



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2023

Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, MN 55976

RE: CCN: 245349
Cycle Start Date: January 30, 2023

Dear Administrator:

On February 16, 2023, we notified you a remedy was imposed. On March 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 March 3, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 3, 2023 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of February 16, 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 January 30, 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.

Feel free to contact me if you have questions.

Sincerely,

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

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



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March 14, 2023

Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, MN 55976

Re: Reinspection Results
Event ID: MH4Q11 and RW0K12

Dear Administrator:

On March 3, 2023 and March 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 February 2, 2023 and February 16, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
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February 16, 2023

Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, MN 55976

RE: CCN: 245349
Cycle Start Date: January 30, 2023

Dear Administrator:

On February 16, 2023, we informed you of imposed enforcement remedies.

On February 2, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be 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 February 2, 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.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 3, 2023, will remain in effect.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 3, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 3, 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.

As we notified you in our letter of February 16, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 30, 2023.

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, Stewartville Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 30, 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 plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 30, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

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) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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.



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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 16, 2023

Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, MN 55976

Re: State Nursing Home Licensing Orders
Event ID: MH4Q11

Dear Administrator:

The above facility was surveyed on January 26, 2023 through February 2, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.



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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00429	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/02/2023
NAME OF PROVIDER OR SUPPLIER STEWARTVILLE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(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 1/26/23, 1/30/23, 1/31/23, 2/1/23, and 2/2/23 a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

02/24/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00429	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/02/2023
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2 000	Continued From page 1 when they will be completed. The following complaint was found to be SUBSTANTIATED: H53497875C (MN90348), with a licensing order issued at 0900. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000			

Minnesota Department of Health

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2 000	Continued From page 2	2 000			
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implement pressure ulcer interventions for 1 of 3 residents (R1) who was admitted to the facility without pressure ulcers. The facility failed to provide ongoing comprehensive skin assessments, monitor for signs of infection/deterioration and ensure R1 was seen at the wound clinic per physician	2 900	Acknowledged and corrected.	2/24/23	

Minnesota Department of Health

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2 900	Continued From page 3 orders. As a result, R1 had a life threatening infection that required an above the knee amputation resulting in an immediate jeopardy. The IJ began on 12/20/22, when R1 was transferred to hospital-B for left above knee amputation related to diagnoses of osteomyelitis (bone infection) and calcaneus sepsis (life threatening bone infection that has spread through the body) from R1's pressure ulcer. The director of nursing (DON), assistant director of nursing (ADON), and social worker (SW)-A were notified of the IJ on 1/30/23, at 3:55 p.m. The IJ was removed on 2/2/23, at 1:51 p.m. Noncompliance remained at the lower scope and severity level of D-isolated indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Pressure Ulcer/Injury (PU/PI); localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin or open ulcer. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Soft tissue damage related to pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 2 Pressure Ulcer: partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not	2 900			

Minnesota Department of Health

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2 900	Continued From page 4 present. Unstageable Pressure Ulcer: 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 should only be removed after careful clinical consideration and consultation with the resident's physician. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. Debridement: the removal of devitalized/necrotic tissue and foreign matter from a wound to improve or facilitate the healing process. Eschar: is dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound. R1's Face sheet printed 1/30/23, identified a diagnoses of Diabetes and morbid obesity. R1's admission Minimum Data Set (MDS), dated 8/10/22, identified R1 did not have cognitive impairment. R1 required limited assistance from one staff for hygiene, dressing, and toileting and required extensive assist from one staff for bed mobility and transfers. In addition, R1 was at risk for pressure ulcers, did not have skin concerns, and utilized a pressure reducing device for his bed. R1's skin care plan 8/18/22, indicated R1 was at risk for delayed healing and additional skin break down due to immobility and diabetes. Corresponding interventions included treat skin	2 900			

Minnesota Department of Health

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 900	Continued From page 5 issues/wounds per MD orders. Record location, size (length, width, depth), color, surrounding skin, presence/absence of drainage/pain/signs of healing. Avoid shearing resident's skin during positioning, transferring, and turning. R1's East Nurse Aide Shift Report document, dated 8/19/22, evening shift, identified that R1's left heel has a pressure ulcer-the nurse knows. R1's record lacked a comprehensive assessment that included description, measurements, interventions to improve and/or prevent further deterioration. Further, it was not evident the physician was notified upon identification. R1's care plan 8/1/22 did not include interventions to treat R1's pressure ulcers once they developed. Additionally, review of physician orders identified delay in treatment and intervention. Physician order dated 8/21/22, directed staff not to put R1's shoes on and physician order dated 8/23/22 directed staff to change left heel dressing every 3 days and as needed: cleanse with wound cleanser, foam heel dressing and secure with Kerlix (roll gauze). Check twice a day for placement, keep dry and intact. This order remained until 10/6/22 even though there had been physician ordered treatment change on 9/7/22. R1's progress note dated 8/23/22, indicated R1's Mepilex (absorbent antimicrobial foam dressing) dressing was changed to his left heel with a moderate amount of serosanguinous drainage (composed of red blood cells and blood serum, typically thin and watery with light red or pink hue). Area measured 8 centimeters (cm) x 8.5	2 900			

Minnesota Department of Health

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2 900	Continued From page 6 cm. Wound appeared to be a drained open blister, top skin is intact, pink, and whitish overall. New dry foam heel dressing applied with Kerlix, blue boots on and left heel floated while in bed. The note did not identify the stage of the ulcer, and the care plan was not revised to identify the aforementioned interventions. R1's progress note dated 8/24/23, indicated R1's left heel large blister is now open, Xerofoam (medicated dressing) applied, Vaseline gauze, ABD pad (an absorbent pad) and wrapped with ace bandage. R1's physician orders did not identify a signed order to change/add the medicated gauze wound treatment from the ordered treatment on 8/23/22, that directed to clean wound with wound cleanser, apply heel dressing, and secure with Kerlix every three days. In review of R1's record it could not be determined the duration of how long Xeroform was used. R1's significant change MDS dated 9/7/22, identified R1 had one stage 2 pressure ulcer. However, R1's skin assessment dated 9/7/22, i identified a stage 2 pressure ulcer on his left heel and had wounds to left buttock. No further assessment was identified, however R1 would be referred to the wound clinic. R1's Nurse Practitioner visit, dated 9/7/2022, indicated R1 has developed a pressure ulcer to the plantar (sole) of his left heel that had been found a few days ago. The ulcer was fairly large, reddened area that encompassed most of the plantar aspect of his heel, two inch diameter eschar in the center of the wound. Nurses think it might be slightly improving. New treatment included, cleanse the wound with wound cleanser, apply Medi honey (an antibacterial	2 900			

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2 900	Continued From page 7 wound gel), foam heel dressing, and secure with Kerlix, change dressing every 3 days and as needed. Further indicated a provider from wound clinic would be coming to visit R1 for wound care yet this week. We will continue to monitor R1 on a routine and as needed basis. Diagnosis of pressure injury of skin of left heel, unspecified injury stage. R1's wound assessment dated 9/15/22, indicated R1's medical record identified R1 developed a "pressure ulcer" to his left heel that measured 5 centimeters (cm) x 6.5 cm with a heavy amount of serosanguinous drainage. The record lacked staging of the pressure ulcer. R1's skin care plan was revised on 9/21/22, identified the left heel "pressure area" and had pressure areas on the tops of his right toes. Additional interventions included; air mattress on bed, followed by podiatry, determine if R1's feet are desensitized to pain/pressure, discourage R1 from using anything sharp/abrasive /drying to feet or nails. R1's progress note dated 9/26/23, indicated R1's wound changed in appearance; wound bed about 98% necrotic tissue. R1's wound note dated 9/28/22, left heel measured 5 cm x 5.7 cm, necrotic, declining. R1's Nurse Practitioner visit, dated 9/28/2022, indicated R1 was being seen today for his left heel, this started out as a blister approximately 8/23/22. The nursing staff have been trying to keep pressure off of it and have been treating it, but it has progressed. R1 has a very large black spot on the bottom/back of his left heel, with slight foul odor. "Diagnosis: pressure injury of skin of	2 900			

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2 900	Continued From page 8 left heel, unspecified injury stage." Referral to the wound clinic was completed. R1's Wound Care Clinic After Visit Summary (AVS) dated 10/6/22, indicated a new order placed for an ultrasound of the lower left extremities. Culture taken of "unstageable left heel pressure ulcer." Will need wound care follow-up on 10/20/22. Included orders to start antibiotic medications. Wound dressing orders included: carefully remove all prior wraps and dressings and rinse all open areas with saline. Soak gauze in Dakin's 1/4 solution (a strong topical antiseptic to clean infected ulcers) and apply to heel for 15 minutes with dressing change daily, apply Iodosorb (wound gel that cleanse the wound by absorbing fluids and removing exudate) to the left posterior heel, place absorbent pad. If dressing becomes soiled, saturated, displaced, please remove, and replace. 100% non-weightbearing to the left lower extremity-PRAFO boot provided for wound offloading of left posterior heel, toe touch as needed for transfers. Use a tubigrip or stockinette to his left lower extremity. R1's culture results dated 10/11/23, identified methicillin resistant staphylococcus aureus (MRSA) was found in left heel wound and antibiotics were changed. R1's Medication Administration Record (MAR) identified the Iodosorb was not transcribed or implemented until 10/26/26. 20 days after the order was to be initiated. Further, R1's MAR identified on 10/8/22, 10/9/22, and 10/10/22, dressing was not changed with Dakin's solution, due to item unavailable. On 10/20/22 not completed as R1 was unavailable. R1's wound note dated 10/18/22, indicated left	2 900			

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2 900	Continued From page 9 heel measured 5.0 cm x 6.5 cm, necrotic, declining. R1's Doctor of Podiatric Medicine (DPM) wound clinic visit, dated 10/20/22, indicated R1 was last seen on 8/19/22. The nursing facility applied the foam dressing to the left heel without removing the plastic covering, this was applied incorrectly so this caused maceration of the pressure injury. Post debridement measurements were 7.6 cm x 6.9 cm x 0.2 cm. New orders to apply Iodosorb, calmoseptime (an ointment that forms a barrier on the skin to protect it from irritants) and ABD pad applied to left heel ulceration. R1's vascular ultrasound scheduled for 11/7/22. Physician orders dated 10/21/22 identified the aforementioned order from the podiatrist, however, did not include the directive to apply the calmoseptime. Corresponding MAR identified the dressing was completed without the calmoseptime from 10/21/22 to 10/26/22. R1's Wound Clinic AVS dated 10/27/22, indicated R1 has an appointment on 11/7/22 at 9:00 am to have an ultrasound completed of his lower extremities, and wound care follow up on 11/10/22. According to R1's record, R1 was not seen for vascular ultrasound as ordered. R1's Physician assistant (PA) advanced wound healing visit and orders, dated 10/27/22, indicated R1's wound was very macerated and has worsened since his last visit. Radiographs of his left heel "unstageable pressure ulcer", revealed no osteomyelitis. Wound was debrided; post debridement measurements were 5.5 cm x 9.1 cm x 0.4 cm. Advised R1 to increase protein intake via diet supplementation to accelerate wound healing. Return in 2 weeks for	2 900			

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2 900	Continued From page 10 re-evaluation. New orders included, discontinue previous order. start daily dressing changes; cleanse wound with saline and gauze, soak the wound using gauze soaked in Dakin's ¼ strength for 10 -15 minutes. Apply Santyl (an ointment used to remove dead tissue from a wound) to the left posterior wound bed (nickel thick), cover with ABD pad. R1's PA advanced wound healing visit, dated 11/10/22, indicated that R1 stated during his visit that his dressing does not get changed every day. R1 further stated he has significant pain in the region of the ulcer edges, failed to complete his vascular ultrasound appointment and R1 reported the transportation never arrived, and was rescheduled today. R1 left heel "unstageable pressure ulcer" was debrided, post debridement measurements were 4.2 cm x 8.1 cm x 0.6 cm. Return to clinic in 1 week. According to R1's record it was not evident R1 returned to the wound clinic within one week as ordered. R1's NP Visit note, dated 11/30/22, indicated R1 was seen due to concerns with right heel, identified right heel as an "unstageable pressure injury", referral in place for the wound clinic for his right heel. The visit note did not include further description of the left and right heel pressure ulcers. R1's quarterly MDS, dated 12/1/22, identified R1 had 2 unstageable pressure ulcers, however R1's record (aside from MDS) did not identify the presence of a second unstageable ulcer. R1's progress note, dated 12/6/22, indicated that social worker (SW)-A escorted R1 to his wound clinic appointment. R1 was sent to the emergency department from the wound clinic for	2 900			

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2 900	Continued From page 11 further evaluation due to R1's elevated INR (a blood test that measures the time for blood to clot), pale complexion, lethargy and possible cellulitis of wound and was admitted to the hospital. In review of R1's medical record, it was not evident an assessment was completed to determine the tissue tolerance over bony areas to pressure in accordance with facility policy. Not evident on-going monitoring was completed. Further not evident weekly comprehensive assessments were completed for all of R1's pressure ulcers that included risk factors, size, depth, stage, wound bed characteristics, drainage, and pain. There was no indication the facility reassessed PU prevention modalities and treatment strategies for effectiveness every 14 days or sooner to ensure appropriateness for healing and/or prevent infection and further deterioration. During a continuous observation on 1/26/23, from 9:35 a.m. to 10:51 a.m. R1 was observed to be lying on his back in bed. R1 was observed to have an above the knee amputation on his left leg and had a wound vac that was attached to the stump that was running. R1's right lower extremity had a blue PRAFO boot (a device worn on the calf and foot that is used to prevent pressure ulcers to the back of the heel) on. R1 stated he had not eaten breakfast yet. During an interview on 1/26/23, at 10:38 a.m. nursing assistant (NA)-A stated she had been the one who had first identified the pressure ulcer on R1's left heel that had resulted in left leg amputation because of infection. R1 was hospitalized for about a month. NA-A explained NAs did not document toileting/reposition in the	2 900			

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2 900	Continued From page 12 electronic health record (EHR); they would use paper care sheets with time slots of 6 am, 8 am, 10 am, 12 pm. We just put a check mark if we toileted or repositioned them. If the care plan changed the sheets would be updated by the nurse so that the NA's knew what to do. Most of the sheets don't direct us to offload heels for for people who need it, NA-A did not think that staff would offload heels if it was not on the care sheet. NA-A stated she could not get residents toileted and repositioned on time per their care plan because there was not enough staff. NA-A stated she had not had time to reposition R1 yet, because she had been busy with other residents. At 10:56 a.m. R1 was transferred via full body lift to his wheelchair. During an interview on 1/26/23, at 2:01 p.m. registered nurse (RN)-A changed R1's right heel dressing; reported the scabbed area measured 2.4 cm x 1.0 cm which would not be stageable. RN-A indicated the ulcer looked like it was getting better. During an observation and interview on 1/26/23, at 2:15 p.m. unit clinical manager (CM)-A stated, the floor nurses should be doing weekly wound assessments, this is typically done on Saturdays and should be documented in the nursing notes. CM-A stated R1 had pressure ulcers to his buttocks and was not sure how long they have been there. At 2:27 p.m. RN-A removed the sacral Mepilex dressing from R1's coccyx area; dressing had pinkish drainage on it. RN-A stated there was a moderate amount of serosanguinous drainage on the dressing. Four open areas were observed on R1's coccyx area. RN-A stated they were all stage 2 pressure ulcers. RN-A measured the areas and started to cleanse the areas with wound cleanser. R1 clenched his	2 900			

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2 900	Continued From page 13 buttocks during the cleansing and stated, Ow! Ow! Ow! Wound beds all were red. Measurements were as follows: middle coccyx area measured 3.1 cm x 1.0 cm, ulcer directly below measured 0.5 cm x 0.5 cm. Right middle buttock ulcer was 1.5 cm x 0.5 cm and right lateral area was 0.7 cm x 0.7 cm. RN-A cut pieces of Aquacel and placed in each wound bed. RN-A stated they did not have any sacral Mepilex so instead she used a square 4 x 4 Mepilex and placed it in the middle of R1's coccyx area. R1 was then repositioned to his left side. During an interview on 1/26/23, at 3:04 p.m. CM-A stated the facility did not have a designated nurse to oversee wound care right now; the wound care system that had been in place "just kind of fell apart". After a wound was identified a comprehensive assessment should be completed that included measurements, staging (if pressure ulcer), wound bed appearance, drainage and surrounding skin area. Assessments were to be completed weekly because if it started to worsen, the provider would be notified for possible change in treatments. The dressing should be changed per the MD order. During an interview on 1/26/23, at 5:17 p.m. CM-A thought R1's left heel wound started as a stage 2 pressure ulcer. CM-A was not sure when the ulcer became unstageable because the weekly wound assessments were not done. CM-A reported she was responsible for tracking the wound clinic appointments and communicating with SW-A to set up transport services; R1's follow-up appointment after the 11/10/22 was missed. On 11/30/22, R1 had developed a blister on his right heel. We obtained a referral to wound clinic, the appointment was made for 12/6/22, when he was transferred to the emergency room.	2 900			

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2 900	Continued From page 14 He was admitted to hospital with osteomyelitis (bone infection) that resulted in a left above the knee amputation. During an interview on 1/26/23 at 4:49 p.m. SW-A, stated she was the one who set up transportation for outside appointments. R1 did not go to his vascular ultrasound appointment. The follow-up wound clinic appointment from the 11/10/22 visit was missed because nursing had not informed her of R1's need for appointment or transportation. R1 did not have another wound clinic appointment until 12/6/22, that she escorted him to. When we got to the clinic, R1 looked very white and pale looking. Clinic staff took him back for examination and came back out and told her they were sending him to the emergency room because he had an elevated INR, he was pale, and had possible cellulitis (skin infection). During an interview on 1/26/23, at 3:24 p.m. assistant director of nursing (ADON) stated the facility did not have anyone in charge of wounds currently. Anyone with a wound should be comprehensively assessed at least weekly. With any worsening the provider would need to be called to ensure appropriate treatment was in place. The resident's wound clinic physicians have been the ones doing the measurements. During an interview on 1/30/23 at 12:59 a.m. director of nursing (DON) stated, when R1 was admitted he had no pressure ulcers. DON stated R1 did not have weekly skin assessments performed as he should have to include pressure ulcer staging, measurement of ulcer, wound bed characteristics, surrounding skin area. Assessment needed to be done weekly to ensure the current treatment was working. DON stated on 11/10/22, R1 was supposed to have a	2 900			

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2 900	Continued From page 15 follow-up appointment with the wound specialist within a week and the MD orders were not followed. R1 did not get to the wound specialist until 12/6/22. At the appointment R1 was immediately hospitalized with sepsis and ultimate left leg above the knee leg amputation. DON stated the floor nurses should be doing weekly bath audits which would be where the comprehensive skin assessments should go. During a phone interview on 1/30/23, at 1:57 p.m. NP-A explained she had seen R1 in September (2022) for his left heel unstageable ulcer so depth could not be determined. NP-A referred R1 to the wound clinic. Then on 11/30/22, NP-A wrote another referral for R1's right heel unstageable ulcer. The missed appointments and lack of assessments resulted in an unstageable pressure ulcer, sepsis, and ultimate loss of his left leg. NP-A stated she had recently seen R1 for his pressure ulcers on his buttocks, she had cultured the wounds, results were MRSA. We will be starting antibiotics. During a phone interview on 1/31/23, at 4:34 p.m. physician assistant wound specialist (PAWS)-A stated R1's left heel "unstageable pressure ulcer" was being managed by the wound clinic. We saw R1 on 10/20/22, at that time the left heel was just a big eschar cap. On 11/10/22, the eschar cap had softened and was macerated because the facility had applied the dressing incorrectly by not taking the plastic off. R1 was supposed to come back in a week for follow-up however, did not come back until 12/6/22. When he presented on 12/6/22 for that appointment he was really sick, pale, weak, cognition was blunted, his INR was high, "he was just way off from his baseline". and that they sent him right over to the ER. . He further stated he, the podiatrist, and ortho looked	2 900			

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2 900	Continued From page 16 at his left heel, it was all open and wet, eschar stringy tissue, "it looked terrible". R1 was diagnosed at the hospital with osteomyelitis and calcaneus sepsis. On 12/20/22, R1 transferred to another hospital where he had an above the knee amputation as a direct result from the infection in the pressure ulcer. Had R1 came back for his follow-up visit as ordered, could have prevented amputation of his leg. Facility policy entitled, "Pressure Sores Protocol," revised 8/3/18, indicated a purpose to identify residents at risk for developing pressure sores. To assure residents are receiving necessary treatment and services to prompt healing, prevent infection and prevent new sores from developing. 1. Identifying at-risk individuals needing prevention and specific factors placing them at risk will be done in the initial comprehensive nursing assessment and in on-going assessments by the nursing staff. 5. Protection of residents from external mechanical forces such as friction, pressure, and shearing will be done as follows: a. positioning devices, such as pillows or foam wedges, should be used to keep bony prominence's from direct contact with one another, according to a written plan of care. B. individuals in bed who are completely immobile should have a care plan that includes the use of devices that totally relieves pressure on heels. The heels should be raised off the bed. F. Any individual assessed to be at risk for developing pressure areas should be placed on a pressure reducing device such as an air mattress, RoHo or gel cushions. The resident should be repositioned, shifting the points of pressure at least every hour. Resident capable of being taught should be instructed to shift weight every 15 minutes while sitting.	2 900			

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2 900	Continued From page 17 Facility policy, entitled, "Tissue Tolerance Audit Policy and Procedure," revised 8/3/18, included: 1. Tissue tolerance is the skin and its supporting structures ability to endure the effects of pressure without adverse effects. Each resident who is dependent on bed and/or chair mobility, will be monitored for tissue tolerance while lying and sitting: a. upon admission, readmission; and b. with a change in condition 2. Once an individualized turning and repositioning schedule is determined a daily skin inspection by the nursing assistant and a weekly skin inspection by the licensed nurse will be done to ensure that there are no adverse effects to the skin and its supporting structures, ensuring that the determined intervals are still appropriate. Facility policy entitled, "Pressure Sore Monitoring," revised 8/3/18, identified a purpose to assure assessment and reassessment completion of all open area and appropriateness of treatment. 1. Staff nurse will assess all open areas on each resident on his/her wing weekly. 2. Staff will document on the skin and wound assessment and record sheet the stage of each area and present treatment. 3. Report of open areas and treatment will be given to the Quality Assurance Nurse. 4. Quality Assurance Nurse will do random assessments of open areas on each unit on an ongoing basis. %. Copies of weekly assessments of open areas will be available to the dietician for her review at her next visit. Residents with significant open areas will be reviewed by the dietician and recommendations made. Scheduled reviews with dietician will be coordinated by the dietary manager. 6. Assessment information will be utilized to assure on-going individual care plan approaches are current and specific for each resident.	2 900			

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2 900	Continued From page 18 The immediate Jeopardy that began on 12/20/22, was removed on 2/2/23 at 1:51 p.m. when it was verified through interview and document review the facility implemented the following: -immediately review/revise/develop their pressure ulcer program policies and protocols. -Provided education to licensed staff on completing comprehensive pressure ulcer assessments and care plan interventions for pressure ulcers. -Comprehensively assess all residents who have any stage pressure ulcers. Evaluated and review/revise care plan for appropriateness of treatment and services to reduce the risk of pressure ulcer development and/or further deterioration of pressure ulcers and infection with notification to the physician as appropriate. -Provided education to direct care staff on pressure ulcer prevention modalities in accordance with the care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further	2 900			

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2 900	Continued From page 19 monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900			

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F 000	INITIAL COMMENTS On 1/26/23, 1/30/23, 1/31/23, 2/1/23, and 2/2/23a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ F686 began on 12/20/22, when R1 was transferred to hospital-B for left above knee amputation related to diagnoses of osteomyelitis (bone infection) and calcaneus sepsis (life threatening bone infection that has spread through the body) from R1's pressure ulcer. The director of nursing (DON) and the assistant director of nursing (ADON) were notified of the IJ on 1/30/23 at 3:55 p.m. The IJ was removed on 2/2/23 at 1:51 p.m. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 1/30/23. The following complaint was found to be SUBSTANTIATED: H53497875C (MN90348). 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.	F 000			

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

Electronically Signed

TITLE

(X6) DATE

02/24/2023

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

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000			
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. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implement pressure ulcer interventions for 1 of 3 residents (R1) who was admitted to the facility without pressure ulcers. The facility failed to provide ongoing comprehensive skin assessments, monitor for signs of infection/deterioration and ensure R1 was seen at the wound clinic per physician orders. As a result, R1 had a life threatening infection that required an above the knee amputation resulting in an immediate jeopardy. The IJ began on 12/20/22, when R1 was	F 686			2/24/23
			The goal of Stewartville Care Center staff is to routinely assess the residents' skin integrity and based on the comprehensive resident assessment, provide skin care and treatment consistent with professional standards of practice that reflect resident preferences. The facility has policies and procedures for skin care that address the prevention of pressure ulcers/injuries and promote healing of existing pressure wounds. The local medical clinic plans to make an advance wound care team available in the near future to provide on-site skin/wound assessments and		

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F 686	Continued From page 2 transferred to hospital-B for left above knee amputation related to diagnoses of osteomyelitis (bone infection) and calcaneus sepsis (life threatening bone infection that has spread through the body) from R1's pressure ulcer. The director of nursing (DON), assistant director of nursing (ADON), and social worker (SW)-A were notified of the IJ on 1/30/23, at 3:55 p.m. The IJ was removed on 2/2/23, at 1:51 p.m. Noncompliance remained at the lower scope and severity level of D-isolated indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Pressure Ulcer/Injury (PU/PI); localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin or open ulcer. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Soft tissue damage related to pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 2 Pressure Ulcer: partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. Unstageable Pressure Ulcer: full-thickness skin and tissue loss in which the extent of tissue	F 686	treatments. To prevent unavoidable pressure ulcers, the staff will continue to follow the facility's procedures which include 1) assessing any pressure ulcers/injuries which are present upon admission 2) identifying the residents' risk factors for developing a pressure ulcer/injury 3) evaluating the resident's specific risk factors and changes in the resident's condition that may impact the development and/or healing of a pressure ulcer/injury 4) implementing, monitoring and modifying interventions in an attempt to stabilize, reduce or remove underlying skin risk factors and 5) providing treatment to heal existing pressure wounds and prevent the development of additional pressure ulcers/injuries. Considering the residents' choices/preferences, clinical condition, and physician input, a care plan is developed that includes goals and approaches aimed at healing any existing pressure ulcers/injuries, limiting the effects of skin risk factors, and addressing related co-morbidities. An evaluation of the resident's skin condition, skin risk factors, and tissue tolerance will continue to be completed at the time of admission, readmission from the hospital, quarterly, and with significant changes in condition. The physician and nutrition services staff are notified of open lesions; the plan of care is revised to reflect skin-related interventions. The direct care staff will inform the licensed nurse of any skin problems noted during		

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F 686	Continued From page 3 damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar should only be removed after careful clinical consideration and consultation with the resident's physician. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. Debridement: the removal of devitalized/necrotic tissue and foreign matter from a wound to improve or facilitate the healing process. Eschar: is dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound. R1's Face sheet printed 1/30/23, identified a diagnoses of Diabetes and morbid obesity. R1's admission Minimum Data Set (MDS), dated 8/10/22, identified R1 did not have cognitive impairment. R1 required limited assistance from one staff for hygiene, dressing, and toileting and required extensive assist from one staff for bed mobility and transfers. In addition, R1 was at risk for pressure ulcers, did not have skin concerns, and utilized a pressure reducing device for his bed. R1's skin care plan 8/18/22, indicated R1 was at risk for delayed healing and additional skin break down due to immobility and diabetes. Corresponding interventions included treat skin issues/wounds per MD orders. Record location, size (length, width, depth), color, surrounding skin, presence/absence of drainage/pain/signs of			F 686	daily cares. Observation of skin on all areas of the body is part of the bathing protocol. The policies and procedures for assessing the residents' skin condition and risk factors were reviewed January 31, 2023. The skin assessment procedures were revised to provide more specific instructions for the nurses on 1) the frequency and methods for conducting routine skin assessments 2) the required follow up notifications, monitoring and documentation when a nonpressure or pressure related skin injury is observed and 3) the need to review and verify instructions received from wound clinic practitioners including subsequent visits to the clinic. All residents will benefit from facility compliance with skin related federal regulations and facility policies. To ensure compliance, a full-body skin reassessment by a licensed nurse was completed for residents with pressure ulcers by January 31, 2023. All other residents had a full-body skin assessment by February 1, 2023. Residents at high risk were prioritized for assessments. Risk was determined by the most recent Skin Risk with Braden Scale Assessment score and included residents who were incontinent, needed assistance with bed mobility/repositioning or who were noncompliant with the skin-related plan of care. Assessment findings were documented in the medical record and care plans were reviewed and updated.		

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F 686	Continued From page 4 healing. Avoid shearing resident's skin during positioning, transferring, and turning. R1's East Nurse Aide Shift Report document, dated 8/19/22, evening shift, identified that R1's left heel has a pressure ulcer-the nurse knows. R1's record lacked a comprehensive assessment that included description, measurements, interventions to improve and/or prevent further deterioration. Further, it was not evident the physician was notified upon identification. R1's care plan 8/1/22 did not include interventions to treat R1's pressure ulcers once they developed. Additionally, review of physician orders identified delay in treatment and intervention. Physician order dated 8/21/22, directed staff not to put R1's shoes on and physician order dated 8/23/22 directed staff to change left heel dressing every 3 days and as needed: cleanse with wound cleanser, foam heel dressing and secure with Kerlix (roll gauze). Check twice a day for placement, keep dry and intact. This order remained until 10/6/22 even though there had been physician ordered treatment change on 9/7/22. R1's progress note dated 8/23/22, indicated R1's Mepilex (absorbent antimicrobial foam dressing) dressing was changed to his left heel with a moderate amount of serosanguinous drainage (composed of red blood cells and blood serum, typically thin and watery with light red or pink hue). Area measured 8 centimeters (cm) x 8.5 cm. Wound appeared to be a drained open blister, top skin is intact, pink, and whitish overall.	F 686	A Registered Nurse with previous skin assessment experience has been assigned the task of assessing residents with open skin areas or other significant skin issues on a weekly basis. The responsibilities of the wound nurse position will include documenting the skin assessment findings including wound measurements, reviewing the skin-related plan of care, revising the care plan as necessary, reviewing the orders/recommendation of the wound clinic practitioners, verifying the need for follow up wound clinic visits, and providing skin care guidance to the direct care staff as necessary. The licensed nurses have been instructed to notify the wound nurse when residents are admitted with or subsequently develop open skin injuries. By February 1, 2023, all licensed nurses were provided instruction on the changes to the skin related policies and procedures and that following the facility's procedures and protocols is a required job expectation. Nurses were required to complete the training before their next scheduled work assignment. The following was also addressed: 1) the importance of accurate and timely skin assessments 2) appropriate follow up on identified skin injuries/lesions 3) developing and implementing a skin-related plan of care to reduce the risk of pressure injuries and treat existing pressure injuries 4) evaluating and revising the plan of care as necessary to prevent/treat skin related injuries and 5) the responsibilities of the recently		

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F 686	Continued From page 5 New dry foam heel dressing applied with Kerlix, blue boots on and left heel floated while in bed. The note did not identify the stage of the ulcer, and the care plan was not revised to identify the aforementioned interventions. R1's progress note dated 8/24/23, indicated R1's left heel large blister is now open, Xerofoam (medicated dressing) applied, Vaseline gauze, ABD pad (an absorbent pad) and wrapped with ace bandage. R1's physician orders did not identify a signed order to change/add the medicated gauze wound treatment from the ordered treatment on 8/23/22, that directed to clean wound with wound cleanser, apply heel dressing, and secure with Kerlix every three days. In review of R1's record it could not be determined the duration of how long Xeroform was used. R1's significant change MDS dated 9/7/22, identified R1 had one stage 2 pressure ulcer. However, R1's skin assessment dated 9/7/22, i identified a stage 2 pressure ulcer on his left heel and had wounds to left buttock. No further assessment was identified, however R1 would be referred to the wound clinic. R1's Nurse Practitioner visit, dated 9/7/2022, indicated R1 has developed a pressure ulcer to the plantar (sole) of his left heel that had been found a few days ago. The ulcer was fairly large, reddened area that encompassed most of the plantar aspect of his heel, two inch diameter eschar in the center of the wound. Nurses think it might be slightly improving. New treatment included, cleanse the wound with wound cleanser, apply Medi honey (an antibacterial wound gel), foam heel dressing, and secure with			F 686	assigned wound nurse and how the new position will be integrated into the current skin management program. The roles and responsibilities of licensed nurses as outlined in the Nurse Practice Act will be reinforced including the need to follow nursing standards including "implementing interventions that are delegated, ordered, or prescribed by a licensed health care provider." By February 1, 2023, all nursing assistants were provided instruction on the definition of pressure ulcers/injuries, circumstances that increase the risks of pressure ulcer/injury, the location and protection of pressure points, the skin conditions/ observations that should be reported to their supervisor, the importance of skin care and timely repositioning and other pressure relieving interventions. Nursing assistants were required to complete the training prior to working their next shift. Resident number 1 - The resident's open areas are assessed weekly by a registered nurse. The left lower extremity incision site is clean and dry. The resident's coccyx was assessed by the nurse practitioner and the wound nurse February 22, 2023; both open areas were determined to be healed. The resident's right heel has a yellow discolored area with defined edges which has remained closed with no drainage. The two open areas on the right medial buttock have healed. The abrasions on the right 4th and 5th toes are scabbed and left open to		

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F 686	Continued From page 6 Kerlix, change dressing every 3 days and as needed. Further indicated a provider from wound clinic would be coming to visit R1 for wound care yet this week. We will continue to monitor R1 on a routine and as needed basis. Diagnosis of pressure injury of skin of left heel, unspecified injury stage. R1's wound assessment dated 9/15/22, indicated R1's medical record identified R1 developed a "pressure ulcer" to his left heel that measured 5 centimeters (cm) x 6.5 cm with a heavy amount of serosanguinous drainage. The record lacked staging of the pressure ulcer. R1's skin care plan was revised on 9/21/22, identified the left heel "pressure area" and had pressure areas on the tops of his right toes. Additional interventions included; air mattress on bed, followed by podiatry, determine if R1's feet are desensitized to pain/pressure, discourage R1 from using anything sharp/abrasive /drying to feet or nails. R1's progress note dated 9/26/23, indicated R1's wound changed in appearance; wound bed about 98% necrotic tissue. R1's wound note dated 9/28/22, left heel measured 5 cm x 5.7 cm, necrotic, declining. R1's Nurse Practitioner visit, dated 9/28/2022, indicated R1 was being seen today for his left heel, this started out as a blister approximately 8/23/22. The nursing staff have been trying to keep pressure off of it and have been treating it, but it has progressed. R1 has a very large black spot on the bottom/back of his left heel, with slight foul odor. "Diagnosis: pressure injury of skin of			F 686	air. Skin treatments continue to be administered as ordered. The physician will be notified of any open wounds and notified if wounds show signs of delayed on nonhealing. The care plan was reviewed and found appropriate. For residents with open skin areas, a record audit will be completed monthly for three months by the Medical Record/Quality Assurance Consultant to ensure that there is a timely skin note/assessment by a licensed nurse, that a physician/nurse practitioner is aware of the resident's current skin status, that any prescribed treatments are being administered as ordered, and that the care plan addresses skin related problems and related treatment/care interventions. To further monitor compliance, the Director of Nursing and the Wound Nurse will meet weekly for four weeks to review and evaluate the wound management/skin assessment process including compliance with the facility's policies, procedures, and protocols. The Director of Nursing/designee will review skin tracking forms and audit random skin related record entries for completeness and accuracy. The Director of Nursing is responsible for compliance. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the quarterly March Quality Assessment and Performance Improvement Committee		

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F 686	Continued From page 7 left heel, unspecified injury stage." Referral to the wound clinic was completed. R1's Wound Care Clinic After Visit Summary (AVS) dated 10/6/22, indicated a new order placed for an ultrasound of the lower left extremities. Culture taken of "unstageable left heel pressure ulcer." Will need wound care follow-up on 10/20/22. Included orders to start antibiotic medications. Wound dressing orders included: carefully remove all prior wraps and dressings and rinse all open areas with saline. Soak gauze in Dakin's 1/4 solution (a strong topical antiseptic to clean infected ulcers) and apply to heel for 15 minutes with dressing change daily, apply Iodosorb (wound gel that cleanse the wound by absorbing fluids and removing exudate) to the left posterior heel, place absorbent pad. If dressing becomes soiled, saturated, displaced, please remove, and replace. 100% non-weightbearing to the left lower extremity-PRAFO boot provided for wound offloading of left posterior heel, toe touch as needed for transfers. Use a tubigrip or stockinette to his left lower extremity. R1's culture results dated 10/11/23, identified methicillin resistant staphylococcus aureus (MRSA) was found in left heel wound and antibiotics were changed. R1's Medication Administration Record (MAR) identified the Iodosorb was not transcribed or implemented until 10/26/26. 20 days after the order was to be initiated. Further, R1's MAR identified on 10/8/22, 10/9/22, and 10/10/22, dressing was not changed with Dakin's solution, due to item unavailable. On 10/20/22 not completed as R1 was unavailable.	F 686	meeting and ongoing as indicated.		

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F 686	Continued From page 8 R1's wound note dated 10/18/22, indicated left heel measured 5.0 cm x 6.5 cm, necrotic, declining. R1's Doctor of Podiatric Medicine (DPM) wound clinic visit, dated 10/20/22, indicated R1 was last seen on 8/19/22. The nursing facility applied the foam dressing to the left heel without removing the plastic covering, this was applied incorrectly so this caused maceration of the pressure injury. Post debridement measurements were 7.6 cm x 6.9 cm x 0.2 cm. New orders to apply Iodosorb, calmoseptime (an ointment that forms a barrier on the skin to protect it from irritants) and ABD pad applied to left heel ulceration. R1's vascular ultrasound scheduled for 11/7/22. Physician orders dated 10/21/22 identified the aforementioned order from the podiatrist, however, did not include the directive to apply the calmoseptime. Corresponding MAR identified the dressing was completed without the calmoseptime from 10/21/22 to 10/26/22. R1's Wound Clinic AVS dated 10/27/22, indicated R1 has an appointment on 11/7/22 at 9:00 am to have an ultrasound completed of his lower extremities, and wound care follow up on 11/10/22. According to R1's record, R1 was not seen for vascular ultrasound as ordered. R1's Physician assistant (PA) advanced wound healing visit and orders, dated 10/27/22, indicated R1's wound was very macerated and has worsened since his last visit. Radiographs of his left heel "unstageable pressure ulcer", revealed no osteomyelitis. Wound was debrided; post debridement measurements were 5.5 cm x 9.1 cm x 0.4 cm. Advised R1 to increase protein	F 686			

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F 686	Continued From page 9 intake via diet supplementation to accelerate wound healing. Return in 2 weeks for re-evaluation. New orders included, discontinue previous order. start daily dressing changes; cleanse wound with saline and gauze, soak the wound using gauze soaked in Dakin's ¼ strength for 10 -15 minutes. Apply Santyl (an ointment used to remove dead tissue from a wound) to the left posterior wound bed (nickel thick), cover with ABD pad. R1's PA advanced wound healing visit, dated 11/10/22, indicated that R1 stated during his visit that his dressing does not get changed every day. R1 further stated he has significant pain in the region of the ulcer edges, failed to complete his vascular ultrasound appointment and R1 reported the transportation never arrived, and was rescheduled today. R1 left heel "unstageable pressure ulcer" was debrided, post debridement measurements were 4.2 cm x 8.1 cm x 0.6 cm. Return to clinic in 1 week. According to R1's record it was not evident R1 returned to the wound clinic within one week as ordered. R1's NP Visit note, dated 11/30/22, indicated R1 was seen due to concerns with right heel, identified right heel as an "unstageable pressure injury", referral in place for the wound clinic for his right heel. The visit note did not include further description of the left and right heel pressure ulcers. R1's quarterly MDS, dated 12/1/22, identified R1 had 2 unstageable pressure ulcers, however R1's record (aside from MDS) did not identify the presence of a second unstageable ulcer. R1's progress note, dated 12/6/22, indicated that	F 686			

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F 686	Continued From page 10 social worker (SW)-A escorted R1 to his wound clinic appointment. R1 was sent to the emergency department from the wound clinic for further evaluation due to R1's elevated INR (a blood test that measures the time for blood to clot), pale complexion, lethargy and possible cellulitis of wound and was admitted to the hospital. In review of R1's medical record, it was not evident an assessment was completed to determine the tissue tolerance over bony areas to pressure in accordance with facility policy. Not evident on-going monitoring was completed. Further not evident weekly comprehensive assessments were completed for all of R1's pressure ulcers that included risk factors, size, depth, stage, wound bed characteristics, drainage, and pain. There was no indication the facility reassessed PU prevention modalities and treatment strategies for effectiveness every 14 days or sooner to ensure appropriateness for healing and/or prevent infection and further deterioration. During a continuous observation on 1/26/23, from 9:35 a.m. to 10:51 a.m. R1 was observed to be lying on his back in bed. R1 was observed to have an above the knee amputation on his left leg and had a wound vac that was attached to the stump that was running. R1's right lower extremity had a blue PRAFO boot (a device worn on the calf and foot that is used to prevent pressure ulcers to the back of the heel) on. R1 stated he had not eaten breakfast yet. During an interview on 1/26/23, at 10:38 a.m. nursing assistant (NA)-A stated she had been the one who had first identified the pressure ulcer on	F 686			

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F 686	Continued From page 11 R1's left heel that had resulted in left leg amputation because of infection. R1 was hospitalized for about a month. NA-A explained NAs did not document toileting/reposition in the electronic health record (EHR); they would use paper care sheets with time slots of 6 am, 8 am, 10 am, 12 pm. We just put a check mark if we toileted or repositioned them. If the care plan changed the sheets would be updated by the nurse so that the NA's knew what to do. Most of the sheets don't direct us to offload heels for for people who need it, NA-A did not think that staff would offload heels if it was not on the care sheet. NA-A stated she could not get residents toileted and repositioned on time per their care plan because there was not enough staff. NA-A stated she had not had time to reposition R1 yet, because she had been busy with other residents. At 10:56 a.m. R1 was transferred via full body lift to his wheelchair. During an interview on 1/26/23, at 2:01 p.m. registered nurse (RN)-A changed R1's right heel dressing; reported the scabbed area measured 2.4 cm x 1.0 cm which would not be stageable. RN-A indicated the ulcer looked like it was getting better. During an observation and interview on 1/26/23, at 2:15 p.m. unit clinical manager (CM)-A stated, the floor nurses should be doing weekly wound assessments, this is typically done on Saturdays and should be documented in the nursing notes. CM-A stated R1 had pressure ulcers to his buttocks and was not sure how long they have been there. At 2:27 p.m. RN-A removed the sacral Mepilex dressing from R1's coccyx area; dressing had pinkish drainage on it. RN-A stated there was a moderate amount of serosanguinous			F 686			

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F 686	Continued From page 12 drainage on the dressing. Four open areas were observed on R1's coccyx area. RN-A stated they were all stage 2 pressure ulcers. RN-A measured the areas and started to cleanse the areas with wound cleanser. R1 clenched his buttocks during the cleansing and stated, Ow! Ow! Ow! Wound beds all were red. Measurements were as follows: middle coccyx area measured 3.1 cm x 1.0 cm, ulcer directly below measured 0.5 cm x 0.5 cm. Right middle buttock ulcer was 1.5 cm x 0.5 cm and right lateral area was 0.7 cm x 0.7 cm. RN-A cut pieces of Aquacel and placed in each wound bed. RN-A stated they did not have any sacral Mepilex so instead she used a square 4 x 4 Mepilex and placed it in the middle of R1's coccyx area. R1 was then repositioned to his left side. During an interview on 1/26/23, at 3:04 p.m. CM-A stated the facility did not have a designated nurse to oversee wound care right now; the wound care system that had been in place "just kind of fell apart". After a wound was identified a comprehensive assessment should be completed that included measurements, staging (if pressure ulcer), wound bed appearance, drainage and surrounding skin area. Assessments were to be completed weekly because if it started to worsen, the provider would be notified for possible change in treatments. The dressing should be changed per the MD order. During an interview on 1/26/23, at 5:17 p.m. CM-A thought R1's left heel wound started as a stage 2 pressure ulcer. CM-A was not sure when the ulcer became unstageable because the weekly wound assessments were not done. CM-A reported she was responsible for tracking the wound clinic appointments and communicating	F 686			

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F 686	Continued From page 13 with SW-A to set up transport services; R1's follow-up appointment after the 11/10/22 was missed. On 11/30/22, R1 had developed a blister on his right heel. We obtained a referral to wound clinic, the appointment was made for 12/6/22, when he was transferred to the emergency room. He was admitted to hospital with osteomyelitis (bone infection) that resulted in a left above the knee amputation. During an interview on 1/26/23 at 4:49 p.m. SW-A, stated she was the one who set up transportation for outside appointments. R1 did not go to his vascular ultrasound appointment. The follow-up wound clinic appointment from the 11/10/22 visit was missed because nursing had not informed her of R1's need for appointment or transportation. R1 did not have another wound clinic appointment until 12/6/22, that she escorted him to. When we got to the clinic, R1 looked very white and pale looking. Clinic staff took him back for examination and came back out and told her they were sending him to the emergency room because he had an elevated INR, he was pale, and had possible cellulitis (skin infection). During an interview on 1/26/23, at 3:24 p.m. assistant director of nursing (ADON) stated the facility did not have anyone in charge of wounds currently. Anyone with a wound should be comprehensively assessed at least weekly. With any worsening the provider would need to be called to ensure appropriate treatment was in place. The resident's wound clinic physicians have been the ones doing the measurements. During an interview on 1/30/23 at 12:59 a.m. director of nursing (DON) stated, when R1 was admitted he had no pressure ulcers. DON stated	F 686			

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F 686	Continued From page 14 R1 did not have weekly skin assessments performed as he should have to include pressure ulcer staging, measurement of ulcer, wound bed characteristics, surrounding skin area. Assessment needed to be done weekly to ensure the current treatment was working. DON stated on 11/10/22, R1 was supposed to have a follow-up appointment with the wound specialist within a week and the MD orders were not followed. R1 did not get to the wound specialist until 12/6/22. At the appointment R1 was immediately hospitalized with sepsis and ultimate left leg above the knee leg amputation. DON stated the floor nurses should be doing weekly bath audits which would be where the comprehensive skin assessments should go. During a phone interview on 1/30/23, at 1:57 p.m. NP-A explained she had seen R1 in September (2022) for his left heel unstageable ulcer so depth could not be determined. NP-A referred R1 to the wound clinic. Then on 11/30/22, NP-A wrote another referral for R1's right heel unstageable ulcer. The missed appointments and lack of assessments resulted in an unstageable pressure ulcer, sepsis, and ultimate loss of his left leg. NP-A stated she had recently seen R1 for his pressure ulcers on his buttocks, she had cultured the wounds, results were MRSA. We will be starting antibiotics. During a phone interview on 1/31/23, at 4:34 p.m. physician assistant wound specialist (PAWS)-A stated R1's left heel "unstageable pressure ulcer" was being managed by the wound clinic. We saw R1 on 10/20/22, at that time the left heel was just a big eschar cap. On 11/10/22, the eschar cap had softened and was macerated because the facility had applied the dressing incorrectly by not	F 686			

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F 686	Continued From page 15 taking the plastic off. R1 was supposed to come back in a week for follow-up however, did not come back until 12/6/22. When he presented on 12/6/22 for that appointment he was really sick, pale, weak, cognition was blunted, his INR was high, "he was just way off from his baseline". and that they sent him right over to the ER. . He further stated he, the podiatrist, and ortho looked at his left heel, it was all open and wet, eschar stringy tissue, "it looked terrible". R1 was diagnosed at the hospital with osteomyelitis and calcaneus sepsis. On 12/20/22, R1 transferred to another hospital where he had an above the knee amputation as a direct result from the infection in the pressure ulcer. Had R1 came back for his follow-up visit as ordered, could have prevented amputation of his leg. Facility policy entitled, "Pressure Sores Protocol," revised 8/3/18, indicated a purpose to identify residents at risk for developing pressure sores. To assure residents are receiving necessary treatment and services to prompt healing, prevent infection and prevent new sores from developing. 1. Identifying at-risk individuals needing prevention and specific factors placing them at risk will be done in the initial comprehensive nursing assessment and in on-going assessments by the nursing staff. 5. Protection of residents from external mechanical forces such as friction, pressure, and shearing will be done as follows: a. positioning devices, such as pillows or foam wedges, should be used to keep bony prominences from direct contact with one another, according to a written plan of care. B. individuals in bed who are completely immobile should have a care plan that includes the use of devices that totally relieve pressure on heels. The heels should be raised off the bed. F. Any	F 686			

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F 686	Continued From page 16 individual assessed to be at risk for developing pressure areas should be placed on a pressure reducing device such as an air mattress, RoHo or gel cushions. The resident should be repositioned, shifting the points of pressure at least every hour. Resident capable of being taught should be instructed to shift weight every 15 minutes while sitting. Facility policy, entitled, "Tissue Tolerance Audit Policy and Procedure," revised 8/3/18, included: 1. Tissue tolerance is the skin and its supporting structures ability to endure the effects of pressure without adverse effects. Each resident who is dependent on bed and/or chair mobility, will be monitored for tissue tolerance while lying and sitting: a. upon admission, readmission; and b. with a change in condition 2. Once an individualized turning and repositioning schedule is determined a daily skin inspection by the nursing assistant and a weekly skin inspection by the licensed nurse will be done to ensure that there are no adverse effects to the skin and its supporting structures, ensuring that the determined intervals are still appropriate. Facility policy entitled, "Pressure Sore Monitoring," revised 8/3/18, identified a purpose to assure assessment and reassessment completion of all open area and appropriateness of treatment. 1. Staff nurse will assess all open areas on each resident on his/her wing weekly. 2. Staff will document on the skin and wound assessment and record sheet the stage of each area and present treatment. 3. Report of open areas and treatment will be given to the Quality Assurance Nurse. 4. Quality Assurance Nurse will do random assessments of open areas on each unit on an ongoing basis. %. Copies of	F 686			

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F 686	Continued From page 17 weekly assessments of open areas will be available to the dietician for her review at her next visit. Residents with significant open areas will be reviewed by the dietician and recommendations made. Scheduled reviews with dietician will be coordinated by the dietary manager. 6. Assessment information will be utilized to assure on-going individual care plan approaches are current and specific for each resident. The immediate Jeopardy that began on 12/20/22, was removed on 2/2/23 at 1:51 p.m. when it was verified through interview and document review the facility implemented the following: -immediately review/revise/develop their pressure ulcer program policies and protocols. -Provided education to licensed staff on completing comprehensive pressure ulcer assessments and care plan interventions for pressure ulcers. -Comprehensively assess all residents who have any stage pressure ulcers. Evaluated and review/revise care plan for appropriateness of treatment and services to reduce the risk of pressure ulcer development and/or further deterioration of pressure ulcers and infection with notification to the physician as appropriate. -Provided education to direct care staff on pressure ulcer prevention modalities in accordance with the care plan.	F 686			