the center of the wound. Threw the swab into the garbage can. RN-C reached again into the wound kit, with the same gloves on and obtained a second betadine swab package. RN-C repeated the process with a second swab, from the outside edge to the center of the wound. RN-C then left the wound open to air. RN-C removed his gloves. RN-C then without gloves on and without performing hand hygiene, applied the light green gripper sock and shoe and did not cover the left heel wound with a dressing according to physician's orders. R2 asked RN-C about his left arm where there were gauze wraps to his forearm and elbow area. RN-C stated that there was not a dressing change order for those areas and did not address. RN-C put all materials back into the general wound kit and put the cover on. RN-C left R2's room, walked to the nurses' station and placed the general kit back into a cupboard without disinfecting the outside of the kit. During an interview on 3/13/24 at 11:35 a.m., RN-C stated he looked at the wound care orders on the computer at the nurses' station, wrote them on a piece of paper and then went to the resident's room with the wound kit to do dressing change. RN-C reviewed R2's dressing change orders and stated he only completed the right shin and heel dressing and had not followed the dressing change orders and identified he had not	2 900			

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2 900	Continued From page 6 performed appropriate hand hygiene. R3's significant change MDS dated 12/17/23, had diagnoses of stroke, deep vein thrombosis, and diabetes. R3 was at risk for pressure ulcers, but did not have pressure ulcers, arterial, venous ulcers or any skin concerns noted. R3 did have pressure reducing devices for bed and chair, was on a turning and reposition schedule, and received nutrition or hydration interventions to manage skin problems. R3 had range of motion impairment on one side of her body, used a wheelchair, was dependent with all transfers, toileting hygiene, shower/bathing and putting on her footwear. R3 required extensive assistance with dressing and personal hygiene. R3 did not walk. R3's skin care plan 10/6/23 included: R3 has diabetic ulcer of the right foot related to diabetes, lack of sensation to affected area, and vascular insufficiency. Interventions included but was not limited to, -Monitor pressure areas for color, sensation and temperature, dated 10/6/23 -monitor, document wound size, depth, margins peri wound skin, sinus, undermining, exudates edema, granulation, infection, necrosis, eschar gangrene. Document progress in wound healing on an ongoing basis. Notify MD as indicated, dated 10/6/23, -Weekly treatment documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observation, dated 10/6/23. R3's physician orders included: -Ted socks (elastic compression socks) on in AM off at bedtime, dated 10/13/23,	2 900			

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2 900	Continued From page 7 -Wash and dry feet and apply lotion twice daily. Do not apply lotion between toes. Notify wound nurse with skin issues or concerns, dated 12/24/23, -Weekly skin checks and complete assessment, every Tuesday evening shift, dated 9/29/23, -Wound care: bottom of right foot. Cleanse with wound cleanser apply alginate (a special dressing to promote healing), apply boarded foam dressing. If worsens, notify wound nurse. Change daily and as needed, dated 2/11/24. During an observation on 3/13/24 at 11:12 a.m., RN-C enter R3's room. R3 was sitting in her recliner by the window. RN-C set the wound kit and two packages of Maxsorb (an alginate dressing material) on the bedside stand next to R3 without a barrier between them. RN-C applied gloves and then removed R3's red right gripper sock and pulled her open toe TEDS (compression stocking) up to mid foot. RN-C removed the tan Mepilex dressing from R3's right bunion area. There was bright red blood noted on dressing. RN-C stated he could not see where the blood coming from. RN-C grabbed the wound cleanser and 4x4's from the wound kit without changing his gloves. He sprayed the cleanser on the 4x4 and set the wound cleanser on the floor, with no barrier between. RN-C grabbed more 4 x 4's from the wound kit, sprayed the 4 x 4's and the wound area, and then set the wound cleanser on the floor again. RN-C changed his gloves, cut a piece of Maxsorb placed it on the wound, then placed a new Mepilex (boarder foam dressing) over the wound. RN-C then picked up the wound cleanser from the floor and put it back into the wound kit. He then put the lid on the kit, removed his gloves, grabbed the garbage bag and left the room.	2 900			

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2 900	Continued From page 8 During an interview on 3/13/24 at 12:19 p.m., RN-B stated with the facilities own staff she provided infection control training, but RN-C was temporary agency staff and was not aware of specific training he had. RN-B stated there should be a barrier between the kit/supplies and the surface they were setting them on as because it prevents cross contamination. RN-B explained wounds were cleaned from the inside of the wound to the outside to prevent contamination of the wound bed. RN-B stated that the nurses working the floor were to look at the wound/dressing orders before they perform the treatments and follow the physician orders. During interview on 3/13/24 at 2:25 p.m., Wound Ostomy Consultant Nurse Practitioner (WOC)-A stated the use of betadine was to clean and dry out wounds. WOC-A did not think the use of it on R2's right heel would have harmed the wound but it was the wrong treatment. With it being the wrong treatment, it could slow down the healing process of this already chronic wound. WOC-A stated a barrier between supplies and the surface important to prevent cross contamination. WOC-A explained the proper way to clean wounds was from the inside (middle) of wound toward the outside, to prevent contamination of the wound. It was her expectation orders for wounds are followed as written. During interview on 3/13/23, at director of nursing (DON) stated it was her expectation the staff carried out the physician orders as written and per the facilities dressing protocol for infection control purposes. Review of facility policy titles Wound Care dated October 2010, indicated in the steps in the procedure:	2 900			

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2 900	Continued From page 9 1. Use disposable cloth (paper towel is adequate) to establish a clean field on resident's over bed table. Place all items to be used during procedure on the clean field. Arrange supplies so that they can be easily reached. 2. Wash and dry your hands thoroughly. 3. Position resident. Place disposable cloth next to resident (under the wound) to serve as a barrier to protect bed linen and other body site. 4. Put on exam gloves. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptable. Wash and dry your hands thoroughly. 6. Put on gloves. Gowns wil only be necessary if soiling of your skin or clothing with blood, urine, feces or other body fluids is likely..... 7. Use no touch technique by using tongue blades and applicators to remove ointments and creams frm their containers. 9.Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound. 10. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. 15. Discard the disposable item into the designated container. Discard all soiled laundry, linen, towel and washcloths into the soiled laundry container. Remove disposable gloves and discard into designated container. Wash and dry your hand thoroughly 20. Wipe reusable supplies with alcohol as indicated (i.e., outside of the containers that were touched by unclean hands, scissor blades, etc.). Return reusable supplies to resident's drawer in treatment cart. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee,	2 900			

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2 900	Continued From page 10 should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900			

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

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F 000	INITIAL COMMENTS On 3/13/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H52901761C (MN00101484) with a deficiency cited at F686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to	F 686			4/12/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/01/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 686	Continued From page 1 promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow physician ordered wound treatments and failed to ensure appropriate infection control practices during wound care including hand hygiene to prevent or mitigate the risk of wound deterioration and/or infection for 2 of 2 residents (R2, R3) reviewed for pressure ulcers. Findings include: R2's admission Minimum Data Set dated 1/9/24, indicated R2 had moderate cognitive impairment, with diagnoses of peripheral vascular disease or peripheral artery disease. R2 required substantial assist with all activities of daily living (ADLs) except for oral hygiene. R2 had no pressure ulcers, arterial, venous ulcers, or other skin problems. R2 had pressure relieving devices on bed and chair and received nutrition or hydration interventions to manage skin problems. R2's skin integrity care plan dated 1/9/24, indicated R2 had potential/actual impairment to skin integrity, with the following interventions: -Barrier cream (dated 1/9/24), -The resident needs pressure relieving/reducing cushion to protect the skin while up in chair (dated 2/5/24). -The resident needs pressure relieving/reducing mattress to protect skin while in bed (2/5/24). R2's physician orders indicated the following orders: -Weekly skin checks and complete assessment	F 686	F686 – §483.25(b) Skin Integrity 1.It is the best practice at Olivia Restorative Therapy and Nursing that Based on the comprehensive assessment of a resident, the facility must ensure that— A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. 2.All residents have the potential to be affected in this area. 3.All licensed nursing staff were re-educated on policies and procedures related to wound care and dressing changes on 3/14/2024 (including but not limited to, verifying physicians order, reviewing residents care plan to assess any special needs for the resident, and infection control.) All licensed nurses were also encouraged to have a laptop on the treatment cart, to verify orders, room-side. 4.On 4/8/2024 audit was revised. An audit titled “F686 Wound Care/ Dressing Changes” was updated to clearly reflect purpose of audit. The purpose of the audit is to ensure wound care orders are being followed as directed by the physician. Additionally, that dressing changes are being followed as noted by the facilities		

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F 686	Continued From page 2 every Sunday day shift for monitoring (dated 1/2/24). -Wound care: right knee- cleanse with wound cleanser, pat dry, paint with Betadine daily. Avoid pressure or trauma (dated 2/22/24). -Wound Care right heel pressure wound: 1) cleanse area with wound cleanser and pat dry. 2) Apply skin prep and allow to dry. 3) Apply collagen powder. 4) Cover with a foam heel dressing and wrap with Kerlix. 5) change every 3 days and PRN. Notify provider and wound nurse with any concerns or sings and symptoms/ of infections (Dated 3/2/24). -Monitor right shin abrasion, clean with wound cleanser, pat dry, apply triple antibiotic ointment, cover with band aid, twice daily and as needed. Avoid pressure or trauma (Dated 3/7/24). -Monitor skin tears to left arm daily, apply dressing as needed until healed (Dated 3/12/24). During an observation on 3/13/24 at 10:04 a.m., registered nurse (RN)-C entered R2's room with a wound kit that contained various wound supplies and set it on top of R2's bed side table without first placing a barrier. RN-C completed R2's dressing changes as follows: RN-C explained to R2 what he was doing and assisted R2 to remove his right tennis shoe and light green gripper sock. RN-C applied gloves and removed the large band aid to R2's right lower inner shin, there was a small amount of yellow drainage noted on the old band aid. RN-C indicated he needed to go get more band aides and left the room without performing hand hygiene. RN-C returned to the room and applied gloves. RN-C then reached into the wound kit and removed 4x4's and the wound cleanser. RN-C sprayed the 4x4 with wound cleanser on a 4x4, laying the wound cleanser on a folding chair, without a barrier, RN-C then wiped	F 686	policy and procedure including steps related to infection control i.e. ensuring appropriate handwashing and a clean field is established. This audit started the week of 3/18/2024, audit will be completed weekly until the week of 6/17/2024. Each weekly audit will include an audit of x2 residents needing wound care/dressing changes to ensure the nurse performing the cares complies with the facility's policy and procedures related to wound care and dressing changes. 5.Education and audits will be brought to QAPI for further recommendations. Education will be provided to staff immediately if required upon completion of each audit to ensure compliance. F686 – §483.25(b)(1) Pressure ulcers. 1.It is the best practice at Olivia Restorative Therapy and Nursing that Based on the comprehensive assessment of a resident, the facility must ensure that— 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. 2.All residents have the potential to be affected in this area. 3.All licensed nursing staff were re-educated on the professional standards of practice to promote healing and prevent		

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F 686	Continued From page 3 the right lower shin wound with the 4x4. RN-C, with the same gloves on reached into the wound kit and took out the triple antibiotic ointment. RN-C took off his gloves, applied new gloves without performing hand hygiene, put ointment on his gloved finger, and applied it to R2's wound. RN-C then recapped the ointment and placed it back into the wound kit. With the same gloves on RN-C applied large band aide to R2's wound, removed his gloves, and marked the date and initials on R2's dressing. RN-C left the room to obtain more gloves and returned to the room. R2 stated he was having some pain in right heel area as RN-C removed the dressing to the back of right heel, with the same gloves on. The right heel wound was about 3.5 cm diameter of peeling periphery skin around a 1.5 cm open area white in color moist looking in the center. RN-C used the wound cleanser that was sitting on the chair beside him, sprayed a 4x4 with the wound cleanser, and cleansed the wound with the 4x4, laid the wound cleanser on R2's bed without a barrier present. RN-C cleansed the wound again and with the same gloves on, RN-C reached into the wound kit and obtained one betadine swab packet. Applied the swab to the outside edge of the wound and worked his way to the center of the wound. Threw the swab into the garbage can. RN-C reached again into the wound kit, with the same gloves on and obtained a second betadine swab package. RN-C repeated the process with a second swab, from the outside edge to the center of the wound. RN-C then left the wound open to air. RN-C removed his gloves. RN-C then without gloves on and without performing hand hygiene, applied the light green gripper sock and shoe and did not cover the left heel wound with a dressing according to physician's orders. R2 asked RN-C about his left arm where there were gauze wraps			F 686	infection on 3/14/2024.) 4.On 4/8/2024 audit was revised. An audit titled "F686 Wound Care/ Dressing Changes" was updated to clearly reflect purpose of audit. The purpose of the audit is to ensure wound care orders are being followed as directed by the physician. Additionally, that dressing changes are being followed as noted by the facilities policy and procedure including steps related to infection control i.e. ensuring appropriate handwashing and a clean field is established. This audit started the week of 3/18/2024, audit will be completed weekly until the week of 6/17/2024. Each weekly audit will include an audit of x2 residents needing wound care/dressing changes to ensure the nurse performing the cares complies with the facility's policy and procedures related to wound care and dressing changes. Revision: on 4/8/2024 audit was revised. An audit titled "F686 Skin Check" was updated to clearly reflect the purpose of this audit. The purpose of this audit is ensure that all residents receive skin checks to assess residents' skin for pressure ulcers/skin breakdown, weekly. An audit will be completed once weekly, on all current residents. Audit began on the week of 3/18/2024 and will end on the week of 6/17/2024. 5.Education and audits will be brought to QAPI for further recommendations. Education will be provided to staff immediately if required upon completion		

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F 686	Continued From page 4 to his forearm and elbow area. RN-C stated that there was not a dressing change order for those areas and did not address. RN-C put all materials back into the general wound kit and put the cover on. RN-C left R2's room, walked to the nurses' station and placed the general kit back into a cupboard without disinfecting the outside of the kit. During an interview on 3/13/24 at 11:35 a.m., RN-C stated he looked at the wound care orders on the computer at the nurses' station, wrote them on a piece of paper and then went to the resident's room with the wound kit to do dressing change. RN-C reviewed R2's dressing change orders and stated he only completed the right shin and heel dressing and had not followed the dressing change orders and identified he had not performed appropriate hand hygiene. R3's significant change MDS dated 12/17/23, had diagnoses of stroke, deep vein thrombosis, and diabetes. R3 was at risk for pressure ulcers, but did not have pressure ulcers, arterial, venous ulcers or any skin concerns noted. R3 did have pressure reducing devices for bed and chair, was on a turning and reposition schedule, and received nutrition or hydration interventions to manage skin problems. R3 had range of motion impairment on one side of her body, used a wheelchair, was dependent with all transfers, toileting hygiene, shower/bathing and putting on her footwear. R3 required extensive assistance with dressing and personal hygiene. R3 did not walk. R3's skin care plan 10/6/23 included: R3 has diabetic ulcer of the right foot related to diabetes, lack of sensation to affected area, and vascular			F 686	of each audit to ensure compliance.		

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F 686	Continued From page 5 insufficiency. Interventions included but was not limited to, -Monitor pressure areas for color, sensation and temperature, dated 10/6/23 -monitor, document wound size, depth, margins peri wound skin, sinus, undermining, exudates edema, granulation, infection, necrosis, eschar gangrene. Document progress in wound healing on an ongoing basis. Notify MD as indicated, dated 10/6/23, -Weekly treatment documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observation, dated 10/6/23. R3's physician orders included: -Ted socks (elastic compression socks) on in AM off at bedtime, dated 10/13/23, -Wash and dry feet and apply lotion twice daily. Do not apply lotion between toes. Notify wound nurse with skin issues or concerns, dated 12/24/23, -Weekly skin checks and complete assessment, every Tuesday evening shift, dated 9/29/23, -Wound care: bottom of right foot. Cleanse with wound cleanser apply alginate (a special dressing to promote healing), apply boarded foam dressing. If worsens, notify wound nurse. Change daily and as needed, dated 2/11/24. During an observation on 3/13/24 at 11:12 a.m., RN-C enter R3's room. R3 was sitting in her recliner by the window. RN-C set the wound kit and two packages of Maxsorb (an alginate dressing material) on the bedside stand next to R3 without a barrier between them. RN-C applied gloves and then removed R3's red right gripper sock and pulled her open toe TEDS	F 686			

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F 686	Continued From page 6 (compression stocking) up to mid foot. RN-C removed the tan Mepilex dressing from R3's right bunion area. There was bright red blood noted on dressing. RN-C stated he could not see where the blood coming from. RN-C grabbed the wound cleanser and 4x4's from the wound kit without changing his gloves. He sprayed the cleanser on the 4x4 and set the wound cleanser on the floor, with no barrier between. RN-C grabbed more 4 x 4's from the wound kit, sprayed the 4 x 4's and the wound area, and then set the wound cleanser on the floor again. RN-C changed his gloves, cut a piece of Maxsorb placed it on the wound, then placed a new Mepilex (boarder foam dressing) over the wound. RN-C then picked up the wound cleanser from the floor and put it back into the wound kit. He then put the lid on the kit, removed his gloves, grabbed the garbage bag and left the room. During an interview on 3/13/24 at 12:19 p.m., RN-B stated with the facilities own staff she provided infection control training, but RN-C was temporary agency staff and was not aware of specific training he had. RN-B stated there should be a barrier between the kit/supplies and the surface they were setting them on as because it prevents cross contamination. RN-B explained wounds were cleaned from the inside of the wound to the outside to prevent contamination of the wound bed. RN-B stated that the nurses working the floor were to look at the wound/dressing orders before they perform the treatments and follow the physician orders. During interview on 3/13/24 at 2:25 p.m., Wound Ostomy Consultant Nurse Practitioner (WOC)-A stated the use of betadine was to clean and dry out wounds. WOC-A did not think the use of it on	F 686			

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F 686	Continued From page 7 R2's right heel would have harmed the wound but it was the wrong treatment. With it being the wrong treatment, it could slow down the healing process of this already chronic wound. WOC-A stated a barrier between supplies and the surface important to prevent cross contamination. WOC-A explained the proper way to clean wounds was from the inside (middle) of wound toward the outside, to prevent contamination of the wound. It was her expectation orders for wounds are followed as written. During interview on 3/13/23, at director of nursing (DON) stated it was her expectation the staff carried out the physician orders as written and per the facilities dressing protocol for infection control purposes. Review of facility policy titles Wound Care dated October 2010, indicated in the steps in the procedure: 1. Use disposable cloth (paper towel is adequate) to establish a clean field on resident's over bed table. Place all items to be used during procedure on the clean field. Arrange supplies so that they can be easily reached. 2. Wash and dry your hands thoroughly. 3. Position resident. Place disposable cloth next to resident (under the wound) to serve as a barrier to protect bed linen and other body site. 4. Put on exam gloves. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptable. Wash and dry your hands thoroughy. 6. Put on gloves. Gowns wil only be necessary if soiling of your skin or clothing with blood, urine, feces or other body fluids is likely..... 7. Use no touch technique by using tongue			F 686			

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F 686	Continued From page 8 blades and applicators to remove ointments and creams frm their containers. 9.Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound. 10. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. 15. Discard the disposable item into the designated container. Discard all soiled laundry, linen, towel and washcloths into the soiled laundry container. Remove disposable gloves and discard into designated container. Wash and dry your hand thoroughly 20. Wipe reusable supplies with alcohol as indicated (i.e., outside of the containers that were touched by unclean hands, scissor blades, etc.). Return reusable supplies to resident's drawer in treatment cart.	F 686			