DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 26, 2023

Administrator
Glenoaks Senior Living Campus
100 Glen Oaks Drive
New London, MN 56273

RE: CCN: 245360
Cycle Start Date: November 17, 2022

Dear Administrator:

On December 9, 2022, we notified you a remedy was imposed. On January 17, 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 December 22, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 17, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 9, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 17, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 22, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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January 26, 2023

Administrator
Glenoaks Senior Living Campus
100 Glen Oaks Drive
New London, MN 56273

Re: Reinspection Results
Event ID: TX4J12

Dear Administrator:

On January 5, 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 November 17, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
December 9, 2022

Administrator
Glenoaks Senior Living Campus
100 Glen Oaks Drive
New London, MN 56273

RE: CCN: 245360
Cycle Start Date: November 17, 2022

Dear Administrator:

On November 17, 2022, 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 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 February 17, 2023 (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 May 17, 2023 (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/ltc_idr.cfm

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENOAKS SENIOR LIVING CAMPUS	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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F 000	INITIAL COMMENTS On 11/15/22 to 11/17/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H53605775C (MN00088328) with deficiencies cited at F656, F684, and F686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		12/22/22

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

Electronically Signed | 12/19/2022

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

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F 656	Continued From page 1 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plan interventions were implemented for 2 of 3 residents (R1, R2) reviewed who required staff assistance with activities of daily living (ADLs)	F 656	F 656: R1's head of bed has been positioned to the correct angle as indicated in the care plan and being repositioned, checked and changed every 2 hours and elbow protector placed on	

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F 656	Continued From page 2 including repositioning, application of pressure relieving devices, and assistance with toileting reviewed for incontinence cares and monitoring of skin integrity. In addition, proper positioning of resident receiving a continuous enteral (tube) feeding (R1) reviewed for complications related to enteral feeding. Findings include: R1's quarterly Minimum Data Set (MDS) dated 9/20/22, identified R1 had severely impaired cognition, and diagnoses of traumatic brain injury and quadriplegia (paralysis of all four limbs). R1 Required total dependence of staff for all ADLs, at risk for pressure ulcers, and received nutritional through an enteral feeding. R1 was frequently incontinent of bladder and had a colostomy (end of colon is brought through the abdominal wall and stool drains into a bag). R1's care plan updated last on 10/4/22, indicated R1 elbow protector applied to right elbow at all times, weekly wound nurse assessment to monitor wound/skin for skin breakdown, healing or changes and skin treatment, document location, size, and treatment of skin injury, the head of bed (HOB) must be upright at least 30 to 45 degrees at all times for all enteral feedings to prevent aspiration, dependent on staff to turn, reposition/out of bed two hours a day to custom wheel chair, check and change every two hours. R1's nursing assistant (NA) current Kardex, undated, identified check and change and reposition every two hours and PRN. R1's Kardex did not identify application of an elbow protector. R1's physician order dated 4/15/22 indicated	F 656	right arm. R2 repositioned every 2 hours with heel protectors and checked by staff for incontinence to help prevent risk of skin breakdown. All care plans have been audited and care requirements and interventions have been documented on the new sheets. The master set sheets are kept at the Nurses station and are to be copied by the Certified Nursing Assistants before the start of their shift and carried with them throughout their shift to determine care needs and interventions. Any new care needs or interventions will be updated on the master sheet completed by the Nursing Leadership timely and the master set sheet will be updated weekly as part of the Quality Assurance process. To ensure compliance and that no other residents are affected of deficient practice, Nursing Leadership will complete random audits weekly for 4 consecutive weeks and then monthly for 4 consecutive months, through 05/2023, and as needed to ensure continued compliance. Results of these audits will be reviewed at QAPI meetings monthly, beginning 01/2023 through 05/2023. The correction date of implementation is 12/22/2022.	

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F 656	Continued From page 3 check elbow protector is in place each shift, off for cleaning/hygiene. R1's physician order dated 5/2/22 indicated keep HOB elevated over 30 degrees at all times every shift. Review of R1's turn and reposition every two hours and as needed (PRN) NA documentation from 11/10/22, through 11/17/22, revealed: 11/10/22, at 9:59 p.m. 11/11/22, at 12:05 a.m., and 8:55 p.m. 11/12/22, at 12:09 a.m. 9:51 p.m., and 11:26 p.m. 11/13/22, at 9:25 p.m. and 11:57 p.m. 11/14/22, at 7:56 p.m. and 11:24 p.m. 11/15/22, no documentation for this day 11/16/22, at 12:40 a.m. and 11:02 p.m. 11/17/22, at 9:59 p.m. Review of R1's bladder elimination/check and change NA documentation from 11/10/22, through 11/17/22, revealed: 11/10/22, at 2:20 a.m., 5:50 a.m., 9:59 p.m., and 11:53 p.m. 11/11/22, at 3:10 a.m., 5:59 a.m., 8:55 a.m., and 11:23 p.m. 11/12/22, at 2:42 a.m., 5:48 a.m., 950 p.m., and 11:15 p.m. 11/13/22, at 2:55 a.m., 5:46 a.m., 9:25 p.m., and 11:35 p.m. 11/14/22, at 2:47 a.m., 5:32 a.m., 7:56 p.m., and 11:11 p.m. 11/15/22, at 3:24 a.m. 11/16/22, at 12:04 a.m., 3:04 a.m., 5:29 a.m., 9:59 p.m., 10:47 p.m. 11/17/22, at 2:57 a.m., and 5:34 a.m. R1's medical record lacked consistent documentation of repositioning and incontinence	F 656		

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F 656	Continued From page 4 cares/check and change. During observations on 11/15/22, at 2:30 p.m., 3:00 p.m., and 3:34 p.m. R1 laid in bed awake in the same position with head of bed up approximately 20 degrees with an enteral feeding infusing in by a pump at 60 milliliters per hour (ml/hr). R1' right arm/elbow rested on the bed mattress with a rolled-up towel positioned in right hand. R1 did not have on an elbow protector or pillow placed under his right arm. Two signs, one above the head of the bed and one across the room were posted on the wall in R1's room "keep HOB [head of bed] above 30 degrees" on a pink sheet of paper. During observations on 11/16/22, at 8:40 a.m., 10:00 a.m., and 11:40 a.m. (3 hours) R1 laid in bed on his back with a pillow placed next to his left side and head of bed up approximately 20 degrees with an enteral feeding infusing by a pump at 60 ml/hr. R1 had an occasional dry cough at 8:40 a.m. R1's right arm/elbow rested on the bed mattress. R1 did not have on an elbow protector on right arm. During an observation/interview on 11/16/22, at 11:56 a.m. licensed practical nurse (LPN)-A, assistant director of nursing (ADON) entered R1's room together. R1's position remained unchanged since 8:40 a.m. (3 hours and 56 minutes). ADON and LPN-A applied gloves and together completed the dressing change on R1's fistula (an abnormal passageway, or tunnel, in the body) site, removed gloves sanitized their hands and ADON and exited the room. LPN-A covered R1 up and lowered entire bed down. LPN-A stated R1 was to be up in the chair for two hours and the nurse aides should be coming in to	F 656		

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F 656	Continued From page 5	F 656		

transfer him soon. R1's head of bed remained up at approximately 20 degrees when LPN-A sanitized her hands and exited the room.

During an observation on 11/16/22, at 12:47 p.m. NA-D and NA-G entered R1's room. NA-D pulled back the covers off R1 and lowered the head of the bed flat with tube feeding running in at 60 ml/hr. R1 did not have a right elbow protector in place. NA-D and NA-G verified R1 had been incontinent large about of urine, removed brief, cleaned perineal area, and applied clean brief. NA-D turned R1 onto left side, placed pillow behind his back and a pillow under feet to float heels. At 1:00 p.m. NA-D raised the head of the bed up to approximately 20 degrees. NA-G confirmed the tube feeding pump did not need to be paused when they placed the head of the bed flat. NA-D and NA-G removed gloves and sanitized hands and exited the room.

During an interview on 11/16/22, at 1:54 p.m. LPN-A stated R1 required total assistance of two to turn and reposition and total assistance of one for all ADLs. LPN-A also stated R1 should be check and changed and repositioned every two hours. LPN-A verified R1 had a pressure sore on his right elbow six months ago and elbow protector should be always on while in bed. LPN-A indicated R1's head of bed was to be at 30 degrees but not sure how to determine that, just eyeball it. LPN-A verified she did not know how the NAs knew how to determine if the head of bed was up to where it should be.

During an observation/interview on 11/17/22, at 9:00 a.m. LPN-A noted in hallway and stood at the medication cart. Surveyor walked down the hallway and LPN-A immediately entered R1's

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F 656	Continued From page 6 room. Observed from doorway R1's HOB was positioned just above flat and between ¼ of the way up with enteral feeding infusing in by a pump at 60 ml/hr. LPN-A raised the HOB up to over 30 degrees. LPN-A verified R1's HOB had not been up to over 30 degrees and should have been to prevent aspiration. During an observation on 11/17/22, at 9:09 a.m. LPN-A asked NA-D to come with her into R1's room. LPN-A explained to NA-D R1's HOB should be above 30 degrees at all times to help prevent aspiration and was positioned lower than 30 degrees. LPN-A explained further R1's neck should be positioned above the abdomen to give you an idea of how to determine how high it should be. NA-D verbalized understanding. During an interview on 11/16/22, at 2:35 p.m. NA-G stated R1 had two signs in his room that indicated the head of bed should be up at least 30 degrees. NA-G stated she assumed R1 could lay flat with the tube feeding running in. NA-G also verified she was unaware R1 should have had an elbow protector on his right arm. During an interview on 11/16/22, at 2:45 p.m. NA-D stated she completed cares on R1 at 8:00 a.m. and not repositioned or check and changed again until 12:47 p.m. (4 hours and 47 minutes). NA-D verified R1 had not been repositioned and checked and changed every two hours like he should have been, this happened daily, and was not documented due to short on time. NA-D also stated she was not aware R1 should have had an elbow protector on his right arm and had never seen one in his room since she started work there 1 ½ months ago.	F 656		

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F 656	Continued From page 7 During an interview on 11/17/22 at 11:30 a.m. with LPN-B stated R1 was at risk for aspiration and the head of bed should be up to at least 30 degrees. LPN-B also stated R1 had been at high risk for skin breakdown, dependent on staff for all cares, and does not need new skin issues, therefore should be check and changed and repositioned every two hours. LPN-B verified R1's right elbow protector should be on at all times with a pillow underneath the arm as well to help prevent further breakdown on the skin that had already healed from a previous right elbow pressure ulcer. During an interview on 11/17/22, at 1:45 pm. NA-F stated R1 had two signs in his room on the wall that indicated the head of the bed should be up to at least 30 degrees to help prevent aspiration. NA-F also stated she had asked the LPN-A how to measure the height and was informed to assure his throat was above stomach to prevent aspiration at all times. R2's quarterly MDS dated 10/21/22, identified R2 had moderately impaired cognition and diagnoses of peripheral vascular disease (PVD) (impaired circulation due to narrowed blood vessels to the limbs), diabetes, and two stage three pressure ulcers. R2 was always incontinent of bowel and bladder, required total assistance of two staff for transfers and all ADLs and extensive assistance of two staff with bed mobility. R2's care plan dated 8/21/22, indicated R2 had impaired skin integrity. R2 should be encouraged to shift weight every two hours due to skin integrity, if able and assist as needed and heel protectors on when in bed. R2 required assist of two staff for bed mobility and toileting.	F 656		

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F 656	Continued From page 8 R2's NA Kardex dated 11/18/22, indicated bed mobility and toileting two person assist, peri care with every incontinent episode. R2's Kardex did not identify application of heel protectors. Review of R2's bladder elimination/check and change NA documentation from 11/10/22, through 11/17/22, revealed: 11/10/22, at 2:22 a.m., 5:52 a.m., 9:59 p.m., and 11:56 p.m. 11/11/22, at 3:12 a.m., 5:59 a.m., 8:49 p.m., and 11:23 p.m. 11/12/22, at 2:43 a.m. ,5:46 a.m., 9:00 p.m., and 11:13 p.m. 11/13/22, at 2:47 a.m., 6:47 a.m., and 11:37 p.m. 11/14/22, at 2:49 a.m., 5:33 a.m., 9:03 p.m., and 11:08 p.m. 11/15/22, at 3:36 a.m., 1:01 p.m., and 9:29 p.m. 11/16/22, at 12:16 a.m., 3:06 a.m. 5:31 a.m., 9:37 p.m., and 10:48 p.m. 11/17/22, at 2:58 a.m. and 5:35 a.m. Requested repositioning documentation on 11/7/22, ADON verified NA's did not save their repositioning sheets and therefore they do not have record of when R2 had been repositioned. R2's medical record lacked consistent documentation of repositioning and incontinence cares/check and change. During an observation on 11/15/22, at 3:20 p.m. R2 laid in bed uncovered with white socks on and heels rested directly on the mattress. NA-B and NA-C applied gloves, stood on each side of the bed, removed the soiled with urine brief, turned R2 from side to side, completed peri cares with	F 656		

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F 656	Continued From page 9 wet wipes wiping from front to back, and applied a clean brief. Protective ointment was not applied to R2. NA-B stated she just identified R2 had a new open area in groin area. NA-C stated it was approximately ½ inch long and very narrow and was not open yesterday. NA-B stated R2 also had two open pressure ulcers over three months. NA-B also stated the entire width of the upper back thigh was pink in color with two open areas, not deep at all, and no drainage. NA-B indicated it had improved and was better some days than others because there were nurses that applied too much stoma powder. NA-C removed R2's white socks, identified skin on heels without redness. NA-A and NA-B removed gloves, sanitized hands and exited the room. R2 laid on her back, was not repositioned, without heel protectors on and heels rested directly on bed mattress. During an observation on 11/15/22, at 3:45 p.m. R2 laid in bed on her back, heels rested directly on the bed mattress without heel protectors on. During continuous observations on 11/16/22, at 11:30 a.m., 12:00 p.m., 12:50 p.m., 1:45 p.m., 2:30 p.m., and 3:15 p.m. resident sat up in her wheelchair (3 hours and 45 minutes). During an interview on 11/15/22, at 3:30 pm R2 stated staff took a while to answer her light, sometimes was aware when she had a wet brief, but most times could not. R2 also stated she did not get repositioned to get off her pressure ulcers like she should, told staff, and was painful to lay in one position for a long time. During an interview on 11/16/22, at 1:40 p.m. NA-E stated R2 required total assistance of at	F 656		

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F 656	Continued From page 10 least two and sometimes three staff to reposition because she was unable to do it herself. NA-E also stated R2 should be repositioned, check and changed, and documented at least every two hours due to pressure ulcer located on her left upper backside of thigh. NA-E verified R2 should always have heel protectors on when in bed and they were located on the floor next to the dresser. During an interview on 11/16/22, at 2:30 p.m. NA-G stated we assisted [R2] up into the wheelchair with a lift at 11:30 a.m. and had not been checked and changed or repositioned since 11:30 a.m. (3 hours). NA-G also stated R2 should be repositioned and check and changed at least every two hours due to her pressure ulcer located on her left upper backside of her thigh. NA-G verified she was not aware heel protectors should have been placed on R2 feet and not identified on the NA Kardex. During an interview on 11/16/22, at 2:50 p.m. NA-D stated R2 did not have heel protectors on today and spent a lot of time in bed. NA-D also stated the heel protectors helped relieve pressure off the heels. NA-D verified R2 had been transferred from bed to wheelchair for lunch at 11:30 a.m. and continued to sit up in the dining room at this time (over 3 hours 50 minutes) probably longer than she should have been. NA-D identified R2 should be repositioned every two hours to help prevent skin break down and was not being done. During an interview on 11/17/22, at 11:40 a.m. LPN-B stated R2 had a current pressure ulcer located on her right upper backside thigh area and should be check and changed and repositioned every two hours to help prevent	F 656		

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F 656	Continued From page 11	F 656		

further complications. LPN-B verified R2 had bogginess in her heels and required heel protectors to be worn while in bed to prevent pressure ulcers as a preventive measure.

During an interview on 11/17/22, at 12:20 pm with director of nursing (DON) stated staff NAs are expected to document every two hours check and change and repositioning on all residents. DON verified she had realized today NAs did not turn in the required documents at the end of each shift for quite a while now. DON also indicated the staff nurse would be expected to verify residents were checked and changed and repositioned at the end of each shift. DON indicated staff were expected to check and change and reposition R2 every two hours to prevent the pressure ulcer areas from getting worse.

Review of facility policy titled Repositioning dated 5/2013, reveled resident repositioning as an intervention to prevents skin breakdown, promotes circulation, and provides pressure relief. Repositioning is critical for a resident who is immobile or dependent upon staff. Residents in bed should be on at least every two-hour repositioning schedule and residents in a chair should be on every hour repositioning schedule.

Review of a facility policy titled Care plans, Comprehensive Care Centered dated 12/2016, a comprehensive, person-centered care plans are developed and implemented services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing.

Review of facility Pressure Ulcer Injury Risk Assessment dated 7/2017, revealed risk factors

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F 656	Continued From page 12 that increase a resident's susceptibility to develop or not heal pressure ulcers include the presence of previously healed pressure ulcers are more likely to have recurrent breakdown and impaired/decreased mobility exposure of skin to urinary and fecal incontinence, and decreased functional ability.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure weekly wound monitoring, measurements and assessments, and treatments were completed for 1 of 1 resident (R1) reviewed for wounds. Findings include: R1's physician orders dated 6/15/22, peri tube skin breakdown care BID and PRN two times a day. Cleanse percutaneous endoscopic gastrostomy (PEG) (a surgery site to place a feeding tube) under bumper and surrounding skin with soap and water and dry thoroughly. Apply thick layer of soothe and cool skin protectant and one layer of drain sponge under bumper.	F 684	All residents will have a weekly skin assessment completed by the Charge Nurse as scheduled in the Point Click Care/UDA Portal. If new areas are identified, the Charge Nurse will complete the N-weekly non-pressure wound assessment to include measurements, complete an incident report of all new areas including pressure wounds, notifying the Medical Doctor and obtaining treatment orders, notifying the family and documenting in the resident medical record. When completing the weekly Skin assessment, if the resident has existing non-pressure areas, the Nurse will	12/22/22

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F 684	Continued From page 13 R1's quarterly Minimum Data Set (MDS) dated 9/20/22, identified R1 had severely impaired cognition, and diagnoses of traumatic brain injury and quadriplegia (paralysis of all four limbs). R1 Required total dependence of staff for all ADLs, at risk for pressure ulcers, and received nutritional through an enteral feeding. R1 was frequently incontinent of bladder and had a colostomy (end of colon is brought through the abdominal wall and stool drains into a bag). R1's care plan updated last on 10/4/22, indicated R1 required weekly wound nurse assessment to monitor wound/skin for skin breakdown, healing or changes and skin treatment, document location, size, and treatment of skin injury. Weekly skin/treatment documentation in accordance to wound nurse assessment, physician orders, and plan of care recommended. R1's physician order dated 10/15/22, leave gastric portion of feeding tube uncapped and down to gravity every shift. R1's physician order dated 10/25/22 and discontinued 11/10/22, dressing over fistula, medial to gastric tube, change every shift and PRN if over 50% saturated. Cleanse site. Apply skin prep. Cover with ABD. R1's physician order dated 11/10/22, identified dressing over fistula (an abnormal passageway, or tunnel, in the body), medial to gastric tube change two times a day (BID) and as needed (PRN) if greater than 50% saturated or dislodged. Cleanse wound with normal saline. Apply Miconazole Nitrate 2% to peri wound skin followed by Calame paste. Apply calcium Alginate (highly absorbent dressing used for wound repair)	F 684	complete the N-Weekly Non-Pressure Wound Assessment to include current measurements. Any areas not improving in a 14 day time period will need re-evaluation with Medical Doctorand documented in the TAR. Any areas determined by the Wound Nurse to be pressure, will have further monitoring weekly by the Wound Nurse with completion of the N-Weekly Pressure Assessment UDA, to include weekly measurements. Any areas not improving in 14 days will have new orders obtained from the Medical Doctor. To prevent the deficient practice from recurring, Nursing Leadership team will audit TARs, risk management, UDAs and progress notes as part of the morning quality audit. Skin assessments and skin risks will be reviewed at monthly QAPI as a standing review item on the QAPI agenda, beginning January, 2023. Audits will be completed weekly for 4 consecutive weeks and then monthly for 4 consecutive months, through 05/2023 and as needed to ensure compliance and prevent the deficient practice from recurring. Audit results will also be reviewed at QAPI meetings monthly beginning 01/2023 through 05/2023. The correction date of implementation is 12/22/2022.	

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F 684	Continued From page 14 dressing into wound base. Cover with gauze. Secure with abdominal pad dressing (ABD) and medipore tape. Progress notes on 11/4/22, 11/5/22, 11/8/22, 11/12/22, 11/14/22, 11/15/22, and 11/16/22, indicated contents out of gastric part are too irritating to [R1's] skin and nothing for the contents to drain into, will not leave gastric portion uncapped. Review of R1's EMAR 11/1/22, through 11/10/22, dressing over fistula, medial gastric tube, change every shift and PRN if over 50% saturated identified: -R1's fistula dressing changes from 11/1/22, through 11/10/22, where not completed 3 times out of 27 times. Review of R1's electronic medical administration record (EMAR) 11/10/22 through 11/16/22, dressing over fistula, medial to gastric tube change BID and PRN if over 50% saturated or dislodged identified: -R1's fistula dressing changes from 11/10/22 through 11/16/22, where not completed 4 out of 12 times. Review of R1's EMAR 11/1/22 through 11/16/22, peg site peri tube skin breakdown care BID and PRN two times a day identified: -R1's peg site dressing changes from 11/1/22 through 11/16/22, where not completed 8 out of 31 times. Review of R1's EMAR leave gastric portion of feeding tube uncapped and down to gravity from 11/1/22 through 11/17/22, identified it was not left open 7 times out of 51 times.	F 684		

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F 684	Continued From page 15 Review of weekly skin assessments completed from 9/28/22 through 11/16/22 identified: -On 9/28/22, G-tube site red around area with yellow discharge. Area cleaned and Bacitracin applied to area. -On 10/19/22, peg tube site on left abdomen has red irritated skin surrounding the opening, fistula has opened on the right middle abdomen and measures 1.7 millimeter (mm) by 1.3 mm. it is covered with an ostomy pouch to catch drainage. Skin around the area is red and irritated. Gastric contents leaking from area are irritating the skin and ostomy bag is being used to help contain the leakage and keep it off surrounding tissue. -On 10/26/22, peg tube site on left abdomen has red irritated skin surrounding the opening, fistula has opened on the right middle abdomen it is covered with an absorbent dressing to catch drainage. Skin around the area is red and irritated. Colostomy site is red and beefy, skin around area is red and irritated. -On 11/2/22, peg tube site area red and irritated, fistula site area open and draining clear to black discharge, area red and irritated, painful to resident, area covered with gauze and ABD. colostomy site, beefy red. -On 11/16/22 and 11/9/22, peg tube site is red and irritated and fistula site area open and draining. R1's weekly skin assessments lacked detailed information regarding skin and wounds. Review of R1's progress notes from 10/14/22, through 11/10/22 identified: -On 10/14/2022, at 9:31 p.m. R1 returned from emergency department has new orders for use of J-tube only to be left open and drain into a bag. Doctor reported resident had a fistula on his	F 684		

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F 684	Continued From page 16 abdomen near the peg site. Keep covered. -On 10/18/2022, at 12:10 a.m. had returned from emergency department and no new orders. Fistula was covered with an ostomy bag to catch dark green to blackish colored drainage. Skin around the fistula is red and painful. Fistula area has increased from a pinhole size on 10/14/22, to a 1 cm by 1.5 cm opening at return today. -On 10/23/22, at 10:52 p.m. R1's fistula site continues with foul smelling drainage. Ostomy bag remains off due to skin breakdown. -On 10/24/22, at 1:15 p.m. R1's fistula site measures 3.7 cm x 1.5 cm in size today, on 10-18-22, it measured 1 cm x 1.5 cm, site is oozing a maroon colored, bowel movement (BM) smelling drainage today, moderate amount, site around fistula is reddened, area washed and dried well and new ABD applied. Appears to have the same drainage small amount around PEG site. Noted area of redness under right breast coming up from the G-Tube site, area measures 6 cm x 4 cm in size, no drainage noted. -On 10/28/22, at 2:36 a.m. unable to collect drainage from gastric portion of feeding tube bag does not stay in place due to pressure and fluids are irritating R1's skin. -On 10/30/22, at 2:41 a.m. R1 abdominal wound draining large amounts of black drainage onto ABD, PEG site very red and tender to touch. R1's abdominal wound measured 4.5. cm by 3 cm and 2 cm away form PEG site, unable to measure depth due to sensitivity. Due to the skin and the way the wound was appeared R1 was sent into the emergency room via ambulance. -On 10/30/22, at 1:42 a.m. R1's gastric portion of tube is leaking when held down to gravity, not okay for R1 to have this on skin. Closed for now. -On 10/31/22, at 9:14 p.m. Has foul odor, dressing saturated with black drainage, peri	F 684		

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F 684	Continued From page 17 wound red and scant amount of bleeding from scattered pinpoint open areas. - On 11/1/22, at 1:40 a.m. R1's site continues to drain black drainage. Changed and applied wet to dry dressing as new orders for emergency visit on 10/30/22. R1's skin around the area is red and irritated, ABD saturated more than 100% and area very tender to touch as well. -On 11/10/22, at 12:54 p.m. referral form wound/ostomy nurse wound vac is contraindicated with fistula and new order for dressing change (see above). R1's medical record was reviewed and lacked any evidence the newly developed area of skin damage had been assessed by a wound nurse despite the wound being identified by direct care staff and emergency room physician on 10/14/22. During an observation on 11/16/22, at 11:56 a.m. assistant director of nursing (ADON) and LPN-A stood on each side of R1's bed with gloves on. R1 laid in bed on his back with fistula located right of gastrojejunostomy (GJ) tube (a tube that goes through the abdomen and into the small intestine and stomach) exposed. RN-A sprayed the fistula with wound cleaner and dabbed it out with a folded 4 x 4 gauze dressing. ADON applied Miconazole Nitrate 2% (antifungal) cream around the edges of the fistula. LPN-A indicated she had removed the old dressing and there was a dime size of thick yellow brown drainage, no odor on the gauze dressing, and ABD was dry. RN-A collected measurements of the fistula wound 3.75 centimeters (cm) by 4.0 cm and depth was 1 cm. ADON stated wound bed looked red and beefy healthy tissue with good blood flow and peri wound area was pink, intact without any signs of infection. LPN-A placed two small pieces of	F 684		

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F 684	Continued From page 18 calcium alginate into wound base, 4 x 4 gauze dressing, ABD on top, and secured it to R1's abdomen with paper tape around all four edges. LPN-A cleaned around peg site with soap and water, applied soothe and cool skin protectant, and a drain sponge dressing. LPN-A stated the peg site had no signs of infection. ADON and LPN-A removed gloves covered R1 with blanket, sanitized hands and exited the room. During an interview on 11/16/22, at 10:07 a.m. assistant director of nursing (ADON) stated pressure/wound assessments are to be completed weekly and was informed one month ago those were to be completed by myself. ADON verified she had not completed the pressure/wound assessments on the following weeks: 10/21/22, 10/28/22, 11/4/22, and 11/11/22. ADON also stated the weekly skin assessments were being completed by the nursing staff but lacked details and expected the staff nurses to document specifically change in size, odor, drainage amount and color, increase in pain and measure it weekly. ADON confirmed from 10/20/22, to 10/24/22, and 10/27/22 to 10/30/22 there was no documentation on the site size for R1's abdominal wound and would expect the staff nurse to have provided more documentation on the measurements to monitor for changes and skin changes of course. ADON stated staff would be expected to document daily on R1's skin /fistula site since it changed so quickly to identify what it looks like including measurements. ADON indicted R1's fistula site most likely needed to be measured and assessed more closely to identify and assess changes sooner, to make changes in interventions and decrease potential for infection. ADON indicated she expected the staff nurses to follow the most recent wound orders received and	F 684		

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	245360	A. BUILDING _____ B. WING _____	C 11/17/2022

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F 684	Continued From page 19 when changes in skin are recognized they should have reported to the supervisor or myself. During an interview on 11/16/22, at 1:54 p.m. LPN-A stated a wound nurse was to measure R1's wound on his abdomen once a week on Wednesdays and not sure if that had been done. LPN-A also stated R1's wound started as a pinpoint open area and within five days it was the size of a quarter, bubbling and draining copious amounts of drainage that smelled like BM and was maroon color, slimy and thick. LPN-A also indicated R1's wound changed fast and good assessments were important. During an interview on 11/17/22, at 11:30 a.m. LPN-B stated the R1's initial wound assessment on the open fistula abdominal site had not been completed until 11/16/22. LPN-B also stated R1's fistula was first noted and confirmed by physician on 10/14/22, and the wound assessment should have been completed on 10/15/22, and weekly thereafter since he had an open area. LPN-B indicated on 10/30/22, the last measurements were documented prior to 11/16/22, (16 days). LPN-B verified R1's abdominal fistula size had improved except for length: 11/30/22, measured 4.5 cm by 3 cm by 2 cm depth versus 11/16/22, 3.75 cm by 4 cm by 1 cm depth. LPN-B also stated the wound assessments are important to identify whether R1's fistula was healing and if treatment plan needed to be changed. LPN-B indicated the wound assessments were not completed most likely due to turn over in staff. During an interview on 11/17/22, at 12:20 p.m. director of nursing (DON) verified pressure/wound assessments had not been completed for two to three months, no staff in	F 684		

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F 684	Continued From page 20 place doing the wound job, and relied on the staff nurses to initiate it. DON also stated the weekly skin assessments completed by the nurses were done however those assessments lacked information such as what the wound looked like in detail and measurements. DON identified staff nurses needed to be educated on how to improve their documentation regarding weekly skin assessments. DON confirmed on 10/10/22, R1's weekly skin assessment was not documented properly and indicated he had no alterations in skin integrity. DON also stated R1's fistula did not get measured for at least three weeks and would have been important because it changed so quickly. DON indicated the wound nurse would provide more detailed assessments, confirm the treatment was effective, check for signs and symptoms of infection, and notify doctor when needed. Facility wound policy was requested and was not received.	F 684		
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 promote healing, prevent infection and prevent	F 686		12/22/22

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F 686	Continued From page 21 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide consistent assessment, monitoring, and timely repositioning for 1 of 2 resident (R2) reviewed with two stage three (full thickness tissue loss) pressure ulcers. This had the potential to affect 5 other residents who had pressure ulcers. Findings include: R2's care plan dated 8/21/22, indicated R2 had impaired skin integrity and at risk for further skin break down related to diagnosis of diabetes mellitus, and morbid obesity. The care plan included interventions of encourage R2 to shift weight every two hours, heel protectors on when in bed, required assist of two for bed mobility and toileting, apply protective ointment to prevent skin breakdown, and utilize pressure reduction equipment such as cushion to wheelchair, and alternating pressure mattress to bed. The care plan directed staff monitor/document location, size, and treatment of skin injury. Report any abnormalities, failure to heal, and signs and symptoms of infection to physician. Complete weekly skin/treatment documentation in accordance to wound nurse assessment and plan of care recommended. R2's physician order dated 8/24/22, change dressing to left thigh three times a day (TID), cleanse site with NS/wound cleanser, pat dry, apply skin prep to surrounding skin and collagen silver and stoma powder. R2's progress note dated 9/22/22, identified R2	F 686	F 686: R2 has had a detailed skin assessment completed and updated. R2's heel protectors are in place, bed elevations to the correct angle, and repositioning every 2 hours in place as indicated in the care plan. All residents will have a weekly skin assessment completed by the Charge Nurse as scheduled in the Point Click Care /UDA Portal. If new areas are identified, the Charge Nurse will complete the N-Weekly non-pressure wound assessment to include measurements, complete an incident report of all new areas including pressure wounds, notifying the Medical Doctor and obtaining treatment orders, notifying the family and documenting in the resident medical record. When completing the weekly skin assessment, if the resident has existing non-pressure areas, the Nurse will complete the N-Weekly non-pressure wound assessment to include current measurements. Any areas not improving in a 14 day time period will need re-evaluation with Medical Doctor and documented in the TAR. Any areas determined by the wound Nurse to be pressure, will have monitoring weekly by the wound nurse with completion of the N-Weekly Pressure Assessment/UDA, to include weekly measurements. Any areas not improving in 14 days will have new orders obtained	

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F 686	Continued From page 22 had monthly wound/ostomy care (WOC) nurse come and look at wound to her left (L) rear thigh. Site has improved since last visit a month ago. Will continue with current treatment of cleansing site, skin prep, collagen silver and stoma powder to wound bed, and collagen silver to help promote debridement. Overall wound measurements for entire area 2.5 inches x 4 inches. There are five wounds within that barrier measuring 0.3 x 3.2 inches, 0.3 x 3.2 inches, 0.3 x 0.3 inches, 0.3 x 0.8 inches, 0.3 x 0.1 inches. R2's quarterly Minimum Data Set (MDS) dated 10/21/22, identified R2 had moderately impaired cognition and diagnoses of peripheral vascular disease (PVD) (impaired circulation due to narrowed blood vessels to the limbs), diabetes, and two stage three pressure ulcers. R2 was always incontinent of bowel and bladder, required total assistance of two staff for transfers and all ADLs and extensive assistance of two staff with bed mobility. Requested repositioning documentation on 11/7/22, ADON verified NA's did not save their repositioning sheets and therefore they do not have record of when R2 had been repositioned. R2's medical record lacked consistent documentation of repositioning. R2's weekly skin assessments identified: -On 9/29/22, left thigh (rear) had stoma powder with skin prep on per orders. No dressing. -On 10/4/22, the abdominal fold is red and open. No measurements included. -On 10/6/22, one on left gluteal fold healing and three on left thigh rear two resolved and one healing.	F 686	from the Medical Doctor. To further prevent the deficient practice from recurring, Nursing Leadership team will audit TARs, risk management, UDAs and progress notes as part of the morning quality audit. Skin assessments and any skin risks will be reviewed at monthly QAPI as a standing review item on the QAPI agenda beginning in January, 2023. Audits will be completed weekly for 4 consecutive weeks and then monthly for 4 consecutive months, through 05/2-23. Audit results will also be reviewed at QAPI meetings monthly beginning 01/2023 through 05/2023. Correction date of implementation is 12/22/2022.	

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F 686	Continued From page 23 -On 10/11/22, left rear thigh open. -On 10/25/22, left rear thigh and site under both breasts, and no description noted on either sites. -On 11/1/22, left rear thigh- no description. -On 11/8/22, resident does not have any alterations in skin integrity and description box was left blank. -On 11/8/22, at 11:55 a.m. left front thigh - scratch -On 11/15/22, left gluteal fold - no description. R2's weekly skin assessments lacked detailed information regarding skin and wounds. R2's NA Kardex dated 11/18/22, indicated bed mobility and toileting two person assist, peri care with every incontinent episode. R2's Kardex did not identify application of heel protectors. R2's monthly pressure/wound assessments identified: -On 9/15/22, located on left rear thigh were five stage two (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough) wounds identified with measurements of 0.3 inches x 3.2 inches, 0.3 inches x 3.2 inches, 0.3 inches x 0.3 inches, 0.3 inches x 0.8 inches, 0.3 inches x 0.1 inches with a depth on all five 0.1 inches. -On 10/13/22, two stage two pressure ulcers (one on left gluteal fold and one on left thigh) and two scabs located on left rear thigh with measurements of 1.8 inches x 0.5 inches, 3.4. inches 0.3 inches, 0.4 inches x 0 and 0.4 inches. Review of R2's progress notes from 10/1/22 through 10/17/22, revealed: -On 10/5/22, skin/wound note - back of left thigh was cleaned and skin prep applied. Open areas improving no drainage currently.	F 686		

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F 686	Continued From page 24 -On 10/9/22, wound progress note- pressure wound on posterior left thigh, washed with wound cleanser, skin prep and stoma powder. Wound had two new areas that have opened up. -On 10/12/22, wound progress note - pressure wound on posterior left thigh, scant amount of serous drainage, washed with wound cleanser, skin prep and stoma powder applied. -On 11/2/22, skin/wound note - new skin tear to left outer lower extremity no bleeding or drainage from area. -On 11/15/22, skin audit completed and no new abnormalities notes and chronic wound on her left thigh that is still trying to heal. R2's medical record lacked documentation of the wound characteristics, measurements to indicate progress or potential complications towards healing. During an observation on 11/15/22, at 3:20 p.m. R2 laid in bed uncovered with white socks on and heels rested directly on the mattress. NA-B and NA-C applied gloves, stood on each side of the bed, removed the soiled with urine brief, turned R2 from side to side, completed peri cares with wet wipes wiping from front to back, and applied a clean brief. Protective ointment was not applied to R2. NA-B stated she just identified R2 had a new open area in groin area. NA-C stated it was approximately ½ inch long and very narrow and was not open yesterday. NA-B stated R2 also had two open additional pressure ulcers over three months. NA-B also stated the entire width of the upper back thigh was pink in color with two open areas, not deep at all, and no drainage. NA-B indicated it had improved and was better some days than others because nurses applied too much stoma powder. NA-C removed R2's white	F 686		

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F 686	Continued From page 25 socks, identified no redness on heels. NA-A and NA-B removed gloves, sanitized hands and exited the room. R2 laid on her back, was not repositioned, without heel protectors on and heels rested directly on bed mattress. During an observation on 11/15/22, at 3:45 p.m. R2 laid in bed on her back, heels rested directly on the bed mattress without heel protectors on. During an observation on 11/16/22, at 9:11 a.m. licensed practical nurse (LPN)-B applied gloves while R2 laid in bed on her back. LPN-B and nursing assistant (NA)-D positioned R2 onto her left side. LPN-B sprayed upper left thigh wound area with dermal wound cleanser and dabbed it with the 4 by 4 gauze. LPN-B states R2 has two linear lines that are open on the upper back thigh, one is the size of the a fingernail and the bottom one is about 8 to 9 centimeter (cm) long, 1 cm wide, and depth is superficial. LPN-B applied the collagen dressing and then stoma powder to dry it out. LPN-B stated the wound is left open to air because with a dressing applied it got worse. LPN-B also stated the surrounding skin was pink and intact and she has seen a lot of improvement and healing well. R2's heels rested directly on the mattress without heel protectors on. During continuous observations on 11/16/22, at 11:30 a.m., 12:00 p.m., 12:50 p.m., 1:45 p.m., 2:30 p.m., and 3:15 p.m. resident sat up in her wheelchair (3 hours and 45 minutes). During an interview on 11/15/22, at 3:30 pm R2 stated staff took a while to answer her light, sometimes was aware when she had a wet brief, but most times could not. R2 also stated she did not get repositioned to get off her pressure ulcers	F 686		

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F 686	Continued From page 26 like she should, told staff, and was painful to lay in one position for a long time. During an interview on 11/16/22, at 10:07 a.m. assistant director of nursing (ADON) stated pressure/wound assessments are to be completed weekly and was informed one month ago those were to be completed by myself. ADON verified she had not completed the pressure/wound assessments on the following weeks: 10/21/22, 10/28/22, 11/4/22, and 11/11/22. ADON verified the pressure wound assessment were not completed last week and she had not looked at R2's skin for a couple of weeks. ADON indicated the weekly pressure/wound assessments had been completed for only the week of 10/13/22, since she was hired for the ADON position and should have been completed weekly. ADON also stated the weekly skin assessments were being completed by the nursing staff but lacked details. ADON stated the staff nurses are expected to document specifically change in size, odor, drainage amount and color, increase in pain and measure it weekly. ADON stated R2's skin assessment completed on 10/25/22, lacked specific information and she expected the staff nurse to enter a description such as still open or drainage or redness under breasts, in the narrative box and that would have clarified the skin condition. ADON verified R2's weekly assessment completed on 11/8/22, indicated R2 had a scratch on left leg but nothing else was documented. During an interview on 11/16/22, at 1:40 p.m. NA-E stated R2 required total assistance of at least two and sometimes three staff to reposition because she was unable to do it herself. NA-E also stated R2 should be repositioned, check and	F 686		

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F 686	Continued From page 27 changed, and documented at least every two hours due to pressure ulcer located on her left upper backside of thigh. NA-E verified R2 should always have heel protectors on when in bed and they were located on the floor next to the dresser. During an interview on 11/16/22, at 2:30 p.m. NA-G stated we assisted [R2] up into the wheelchair with a lift at 11:30 a.m. and had not been checked and changed or repositioned since 11:30 a.m. (3 hours). NA-G also stated R2 should be repositioned and check and changed at least every two hours due to her pressure ulcer located on her left upper backside of her thigh. NA-G verified she was not aware heel protectors should have been placed on R2 feet and not identified on the NA Kardex. During an interview on 11/16/22, at 2:50 p.m. NA-D stated R2 did not have heel protectors on today and spent a lot of time in bed. NA-D also stated the heel protectors helped relieve pressure off the heels. NA-D verified R2 had been transferred from bed to wheelchair for lunch at 11:30 a.m. and continued to sit up in the dining room at this time (over 3 hours 50 minutes) probably longer than she should have been. NA-D identified R2 should be repositioned every two hours to help prevent skin break down and was not being done. During an interview on 11/17/22, at 11:40 a.m. LPN-B stated R2 had a current pressure ulcer located on her right upper backside thigh area and should be check and changed and repositioned every two hours to help prevent further complications. LPN-B verified R2 had bogginess in her heels and required heel protectors to be worn while in bed to prevent	F 686		

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F 686	Continued From page 28 pressure ulcers as a preventive measure. During an interview on 11/17/22, at 12:20 p.m. director of nursing (DON) verified pressure/wound assessments had not been completed for two to three months, no staff in place doing the wound job, and relied on the staff nurses to initiate it. DON also stated the weekly skin assessments completed by the nurses were done however those assessments lacked information such as what the wound looked like in detail and measurements. DON identified staff nurses needed to be educated on how to improve their documentation regarding weekly skin assessments. DON confirmed on 11/8/22, R2's weekly skin assessment was not documented properly and indicated R2 had no alterations in skin integrity. DON stated staff NAs are expected to document every two hours check and change and repositioning on all residents. DON verified she realized today NAs had not turned in the required documents at the end of each shift for quite a while now. DON indicated the staff nurse would be expected to verify residents were checked and changed and repositioned at the end of each shift. DON indicated staff were expected to check and change and reposition R2 every two hours to prevent the pressure ulcer areas from getting worse. Review of facility policy titled Repositioning dated 5/2013, revealed resident repositioning as an intervention to prevents skin breakdown, promotes circulation, and provides pressure relief. Repositioning is critical for a resident who is immobile or dependent upon staff. Residents in bed should be on at least every two-hour repositioning schedule and residents in a chair should be on every hour repositioning schedule.	F 686		

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F 686	Continued From page 29 Review of facility Pressure Ulcer Injury Risk Assessment dated 7/2017, revealed risk factors that increase a resident's susceptibility to develop or not heal pressure ulcers include the presence of previously healed pressure ulcers are more likely to have recurrent breakdown and impaired/decreased mobility exposure of skin to urinary and fecal incontinence, and decreased functional ability. Review of facility policy titled Pressure Ulcers/Skin Breakdown dated 4/2018, revealed an individual's significant risk factors for developing pressure ulcer include immobility and history of pressure ulcer(s). The nurse would be expected to describe and document a full assessment of pressure sore to include: location, stage, length, width and depth, presence of exudates or necrotic tissue, and resident's mobility status.	F 686		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 9, 2022

Administrator
Glenoaks Senior Living Campus
100 Glen Oaks Drive
New London, MN 56273

Re: State Nursing Home Licensing Orders
Event ID: TX4J11

Dear Administrator:

The above facility was surveyed on November 15, 2022 through November 17, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00314	A. BUILDING: _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENOAKS SENIOR LIVING CAMPUS	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

(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 11/15/22 to 11/17/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be 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	2 000		

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2 000	Continued From page 1 be completed The following complaint was found to be SUBSTANTIATED: H53605775C (MN00088328) with licensing orders issued at 0565 and 0905. 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	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plan interventions were implemented for 2 of 3 residents (R1, R2) reviewed who required staff assistance with activities of daily living (ADLs) including repositioning, application of pressure relieving devices, and assistance with toileting reviewed for incontinence cares and monitoring of skin integrity. In addition, proper positioning of resident receiving a continuous enteral (tube) feeding (R1) reviewed for complications related to enteral feeding. Findings include: R1's quarterly Minimum Data Set (MDS) dated 9/20/22, identified R1 had severely impaired cognition, and diagnoses of traumatic brain injury	2 565	CORRECTED	12/22/22

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2 565	Continued From page 3 and quadriplegia (paralysis of all four limbs). R1 Required total dependence of staff for all ADLs, at risk for pressure ulcers, and received nutritional through an enteral feeding. R1 was frequently incontinent of bladder and had a colostomy (end of colon is brought through the abdominal wall and stool drains into a bag). R1's care plan updated last on 10/4/22, indicated R1 elbow protector applied to right elbow at all times, weekly wound nurse assessment to monitor wound/skin for skin breakdown, healing or changes and skin treatment, document location, size, and treatment of skin injury, the head of bed (HOB) must be upright at least 30 to 45 degrees at all times for all enteral feedings to prevent aspiration, dependent on staff to turn, reposition/out of bed two hours a day to custom wheel chair, check and change every two hours. R1's nursing assistant (NA) current Kardex, undated, identified check and change and reposition every two hours and PRN. R1's Kardex did not identify application of an elbow protector. R1's physician order dated 4/15/22 indicated check elbow protector is in place each shift, off for cleaning/hygiene. R1's physician order dated 5/2/22 indicated keep HOB elevated over 30 degrees at all times every shift. Review of R1's turn and reposition every two hours and as needed (PRN) NA documentation from 11/10/22, through 11/17/22, revealed: 11/10/22, at 9:59 p.m. 11/11/22, at 12:05 a.m., and 8:55 p.m. 11/12/22, at 12:09 a.m. 9:51 p.m., and 11:26 p.m. 11/13/22, at 9:25 p.m. and 11:57 p.m.	2 565		

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2 565	Continued From page 4 11/14/22, at 7:56 p.m. and 11:24 p.m. 11/15/22, no documentation for this day 11/16/22, at 12:40 a.m. and 11:02 p.m. 11/17/22, at 9:59 p.m. Review of R1's bladder elimination/check and change NA documentation from 11/10/22, through 11/17/22, revealed: 11/10/22, at 2:20 a.m., 5:50 a.m., 9:59 p.m., and 11:53 p.m. 11/11/22, at 3:10 a.m., 5:59 a.m., 8:55 a.m., and 11:23 p.m. 11/12/22, at 2:42 a.m., 5:48 a.m., 950 p.m., and 11:15 p.m. 11/13/22, at 2:55 a.m., 5:46 a.m., 9:25 p.m., and 11:35 p.m. 11/14/22, at 2:47 a.m., 5:32 a.m., 7:56 p.m., and 11:11 p.m. 11/15/22, at 3:24 a.m. 11/16/22, at 12:04 a.m., 3:04 a.m., 5:29 a.m., 9:59 p.m., 10:47 p.m. 11/17/22, at 2:57 a.m., and 5:34 a.m. R1's medical record lacked consistent documentation of repositioning and incontinence cares/check and change. During observations on 11/15/22, at 2:30 p.m., 3:00 p.m., and 3:34 p.m. R1 laid in bed awake in the same position with head of bed up approximately 20 degrees with an enteral feeding infusing in by a pump at 60 milliliters per hour (ml/hr). R1' right arm/elbow rested on the bed mattress with a rolled-up towel positioned in right hand. R1 did not have on an elbow protector or pillow placed under his right arm. Two signs, one above the head of the bed and one across the room were posted on the wall in R1's room "keep HOB [head of bed] above 30 degrees" on a pink sheet of paper.	2 565		

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2 565	Continued From page 5 During observations on 11/16/22, at 8:40 a.m., 10:00 a.m., and 11:40 a.m. (3 hours) R1 laid in bed on his back with a pillow placed next to his left side and head of bed up approximately 20 degrees with an enteral feeding infusing by a pump at 60 ml/hr. R1 had an occasional dry cough at 8:40 a.m. R1's right arm/elbow rested on the bed mattress. R1 did not have on an elbow protector on right arm. During an observation/interview on 11/16/22, at 11:56 a.m. licensed practical nurse (LPN)-A, assistant director of nursing (ADON) entered R1's room together. R1's position remained unchanged since 8:40 a.m. (3 hours and 56 minutes). ADON and LPN-A applied gloves and together completed the dressing change on R1's fistula (an abnormal passageway, or tunnel, in the body) site, removed gloves sanitized their hands and ADON and exited the room. LPN-A covered R1 up and lowered entire bed down. LPN-A stated R1 was to be up in the chair for two hours and the nurse aides should be coming in to transfer him soon. R1's head of bed remained up at approximately 20 degrees when LPN-A sanitized her hands and exited the room. During an observation on 11/16/22, at 12:47 p.m. NA-D and NA-G entered R1's room. NA-D pulled back the covers off R1 and lowered the head of the bed flat with tube feeding running in at 60 ml/hr. R1 did not have a right elbow protector in place. NA-D and NA-G verified R1 had been incontinent large about of urine, removed brief, cleaned perineal area, and applied clean brief. NA-D turned R1 onto left side, placed pillow behind his back and a pillow under feet to float heels. At 1:00 p.m. NA-D raised the head of the bed up to approximately 20 degrees. NA-G	2 565		

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2 565	Continued From page 6 confirmed the tube feeding pump did not need to be paused when they placed the head of the bed flat. NA-D and NA-G removed gloves and sanitized hands and exited the room. During an interview on 11/16/22, at 1:54 p.m. LPN-A stated R1 required total assistance of two to turn and reposition and total assistance of one for all ADLs. LPN-A also stated R1 should be check and changed and repositioned every two hours. LPN-A verified R1 had a pressure sore on his right elbow six months ago and elbow protector should be always on while in bed. LPN-A indicated R1's head of bed was to be at 30 degrees but not sure how to determine that, just eyeball it. LPN-A verified she did not know how the NAs knew how to determine if the head of bed was up to where it should be. During an observation/interview on 11/17/22, at 9:00 a.m. LPN-A noted in hallway and stood at the medication cart. Surveyor walked down the hallway and LPN-A immediately entered R1's room. Observed from doorway R1's HOB was positioned just above flat and between ¼ of the way up with enteral feeding infusing in by a pump at 60 ml/hr. LPN-A raised the HOB up to over 30 degrees. LPN-A verified R1's HOB had not been up to over 30 degrees and should have been to prevent aspiration. During an observation on 11/17/22, at 9:09 a.m. LPN-A asked NA-D to come with her into R1's room. LPN-A explained to NA-D R1's HOB should be above 30 degrees at all times to help prevent aspiration and was positioned lower than 30 degrees. LPN-A explained further R1's neck should be positioned above the abdomen to give you an idea of how to determine how high it should be. NA-D verbalized understanding.	2 565		

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2 565	Continued From page 7 During an interview on 11/16/22, at 2:35 p.m. NA-G stated R1 had two signs in his room that indicated the head of bed should be up at least 30 degrees. NA-G stated she assumed R1 could lay flat with the tube feeding running in. NA-G also verified she was unaware R1 should have had an elbow protector on his right arm. During an interview on 11/16/22, at 2:45 p.m. NA-D stated she completed cares on R1 at 8:00 a.m. and not repositioned or check and changed again until 12:47 p.m. (4 hours and 47 minutes). NA-D verified R1 had not been repositioned and checked and changed every two hours like he should have been, this happened daily, and was not documented due to short on time. NA-D also stated she was not aware R1 should have had an elbow protector on his right arm and had never seen one in his room since she started work there 1 ½ months ago. During an interview on 11/17/22 at 11:30 a.m. with LPN-B stated R1 was at risk for aspiration and the head of bed should be up to at least 30 degrees. LPN-B also stated R1 had been at high risk for skin breakdown, dependent on staff for all cares, and does not need new skin issues, therefore should be check and changed and repositioned every two hours. LPN-B verified R1's right elbow protector should be on at all times with a pillow underneath the arm as well to help prevent further breakdown on the skin that had already healed from a previous right elbow pressure ulcer. During an interview on 11/17/22, at 1:45 pm. NA-F stated R1 had two signs in his room on the wall that indicated the head of the bed should be up to at least 30 degrees to help prevent	2 565		

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2 565	Continued From page 8 aspiration. NA-F also stated she had asked the LPN-A how to measure the height and was informed to assure his throat was above stomach to prevent aspiration at all times. R2's quarterly MDS dated 10/21/22, identified R2 had moderately impaired cognition and diagnoses of peripheral vascular disease (PVD) (impaired circulation due to narrowed blood vessels to the limbs), diabetes, and two stage three pressure ulcers. R2 was always incontinent of bowel and bladder, required total assistance of two staff for transfers and all ADLs and extensive assistance of two staff with bed mobility. R2's care plan dated 8/21/22, indicated R2 had impaired skin integrity. R2 should be encouraged to shift weight every two hours due to skin integrity, if able and assist as needed and heel protectors on when in bed. R2 required assist of two staff for bed mobility and toileting. R2's NA Kardex dated 11/18/22, indicated bed mobility and toileting two person assist, peri care with every incontinent episode. R2's Kardex did not identify application of heel protectors. Review of R2's bladder elimination/check and change NA documentation from 11/10/22, through 11/17/22, revealed: 11/10/22, at 2:22 a.m., 5:52 a.m., 9:59 p.m., and 11:56 p.m. 11/11/22, at 3:12 a.m., 5:59 a.m., 8:49 p.m., and 11:23 p.m. 11/12/22, at 2:43 a.m. ,5:46 a.m., 9:00 p.m., and 11:13 p.m. 11/13/22, at 2:47 a.m., 6:47 a.m., and 11:37 p.m. 11/14/22, at 2:49 a.m., 5:33 a.m., 9:03 p.m., and 11:08 p.m.	2 565		

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2 565	Continued From page 9 11/15/22, at 3:36 a.m., 1:01 p.m., and 9:29 p.m. 11/16/22, at 12:16 a.m., 3:06 a.m. 5:31 a.m., 9:37 p.m., and 10:48 p.m. 11/17/22, at 2:58 a.m. and 5:35 a.m. Requested repositioning documentation on 11/7/22, ADON verified NA's did not save their repositioning sheets and therefore they do not have record of when R2 had been repositioned. R2's medical record lacked consistent documentation of repositioning and incontinence cares/check and change. During an observation on 11/15/22, at 3:20 p.m. R2 laid in bed uncovered with white socks on and heels rested directly on the mattress. NA-B and NA-C applied gloves, stood on each side of the bed, removed the soiled with urine brief, turned R2 from side to side, completed peri cares with wet wipes wiping from front to back, and applied a clean brief. Protective ointment was not applied to R2. NA-B stated she just identified R2 had a new open area in groin area. NA-C stated it was approximately ½ inch long and very narrow and was not open yesterday. NA-B stated R2 also had two open pressure ulcers over three months. NA-B also stated the entire width of the upper back thigh was pink in color with two open areas, not deep at all, and no drainage. NA-B indicated it had improved and was better some days than others because there were nurses that applied too much stoma powder. NA-C removed R2's white socks, identified skin on heels without redness. NA-A and NA-B removed gloves, sanitized hands and exited the room. R2 laid on her back, was not repositioned, without heel protectors on and heels rested directly on bed mattress.	2 565		

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2 565	Continued From page 10 During an observation on 11/15/22, at 3:45 p.m. R2 laid in bed on her back, heels rested directly on the bed mattress without heel protectors on. During continuous observations on 11/16/22, at 11:30 a.m., 12:00 p.m., 12:50 p.m., 1:45 p.m., 2:30 p.m., and 3:15 p.m. resident sat up in her wheelchair (3 hours and 45 minutes). During an interview on 11/15/22, at 3:30 pm R2 stated staff took a while to answer her light, sometimes was aware when she had a wet brief, but most times could not. R2 also stated she did not get repositioned to get off her pressure ulcers like she should, told staff, and was painful to lay in one position for a long time. During an interview on 11/16/22, at 1:40 p.m. NA-E stated R2 required total assistance of at least two and sometimes three staff to reposition because she was unable to do it herself. NA-E also stated R2 should be repositioned, check and changed, and documented at least every two hours due to pressure ulcer located on her left upper backside of thigh. NA-E verified R2 should always have heel protectors on when in bed and they were located on the floor next to the dresser. During an interview on 11/16/22, at 2:30 p.m. NA-G stated we assisted [R2] up into the wheelchair with a lift at 11:30 a.m. and had not been checked and changed or repositioned since 11:30 a.m. (3 hours). NA-G also stated R2 should be repositioned and check and changed at least every two hours due to her pressure ulcer located on her left upper backside of her thigh. NA-G verified she was not aware heel protectors should have been placed on R2 feet and not identified on the NA Kardex.	2 565		

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2 565	Continued From page 11 During an interview on 11/16/22, at 2:50 p.m. NA-D stated R2 did not have heel protectors on today and spent a lot of time in bed. NA-D also stated the heel protectors helped relieve pressure off the heels. NA-D verified R2 had been transferred from bed to wheelchair for lunch at 11:30 a.m. and continued to sit up in the dining room at this time (over 3 hours 50 minutes) probably longer than she should have been. NA-D identified R2 should be repositioned every two hours to help prevent skin break down and was not being done. During an interview on 11/17/22, at 11:40 a.m. LPN-B stated R2 had a current pressure ulcer located on her right upper backside thigh area and should be check and changed and repositioned every two hours to help prevent further complications. LPN-B verified R2 had bogginess in her heels and required heel protectors to be worn while in bed to prevent pressure ulcers as a preventive measure. During an interview on 11/17/22, at 12:20 pm with director of nursing (DON) stated staff NAs are expected to document every two hours check and change and repositioning on all residents. DON verified she had realized today NAs did not turn in the required documents at the end of each shift for quite a while now. DON also indicated the staff nurse would be expected to verify residents were checked and changed and repositioned at the end of each shift. DON indicated staff were expected to check and change and reposition R2 every two hours to prevent the pressure ulcer areas from getting worse. Review of facility policy titled Repositioning dated 5/2013, reveled resident repositioning as an intervention to prevents skin breakdown,	2 565		

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2 565	Continued From page 12 promotes circulation, and provides pressure relief. Repositioning is critical for a resident who is immobile or dependent upon staff. Residents in bed should be on at least every two-hour repositioning schedule and residents in a chair should be on every hour repositioning schedule. Review of a facility policy titled Care plans, Comprehensive Care Centered dated 12/2016, a comprehensive, person-centered care plans are developed and implemented services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing. Review of facility Pressure Ulcer Injury Risk Assessment dated 7/2017, revealed risk factors that increase a resident's susceptibility to develop or not heal pressure ulcers include the presence of previously healed pressure ulcers are more likely to have recurrent breakdown and impaired/decreased mobility exposure of skin to urinary and fecal incontinence, and decreased functional ability. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could train all staff to follow each resident's care plan. The DON or designee could then perform random audits to ensure each residents care plan is being followed by all staff. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position	2 905		12/22/22

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2 905	Continued From page 13 of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide consistent assessment, monitoring, and timely repositioning for 1 of 2 resident (R2) reviewed with two stage three (full thickness tissue loss) pressure ulcers. This had the potential to affect 5 other residents who had pressure ulcers. Findings include: R2's care plan dated 8/21/22, indicated R2 had impaired skin integrity and at risk for further skin break down related to diagnosis of diabetes mellitus, and morbid obesity. The care plan included interventions of encourage R2 to shift weight every two hours, heel protectors on when in bed, required assist of two for bed mobility and toileting, apply protective ointment to prevent skin breakdown, and utilize pressure reduction equipment such as cushion to wheelchair, and alternating pressure mattress to bed. The care plan directed staff monitor/document location, size, and treatment of skin injury. Report any abnormalities, failure to heal, and signs and symptoms of infection to physician. Complete weekly skin/treatment documentation in accordance to wound nurse assessment and plan of care recommended.	2 905	CORRECTED	

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2 905	Continued From page 14 R2's physician order dated 8/24/22, change dressing to left thigh three times a day (TID), cleanse site with NS/wound cleanser, pat dry, apply skin prep to surrounding skin and collagen silver and stoma powder. R2's progress note dated 9/22/22, identified R2 had monthly wound/ostomy care (WOC) nurse come and look at wound to her left (L) rear thigh. Site has improved since last visit a month ago. Will continue with current treatment of cleansing site, skin prep, collagen silver and stoma powder to wound bed, and collagen silver to help promote debridement. Overall wound measurements for entire area 2.5 inches x 4 inches. There are five wounds within that barrier measuring 0.3 x 3.2 inches, 0.3 x 3.2 inches, 0.3 x 0.3 inches, 0.3 x 0.8 inches, 0.3 x 0.1 inches. R2's quarterly Minimum Data Set (MDS) dated 10/21/22, identified R2 had moderately impaired cognition and diagnoses of peripheral vascular disease (PVD) (impaired circulation due to narrowed blood vessels to the limbs), diabetes, and two stage three pressure ulcers. R2 was always incontinent of bowel and bladder, required total assistance of two staff for transfers and all ADLs and extensive assistance of two staff with bed mobility. Requested repositioning documentation on 11/7/22, ADON verified NA's did not save their repositioning sheets and therefore they do not have record of when R2 had been repositioned. R2's medical record lacked consistent documentation of repositioning. R2's weekly skin assessments identified: -On 9/29/22, left thigh (rear) had stoma powder	2 905		

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2 905	Continued From page 15 with skin prep on per orders. No dressing. -On 10/4/22, the abdominal fold is red and open. No measurements included. -On 10/6/22, one on left gluteal fold healing and three on left thigh rear two resolved and one healing. -On 10/11/22, left rear thigh open. -On 10/25/22, left rear thigh and site under both breasts, and no description noted on either sites. -On 11/1/22, left rear thigh- no description. -On 11/8/22, resident does not have any alterations in skin integrity and description box was left blank. -On 11/8/22, at 11:55 a.m. left front thigh - scratch -On 11/15/22, left gluteal fold - no description. R2's weekly skin assessments lacked detailed information regarding skin and wounds. R2's NA Kardex dated 11/18/22, indicated bed mobility and toileting two person assist, peri care with every incontinent episode. R2's Kardex did not identify application of heel protectors. R2's monthly pressure/wound assessments identified: -On 9/15/22, located on left rear thigh were five stage two (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough) wounds identified with measurements of 0.3 inches x 3.2 inches, 0.3 inches x 3.2 inches, 0.3 inches x 0.3 inches, 0.3 inches x 0.8 inches, 0.3 inches x 0.1 inches with a depth on all five 0.1 inches. -On 10/13/22, two stage two pressure ulcers (one on left gluteal fold and one on left thigh) and two scabs located on left rear thigh with measurements of 1.8 inches x 0.5 inches, 3.4. inches 0.3 inches, 0.4 inches x 0 and 0.4 inches.	2 905		

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2 905	Continued From page 16 Review of R2's progress notes from 10/1/22 through 10/17/22, revealed: -On 10/5/22, skin/wound note - back of left thigh was cleaned and skin prep applied. Open areas improving no drainage currently. -On 10/9/22, wound progress note- pressure wound on posterior left thigh, washed with wound cleanser, skin prep and stoma powder. Wound had two new areas that have opened up. -On 10/12/22, wound progress note - pressure wound on posterior left thigh, scant amount of serous drainage, washed with wound cleanser, skin prep and stoma powder applied. -On 11/2/22, skin/wound note - new skin tear to left outer lower extremity no bleeding or drainage from area. -On 11/15/22, skin audit completed and no new abnormalities notes and chronic wound on her left thigh that is still trying to heal. R2's medical record lacked documentation of the wound characteristics, measurements to indicate progress or potential complications towards healing. During an observation on 11/15/22, at 3:20 p.m. R2 laid in bed uncovered with white socks on and heels rested directly on the mattress. NA-B and NA-C applied gloves, stood on each side of the bed, removed the soiled with urine brief, turned R2 from side to side, completed peri cares with wet wipes wiping from front to back, and applied a clean brief. Protective ointment was not applied to R2. NA-B stated she just identified R2 had a new open area in groin area. NA-C stated it was approximately ½ inch long and very narrow and was not open yesterday. NA-B stated R2 also had two open additional pressure ulcers over three months. NA-B also stated the entire width of the upper back thigh was pink in color with two open	2 905		

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2 905	Continued From page 17 areas, not deep at all, and no drainage. NA-B indicated it had improved and was better some days than others because nurses applied too much stoma powder. NA-C removed R2's white socks, identified no redness on heels. NA-A and NA-B removed gloves, sanitized hands and exited the room. R2 laid on her back, was not repositioned, without heel protectors on and heels rested directly on bed mattress. During an observation on 11/15/22, at 3:45 p.m. R2 laid in bed on her back, heels rested directly on the bed mattress without heel protectors on. During an observation on 11/16/22, at 9:11 a.m. licensed practical nurse (LPN)-B applied gloves while R2 laid in bed on her back. LPN-B and nursing assistant (NA)-D positioned R2 onto her left side. LPN-B sprayed upper left thigh wound area with dermal wound cleanser and dabbed it with the 4 by 4 gauze. LPN-B states R2 has two linear lines that are open on the upper back thigh, one is the size of the a fingernail and the bottom one is about 8 to 9 centimeter (cm) long, 1 cm wide, and depth is superficial. LPN-B applied the collagen dressing and then stoma powder to dry it out. LPN-B stated the wound is left open to air because with a dressing applied it got worse. LPN-B also stated the surrounding skin was pink and intact and she has seen a lot of improvement and healing well. R2's heels rested directly on the mattress without heel protectors on. During continuous observations on 11/16/22, at 11:30 a.m., 12:00 p.m., 12:50 p.m., 1:45 p.m., 2:30 p.m., and 3:15 p.m. resident sat up in her wheelchair (3 hours and 45 minutes). During an interview on 11/15/22, at 3:30 pm R2 stated staff took a while to answer her light,	2 905		

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2 905	Continued From page 18 sometimes was aware when she had a wet brief, but most times could not. R2 also stated she did not get repositioned to get off her pressure ulcers like she should, told staff, and was painful to lay in one position for a long time. During an interview on 11/16/22, at 10:07 a.m. assistant director of nursing (ADON) stated pressure/wound assessments are to be completed weekly and was informed one month ago those were to be completed by myself. ADON verified she had not completed the pressure/wound assessments on the following weeks: 10/21/22, 10/28/22, 11/4/22, and 11/11/22. ADON verified the pressure wound assessment were not completed last week and she had not looked at R2's skin for a couple of weeks. ADON indicated the weekly pressure/wound assessments had been completed for only the week of 10/13/22, since she was hired for the ADON position and should have been completed weekly. ADON also stated the weekly skin assessments were being completed by the nursing staff but lacked details. ADON stated the staff nurses are expected to document specifically change in size, odor, drainage amount and color, increase in pain and measure it weekly. ADON stated R2's skin assessment completed on 10/25/22, lacked specific information and she expected the staff nurse to enter a description such as still open or drainage or redness under breasts, in the narrative box and that would have clarified the skin condition. ADON verified R2's weekly assessment completed on 11/8/22, indicated R2 had a scratch on left leg but nothing else was documented. During an interview on 11/16/22, at 1:40 p.m. NA-E stated R2 required total assistance of at least two and sometimes three staff to reposition	2 905		

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2 905	Continued From page 19 because she was unable to do it herself. NA-E also stated R2 should be repositioned, check and changed, and documented at least every two hours due to pressure ulcer located on her left upper backside of thigh. NA-E verified R2 should always have heel protectors on when in bed and they were located on the floor next to the dresser. During an interview on 11/16/22, at 2:30 p.m. NA-G stated we assisted [R2] up into the wheelchair with a lift at 11:30 a.m. and had not been checked and changed or repositioned since 11:30 a.m. (3 hours). NA-G also stated R2 should be repositioned and check and changed at least every two hours due to her pressure ulcer located on her left upper backside of her thigh. NA-G verified she was not aware heel protectors should have been placed on R2 feet and not identified on the NA Kardex. During an interview on 11/16/22, at 2:50 p.m. NA-D stated R2 did not have heel protectors on today and spent a lot of time in bed. NA-D also stated the heel protectors helped relieve pressure off the heels. NA-D verified R2 had been transferred from bed to wheelchair for lunch at 11:30 a.m. and continued to sit up in the dining room at this time (over 3 hours 50 minutes) probably longer than she should have been. NA-D identified R2 should be repositioned every two hours to help prevent skin break down and was not being done. During an interview on 11/17/22, at 11:40 a.m. LPN-B stated R2 had a current pressure ulcer located on her right upper backside thigh area and should be check and changed and repositioned every two hours to help prevent further complications. LPN-B verified R2 had bogginess in her heels and required heel	2 905		

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2 905	Continued From page 20 protectors to be worn while in bed to prevent pressure ulcers as a preventive measure. During an interview on 11/17/22, at 12:20 p.m. director of nursing (DON) verified pressure/wound assessments had not been completed for two to three months, no staff in place doing the wound job, and relied on the staff nurses to initiate it. DON also stated the weekly skin assessments completed by the nurses were done however those assessments lacked information such as what the wound looked like in detail and measurements. DON identified staff nurses needed to be educated on how to improve their documentation regarding weekly skin assessments. DON confirmed on 11/8/22, R2's weekly skin assessment was not documented properly and indicated R2 had no alterations in skin integrity. DON stated staff NAs are expected to document every two hours check and change and repositioning on all residents. DON verified she realized today NAs had not turned in the required documents at the end of each shift for quite a while now. DON indicated the staff nurse would be expected to verify residents were checked and changed and repositioned at the end of each shift. DON indicated staff were expected to check and change and reposition R2 every two hours to prevent the pressure ulcer areas from getting worse. Review of facility policy titled Repositioning dated 5/2013, revealed resident repositioning as an intervention to prevents skin breakdown, promotes circulation, and provides pressure relief. Repositioning is critical for a resident who is immobile or dependent upon staff. Residents in bed should be on at least every two-hour repositioning schedule and residents in a chair should be on every hour repositioning schedule.	2 905		

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2 905	Continued From page 21 Review of facility Pressure Ulcer Injury Risk Assessment dated 7/2017, revealed risk factors that increase a resident's susceptibility to develop or not heal pressure ulcers include the presence of previously healed pressure ulcers are more likely to have recurrent breakdown and impaired/decreased mobility exposure of skin to urinary and fecal incontinence, and decreased functional ability. Review of facility policy titled Pressure Ulcers/Skin Breakdown dated 4/2018, revealed an individual's significant risk factors for developing pressure ulcer include immobility and history of pressure ulcer(s). The nurse would be expected to describe and document a full assessment of pressure sore to include: location, stage, length, width and depth, presence of exudates or necrotic tissue, and resident's mobility status. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident Care Plans are followed by staff for timely positioning of residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 905		