DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 8, 2022

Administrator
Meeker Manor Rehabilitation Center, LLC
600 South Davis Avenue
Litchfield, MN 55355

RE: CCN: 245361
Cycle Start Date: September 28, 2022

Dear Administrator:

On November 1, 2022, the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 8, 2022

Administrator
Meeker Manor Rehabilitation Center, LLC
600 South Davis Avenue
Litchfield, MN 55355

Re: Reinspection Results
Event ID: R4SQ12

Dear Administrator:

On November 1, 2022 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 September 28, 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 17, 2022

Administrator
Meeker Manor Rehabilitation Center, LLC
600 South Davis Avenue
Litchfield, MN 55355

RE: CCN: 245361
Cycle Start Date: September 28, 2022

Dear Administrator:

On September 28, 2022, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 1, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 1, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 1, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 1, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Meeker Manor Rehabilitation Center, Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 1, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 28, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

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
	245361	A. BUILDING _____ B. WING _____	C 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEEKER MANOR REHABILITATION CENTER, LLC	600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/26/22 through 9/28/22, 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, Requirments for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H53614764C (MN87045), with a deficiency cited at F686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		9/30/22

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

Electronically Signed | 10/21/2022

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 686	Continued From page 1 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure pressure ulcer management and care were provided to prevent deterioration or development of pressure ulcers for 2 of 3 residents (R2, R4) reviewed for pressure ulcers. This resulted in actual harm for R2 when physician ordered treatments were not followed causing deterioration of the ulcer and delayed healing of a Stage 4 pressure ulcer. Findings include: R2's face sheet was dated 9/27/22 identified R2 was admitted to facility May 2022 with a stage 4 pressure ulcer to her left upper buttock, coccyx area. Stage 4 pressure ulcer is defined as full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. R2's diagnoses list dated 9/27/22, included Stage 4 pressure ulcer to coccyx, Parkinson disease, osteomyelitis (inflammation of the bone or bone marrow due to infection) of sacral region, methicillin resistant staphylococcus aureus (MRSA, type of bacterial infection) and weakness. R2's significant change Minimum Data Set (MDS) dated 7/19/22, indicated that R2 was cognitively intact, required extensive assist of 2 staff for toilet use, and extensive assist of one staff for bed mobility, transfers, walking in room, dressing, personal hygiene, and bathing. R2 had impaired	F 686	F686: Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions in the statement of deficiencies. The facility has appealed the alleged deficiencies and licensing violations. This plan of correction is prepared and executed as a means to continuously promote and improve quality of care and compliance with all applicable state and federal regulatory requirements and constitutes the facility's compliance. In response to the above stated citation the facility has taken the following action(s): • R2 & R4 completed weekly wound assessments. • R2 & R4 care plans were reviewed to ensure accuracy. • Whole facility skin assessments completed, including Weekly Skin Inspection, Braden Scale, & Tissue Tolerance Evaluation. • All appropriate staff to be educated prior to their first shift. • All other residents with noted pressure ulcers were comprehensively assessed by the completion of the Weekly Skin Inspection, Braden Scale, & Tissue Tolerance evaluation. Care plans reviewed & updated as necessary by DON and/or designee. • All admitting residents will have skin	

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F 686	Continued From page 2 range of motion to lower extremities and frequently incontinent of bladder and bowel. Further, the MDS identified R2 had a stage 4 pressure ulcer. Interventions included: pressure relieving devices on bed and in wheelchair, turning and repositioning program, and received pressure ulcer care. R2 care plan dated 5/7/22, identified R2 had a stage 4 pressure ulcer on her coccyx and was at risk for further pressure ulcers. Interventions included: -Monitor skin daily during cares, weekly skin inspection by nurse, treatment to open areas per orders, weekly measurements, and assessment of wound (start date 5/7/22). -Avoid laying on back, monitor dressing every shift for intactness and adherence. Dressing changes Monday, Wednesday, Friday and PRN if soiled. Monitor/document/ report to MD changes to skin status: appearance, color, wound healing, signs and symptoms of infection, wound size and stage. requires supplemental protein, ensure that resident is repositioned every 2-3 hours from side to side to avoid pressure to coccyx (start date 5/18/22). -Requires a pressure reliving mattress on bed. Interventions included pressure redistribution mattress on bed and cushion in chair, weekly assessment and measurements of wound, and hyperbaric oxygen therapy at wound clinic (start date 6/6/22.) R2's undated admission skin concerns document had an outline of a body with an arrow pointing to the coccyx area. The only information indicated on the form was R2 had pressure ulcer that measured 4.0 x 4.0 centimeters (cm) with	F 686	assessed upon admission to identify appropriate plan of care. • DON or designee will audit residents with pressure ulcers five times per week for two weeks, then three times per week for four weeks, then bi-weekly for four weeks, & monthly thereafter for one month. Any deficient practice will be identified & corrected at the time of occurrence. • Results will be reviewed monthly at QAPI to ensure progress. Corrective action will be completed by 12/29/2022.	

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F 686	Continued From page 3 tunneling. R2's Initial wound ostomy consultant (WOC) NP-B visit dated 5/13/22 had wound measuring 2.5 x 1.5 x 2.0 cm with tunneling at 9 o'clock position. R2's record identified on 6/9/22, NP-B made a referral for R2 to be seen in the wound clinic for management of the stage 4 pressure ulcer. R2's record further identified between 5/13/22 to 7/15/22, R2 was seen by NP-B weekly for wound debridement and had three times a week dressing changes. The weekly assessments and the Tissue Tolerance Test form dated 7/19/22 identified R2's pressure ulcer was non-healing. R2's record then identified a new order for wound vac on 7/18/22 and first wound clinic appointment was on 7/22/22. R2's progress note dated 6/16/22, indicated R2 had an MRSA infection in her sacral (coccyx)wound. Subsequent lab report dated 7/11/22, continued to have MRSA infection to R2's wound. Physician order for the wound vac dated 7/18/22 included the following: -wound vac at 125 mm of mercury (Hg) -remove previous adhesive from skin and cleanse wound with VASHE (wound cleaner) and leave VASHE soaked gauze in wound for 3-5 minutes. Pat dry. Apply skin prep around wound and let dry -cut small strip of white foam to pack into tunnel at 9 o'clock and leave tail out -cut approximately one inch round piece of black foam and pack into wound -take a stoma ring and shape to a circle and place around wound	F 686		

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F 686	Continued From page 4 -cut four strips of drape to make a windowpane dressing -change dressing every day shift Monday, Wednesday, and Friday (later changed on 9/7/22 to wound clinic will change dressing on Tuesday's and Friday's at the facility.) During an interview on 9/27/22 at 2:00 p.m. wound clinic registered nurse (RN)-H indicated there were several problems with the facility completing R2's wound vac dressing changes per the physician orders. There were times the facility did not send the correct supplies with R2 for dressing changes and other time when R2 would show up with no dressing at all. RN-H indicated on 8/24/22, R2's treatment orders changed to leave out the white foam, but the facility continued to use it until 9/13/22. RN-H stated there were several phone calls made to the director of nursing (DON) and nursing staff about the dressing change issues. RN-H was not aware of the dates the facility was contacted, but would have been after R2's appointments when an issue was identified. RN-H explained because of the mismanagement by the facility with the three times a week dressing, treatment orders were changed on 9/7/22 to twice weekly with the wound clinic doing one of the dressing changes. RN-H stated the mismanagement slowed down the healing of the R2's ulcer, however after the change there had been improvements to the wound. RN-H stated R2 reported she had no dressing on her wound over this last weekend. R2's Wound clinic visit notes identified the following: -7/22/22, initial visit, unable to do wound vac dressing as proper dressing supplies not sent from facility. Wound measurements were 3.0 x	F 686		

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F 686	Continued From page 5 2.8 x 2.5 cm. Order written for position changes every 1-2 hours. R2's care plan was not revised to reflect 1-2 hour reposition schedule. -8/12/22 wound vac falling off due to large amount of stool under the tape and in the foam and being pulled into the wound vac through the tubing, measurements 3.7 x 2.5 x 2.5 cm. -8/24/22, wound vac not able to be used last several days due to staffing at nursing home, measurements 3.0 x 4.0 x 2.2 cm. -8/31/22, nursing home staff still having issues with getting VAC replaced. Wound clinic has communicated with nursing home multiple times. Wound clinic now to change on days that she sees the provider, once weekly. Wound vac not in place for several days. Measurements 2.8 x 4.5 x 2.2 cm. -9/7/22, dressing changes continue to be an issue with nursing home. Changed dressing to Tuesdays and Fridays, with Tuesdays dressing done at the wound clinic. Did not send the dressing supplies for dressing change. Measurements 3.0 x 3.3 x 2.5 cm. -9/13/22, came in with white foam only in, which was discontinued on 8/24/22. R2 stated she didn't think that dressing had been changed since 9/7/22 until 9/12/22. Measurements 2.1 x 3.3 x 1.5 cm. Wound Vac dressing changes moved to Tuesdays and Fridays. R2's care plan was not revised to reflect the change to appointments. -9/20/22, no wound vac supplies were sent with R2 to appointment. Measurements 2.5 x 4 x 1.5 cm. -9/27/22, arrived with stool in VAC. Measurements 2.2 x 2.5 x 1.5 cm. During an observation on 9/27/22, at 9:40 a.m. R2 laid in her bed, nursing assistant (NA)-D was assisting R2 with personal morning hygiene	F 686		

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F 686	Continued From page 6 cares. NA-D assisted R2 to roll to her left side, NA-D removed the incontinent garment. The wound vac dressing was clean and appropriately placed on R2's coccyx. The wound vac settings were also observed to be correct according to physician order. During an interview on 9/27/22, at 10:00 a.m. R2 stated she received hyperbaric oxygen therapy five days a week. R2 indicated she was able to make slight position changes alone however needed assistance from staff to make major changes. R2 indicated staff did not come to assist her with position changes every 1-2 hours and she usually had to call for them to help her reposition. R2 stated she had pain during the dressing changes, would ask for medications, but did not always receive them. During an interview on 9/26/22, at 4:20 p.m. RN-B articulated R2 was seen by the wound clinic for dressing changes on Tuesday's and on Friday's the wound vac dressing was changed by the facility staff. RN-B indicated they were unaware of any concerns pertaining to the wound vac dressing changes done by the facility. RN-B further indicated nursing would notify the DON first then RN-B if there had been any issues. Attempt was made to contact R2's physician on 9/27/22 at 2:00 p.m., a return call was not received. During an interview on 9/27/22, at 4:20 p.m. director of nursing (DON) stated it was expected wound cares were completed as ordered by NP or physician. DON indicated the facility licensed staff did wound vac training about a year to year and half ago and had two nurses who were very	F 686		

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F 686	Continued From page 7	F 686		

proficient. DON stated she had become aware the wrong dressings were being used about two weeks ago. The right order was put into the computer and the white foam dressing were removed from R2's room.

Even though the wound clinic notes in the R2's record identified from 7/22/22 to 9/27/22 indicated ongoing issues with the wound vac such as the wrong dressing was applied, fecal matter in the wound vac, foam dressing was pulled in through the tubing, and the wound vac was not in place.

R4
R4's diagnosis listing dated 9/27/22, included Type 2 diabetes, morbid obese, and history of chronic venous ulcers to his both legs.

Review of R4's Braden assessment (risk assessment for development of PU) dated 8/5/22, identified R3 was at mild risk for developing pressure ulcers.

R4's quarterly Minimum Data Set (MDS) dated 8/5/22, indicated that R2 was cognitively intact, required extensive assist of two staff for bed mobility and transfers, extensive assist of one staff for dressing, toilet use, personal hygiene. The MDS identified R4 was occasionally incontinent of bladder and frequently incontinent of bowel. R2 was at risk for pressure ulcers and had moisture associated skin damage (MASD). R4 required pressure reducing device on bed and wheelchair and received non-surgical dressing changes with ointments/medication applied to other areas besides feet.

R4's tissue tolerance test (TTT- the ability of the skin and its supporting structures to endure the

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	245361	A. BUILDING _____ B. WING _____	C 09/28/2022

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F 686	Continued From page 8 effects of pressure, without adverse effects) assessment dated 5/7/22 identified R4 was able to make major position changes himself but did not always do so. The form identified staff were to prompt R4 to turn and reposition every 2-3 hours and as needed and encourage R4 to get up in wheelchair. Review of R4's care plan dated 4/7/21, indicated that R4 had an alteration skin integrity; with open area to right lower leg and history of lower leg ulcer. History of refusing cream for dry skin and liquid protein supplement. Interventions included: -Monitor skin for breakdown and signs/symptoms of infection and report to physician -Document on skin condition and keep physician informed of changes -Monitor skin integrity daily during cares, weekly skin inspection by nurse -Risk and benefits completed for refusal of turning and repositioning (dated 4/20/21), -Prompt to turn and reposition every 2-3 hours and PRN and assist as needed (dated 4/7/21) Review of R4's weekly skin inspections and notes from NP-B from 8/22/22 through 9/22/22 identified R4 had developed a deep tissue pressure injury to buttocks. -Weekly skin inspection dated 8/22/22, indicated R4 had a 1.0 x 1.5 centimeter (cm) on his left buttock that was deep red to purple in color that was not open. Ointment applied, pillows placed under hips, and weight offloaded. -Physician visit dated 8/25/22, nurse practitioner (NP)-B identified left buttock deep tissue injury measuring 1.0 x 1.5 x 0 cm. (Deep tissue injury is defined as intact skin with localized area of	F 686		

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F 686	Continued From page 9 persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface) The note directed staff to monitor for friction during repositioning and to to keep clean and dry due to incontinence. Treatment order: cleans, pat dry, and apply Calmoseptime (ointment to prevent and heal skin irritations) to area twice daily and as needed. -Weekly pressure wound note dated 9/2/22, NP-B identified left buttock was healed and closed. Continue treatment. -Weekly skin inspection dated 9/22/22 indicated no skin concerns. R4's record lacked weekly monitoring of the skin to ensure the area remained healed. R4's record lacked a comprehensive pressure ulcer assessment that identified risk factors including decreased mobility, medication that impaired healing, co-morbities, refusals/rejection of care and treatment, cognitive status, incontinence status, nutrition and hydration, and pressure points for turning and reposition needs. Continuous observation on 9/27/22 that started at 10:20 a.m. and ended 1:20 p.m. identified R3 was not turned/repositioned for almost 3 hours with a resulting red area on his right hip. -At 10:20 a.m. R4 was laid in his bed on his right side with his call light within reach. Head of bed elevated to approximately 60 degrees. -At 10:35 a.m. R4 continued to lay in the same position. -At 11:05 a.m. R4 put his call light on. Nursing assistant (NA)-C entered R4's room, emptied the	F 686		

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F 686	Continued From page 10 urinal, and provided gave R4 a pack of crackers. NA-C did not offer or encourage R4 to change positions. -At 11:20 a.m. R4 continued to lay in the same position. -At 11:35 a.m. R4 continued to lay in the same position as he talked on his cell phone. -At 11:44 a.m. R4 continued to lay in the same position on his right side. NA-D entered R4's room and emptied R4's urinal. NA-D did not prompt, offer, or encourage R4 to reposition -At 12:00 p.m. unknown housekeeper entered R4's room. R4 conversed with the housekeeper while remaining on his right side. Between 12:01 p.m. and 12:27 p.m. R4 continued to lay on his right side in the same position. -At 12:27 p.m. NA-D took lunch tray into R4's room and placed the tray on the bedside table. NA-D asked R4 if he needed anything else. After R4 stated "no", NA-D left the room without attempting or offering to reposition R4 off his right side. R4 laid on his right side while eating his lunch. -At 12:45 p.m. R4 was done eating his lunch. At 12:55 p.m. unknown kitchen staff member entered R4's room and removed the tray. -At 1:15 p.m. NA-D was not aware of when R4 had last been repositioned. NA-D entered R4's room, NA-D asked R4 to reposition to his back which he was able to do. NA-D pulled the pillow out from right hip area. R4's right hip had a red area the size of a softball. The red area had indentations about ¼ inch deep where he had been laying on the wrinkles of his bedding. During an interview on 9/26/22, at 1:05 p.m. R4 stated he did not think he had been out of bed in the past year because he had bad hips and knees that were painful. R4 indicated he laid on	F 686		

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F 686	Continued From page 11 his right side because his left hip and knee hurt worse than the right. R4 stated he was able to turn himself with the assist of the positioning bar over his bed. R4 stated that he has had open areas on his bottom in the past, but did not think he had any open areas currently. R4 indicated that staff did not prompt or remind him to reposition, he would use the positioning bar when he wanted to move. During an interview on 9/27/22, at 11:08 a.m. NA-C stated staff would wash R4 up daily, turn and reposition him every two hours, and empty his urinal. NA-C indicated R4 would sometimes refuse cares but staff would go back and re-approach. During an interview on 9/27/22, at 11:45 a.m. NA-D stated R4 was supposed to be repositioned every two to three hours. NA-D stated sometimes they would put calmoseptime lotion on his bottom; he did not have any open areas. During an interview on 9/27/22, at 3:40 p.m. licensed practical nurse (LPN)-A indicated R4 was at risk for pressure ulcers. R4 sometimes refused cares, but staff would go back and re-approach R4. LPN-A stated R4 usually would allow staff to perform tasks o the second approach. LPN-A indicated refusals were supposed to be documented. During an interview on 9/28/22, at 1:30 p.m. RN-B indicated a tissue tolerance test was completed on R4 today; RN-B indicated the reddened area to R4's right hip had resolved since identified yesterday (9/27/22). During an interview on 9/27/22, at 4:00 p.m.	F 686		

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F 686	Continued From page 12 director of nursing (DON) reviewed R4's record and verified that R4 was missing some weekly skin assessments. It was her expectation that they were completed. DON also indicated that she usually reviews the weekly skin inspection documentation weekly but did not keep a record of her audits. When asked about how they get the time frame for repositioning DON stated from the Tissue Tolerance Test (TTT) done yearly. DON stated that R4 was already on an air mattress and that R4 did not always cooperate with his cares, but expected staff to attempt and document refusals. Facility policy Skin Assessment and Wound Management policy dated 5/27/22, included 5) a weekly skin inspection will be completed by licensed staff. Pressure Wounds, New Skin Problem: when a pressure ulcer is identified, the following actions will be taken; 1) notify MD/treatment ordered, 3) complete education with resident/resident representative including risks and benefits, 4) initiate weekly pressure wound evaluation, update care plan. The policy did not address modality's for pressure ulcer prevention, did not addressing identification or staging, following physician orders, wound vacs, nor direction for completing comprehensive assessments.	F 686		

Electronically delivered
October 17, 2022

Administrator
Meeker Manor Rehabilitation Center, LLC
600 South Davis Avenue
Litchfield, MN 55355

Re: State Nursing Home Licensing Orders
Event ID: R4SQ11

Dear Administrator:

The above facility was surveyed on September 26, 2022 through September 28, 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:

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

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

Please feel free to call me with any questions.

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

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2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure pressure ulcer management and care were provided to prevent deterioration or development of pressure ulcers for 2 of 3 residents (R2, R4) reviewed for pressure ulcers. This resulted in actual harm for R2 when physician ordered treatments were not followed causing deterioration of the ulcer and delayed healing of a Stage 4 pressure ulcer. Findings include: R2's face sheet was dated 9/27/22 identified R2 was admitted to facility May 2022 with a stage 4 pressure ulcer to her left upper buttock, coccyx area. Stage 4 pressure ulcer is defined as full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament,	2 900	Corrected.	9/30/22

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

Electronically Signed | | 10/21/22

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2 900	Continued From page 1 cartilage or bone in the ulcer. R2's diagnoses list dated 9/27/22, included Stage 4 pressure ulcer to coccyx, Parkinson disease, osteomyelitis (inflammation of the bone or bone marrow due to infection) of sacral region, methicillin resistant staphylococcus aureus (MRSA, type of bacterial infection) and weakness. R2's significant change Minimum Data Set (MDS) dated 7/19/22, indicated that R2 was cognitively intact, required extensive assist of 2 staff for toilet use, and extensive assist of one staff for bed mobility, transfers, walking in room, dressing, personal hygiene, and bathing. R2 had impaired range of motion to lower extremities and frequently incontinent of bladder and bowel. Further, the MDS identified R2 had a stage 4 pressure ulcer. Interventions included: pressure relieving devices on bed and in wheelchair, turning and repositioning program, and received pressure ulcer care. R2 care plan dated 5/7/22, identified R2 had a stage 4 pressure ulcer on her coccyx and was at risk for further pressure ulcers. Interventions included: -Monitor skin daily during cares, weekly skin inspection by nurse, treatment to open areas per orders, weekly measurements, and assessment of wound (start date 5/7/22). -Avoid laying on back, monitor dressing every shift for intactness and adherence. Dressing changes Monday, Wednesday, Friday and PRN if soiled. Monitor/document/ report to MD changes to skin status: appearance, color, wound healing, signs and symptoms of infection, wound size and stage. requires supplemental protein, ensure that	2 900		

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2 900	Continued From page 2 resident is repositioned every 2-3 hours from side to side to avoid pressure to coccyx (start date 5/18/22). -Requires a pressure reliving mattress on bed. Interventions included pressure redistribution mattress on bed and cushion in chair, weekly assessment and measurements of wound, and hyperbaric oxygen therapy at wound clinic (start date 6/6/22.) R2's undated admission skin concerns document had an outline of a body with an arrow pointing to the coccyx area. The only information indicated on the form was R2 had pressure ulcer that measured 4.0 x 4.0 centimeters (cm) with tunneling. R2's Initial wound ostomy consultant (WOC) NP-B visit dated 5/13/22 had wound measuring 2.5 x 1.5 x 2.0 cm with tunneling at 9 o'clock position. R2's record identified on 6/9/22, NP-B made a referral for R2 to be seen in the wound clinic for management of the stage 4 pressure ulcer. R2's record further identified between 5/13/22 to 7/15/22, R2 was seen by NP-B weekly for wound debridement and had three times a week dressing changes. The weekly assessments and the Tissue Tolerance Test form dated 7/19/22 identified R2's pressure ulcer was non-healing. R2's record then identified a new order for wound vac on 7/18/22 and first wound clinic appointment was on 7/22/22. R2's progress note dated 6/16/22, indicated R2 had an MRSA infection in her sacral (coccyx)wound. Subsequent lab report dated 7/11/22, continued to have MRSA infection to R2's wound.	2 900		

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2 900	Continued From page 3 Physician order for the wound vac dated 7/18/22 included the following: -wound vac at 125 mm of mercury (Hg) -remove previous adhesive from skin and cleanse wound with VASHE (wound cleaner) and leave VASHE soaked gauze in wound for 3-5 minutes. Pat dry. Apply skin prep around wound and let dry -cut small strip of white foam to pack into tunnel at 9 o'clock and leave tail out -cut approximately one inch round piece of black foam and pack into wound -take a stoma ring and shape to a circle and place around wound -cut four strips of drape to make a windowpane dressing -change dressing every day shift Monday, Wednesday, and Friday (later changed on 9/7/22 to wound clinic will change dressing on Tuesday's and Friday's at the facility.) During an interview on 9/27/22 at 2:00 p.m. wound clinic registered nurse (RN)-H indicated there were several problems with the facility completing R2's wound vac dressing changes per the physician orders. There were times the facility did not send the correct supplies with R2 for dressing changes and other time when R2 would show up with no dressing at all. RN-H indicated on 8/24/22, R2's treatment orders changed to leave out the white foam, but the facility continued to use it until 9/13/22. RN-H stated there were several phone calls made to the director of nursing (DON) and nursing staff about the dressing change issues. RN-H was not aware of the dates the facility was contacted, but would have been after R2's appointments when an issue was identified. RN-H explained because of the mismanagement by the facility with the three times a week dressing, treatment orders were	2 900		

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2 900	Continued From page 4 changed on 9/7/22 to twice weekly with the wound clinic doing one of the dressing changes. RN-H stated the mismanagement slowed down the healing of the R2's ulcer, however after the change there had been improvements to the wound. RN-H stated R2 reported she had no dressing on her wound over this last weekend. R2's Wound clinic visit notes identified the following: -7/22/22, initial visit, unable to do wound vac dressing as proper dressing supplies not sent from facility. Wound measurements were 3.0 x 2.8 x 2.5 cm. Order written for position changes every 1-2 hours. R2's care plan was not revised to reflect 1-2 hour reposition schedule. -8/12/22 wound vac falling off due to large amount of stool under the tape and in the foam and being pulled into the wound vac through the tubing, measurements 3.7 x 2.5 x 2.5 cm. -8/24/22, wound vac not able to be used last several days due to staffing at nursing home, measurements 3.0 x 4.0 x 2.2 cm. -8/31/22, nursing home staff still having issues with getting VAC replaced. Wound clinic has communicated with nursing home multiple times. Wound clinic now to change on days that she sees the provider, once weekly. Wound vac not in place for several days. Measurements 2.8 x 4.5 x 2.2 cm. -9/7/22, dressing changes continue to be an issue with nursing home. Changed dressing to Tuesdays and Fridays, with Tuesdays dressing done at the wound clinic. Did not send the dressing supplies for dressing change. Measurements 3.0 x 3.3 x 2.5 cm. -9/13/22, came in with white foam only in, which was discontinued on 8/24/22. R2 stated she didn't think that dressing had been changed since 9/7/22 until 9/12/22. Measurements 2.1 x 3.3 x	2 900		

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2 900	Continued From page 5 1.5 cm. Wound Vac dressing changes moved to Tuesdays and Fridays. R2's care plan was not revised to reflect the change to appointments. -9/20/22, no wound vac supplies were sent with R2 to appointment. Measurements 2.5 x 4 x 1.5 cm. -9/27/22, arrived with stool in VAC. Measurements 2.2 x 2.5 x 1.5 cm. During an observation on 9/27/22, at 9:40 a.m. R2 laid in her bed, nursing assistant (NA)-D was assisting R2 with personal morning hygiene cares. NA-D assisted R2 to roll to her left side, NA-D removed the incontinent garment. The wound vac dressing was clean and appropriately placed on R2's coccyx. The wound vac settings were also observed to be correct according to physician order. During an interview on 9/27/22, at 10:00 a.m. R2 stated she received hyperbaric oxygen therapy five days a week. R2 indicated she was able to make slight position changes alone however needed assistance from staff to make major changes. R2 indicated staff did not come to assist her with position changes every 1-2 hours and she usually had to call for them to help her reposition. R2 stated she had pain during the dressing changes, would ask for medications, but did not always receive them. During an interview on 9/26/22, at 4:20 p.m. RN-B articulated R2 was seen by the wound clinic for dressing changes on Tuesday's and on Friday's the wound vac dressing was changed by the facility staff. RN-B indicated they were unaware of any concerns pertaining to the wound vac dressing changes done by the facility. RN-B further indicated nursing would notify the DON first then RN-B if there had been any issues.	2 900		

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	00775	A. BUILDING: _____ B. WING _____	09/28/2022

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2 900	Continued From page 6 Attempt was made to contact R2's physician on 9/27/22 at 2:00 p.m., a return call was not received. During an interview on 9/27/22, at 4:20 p.m. director of nursing (DON) stated it was expected wound cares were completed as ordered by NP or physician. DON indicated the facility licensed staff did wound vac training about a year to year and half ago and had two nurses who were very proficient. DON stated she had become aware the wrong dressings were being used about two weeks ago. The right order was put into the computer and the white foam dressing were removed from R2's room. Even though the wound clinic notes in the R2's record identified from 7/22/22 to 9/27/22 indicated ongoing issues with the wound vac such as the wrong dressing was applied, fecal matter in the wound vac, foam dressing was pulled in through the tubing, and the wound vac was not in place. R4 R4's diagnosis listing dated 9/27/22, included Type 2 diabetes, morbid obese, and history of chronic venous ulcers to his both legs. Review of R4's Braden assessment (risk assessment for development of PU) dated 8/5/22, identified R3 was at mild risk for developing pressure ulcers. R4's quarterly Minimum Data Set (MDS) dated 8/5/22, indicated that R2 was cognitively intact, required extensive assist of two staff for bed mobility and transfers, extensive assist of one staff for dressing, toilet use, personal hygiene. The MDS identified R4 was occasionally	2 900		

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2 900	Continued From page 7 incontinent of bladder and frequently incontinent of bowel. R2 was at risk for pressure ulcers and had moisture associated skin damage (MASD). R4 required pressure reducing device on bed and wheelchair and received non-surgical dressing changes with ointments/medication applied to other areas besides feet. R4's tissue tolerance test (TTT- the ability of the skin and its supporting structures to endure the effects of pressure, without adverse effects) assessment dated 5/7/22 identified R4 was able to make major position changes himself but did not always do so. The form identified staff were to prompt R4 to turn and reposition every 2-3 hours and as needed and encourage R4 to get up in wheelchair. Review of R4's care plan dated 4/7/21, indicated that R4 had an alteration skin integrity; with open area to right lower leg and history of lower leg ulcer. History of refusing cream for dry skin and liquid protein supplement. Interventions included: -Monitor skin for breakdown and signs/symptoms of infection and report to physician -Document on skin condition and keep physician informed of changes -Monitor skin integrity daily during cares, weekly skin inspection by nurse -Risk and benefits completed for refusal of turning and repositioning (dated 4/20/21), -Prompt to turn and reposition every 2-3 hours and PRN and assist as needed (dated 4/7/21) Review of R4's weekly skin inspections and notes from NP-B from 8/22/22 through 9/22/22 identified R4 had developed a deep tissue pressure injury to buttocks.	2 900		

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2 900	Continued From page 8 -Weekly skin inspection dated 8/22/22, indicated R4 had a 1.0 x 1.5 centimeter (cm) on his left buttock that was deep red to purple in color that was not open. Ointment applied, pillows placed under hips, and weight offloaded. -Physician visit dated 8/25/22, nurse practitioner (NP)-B identified left buttock deep tissue injury measuring 1.0 x 1.5 x 0 cm. (Deep tissue injury is defined as intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface) The note directed staff to monitor for friction during repositioning and to to keep clean and dry due to incontinence. Treatment order: cleans, pat dry, and apply Calmoseptime (ointment to prevent and heal skin irritations) to area twice daily and as needed. -Weekly pressure wound note dated 9/2/22, NP-B identified left buttock was healed and closed. Continue treatment. -Weekly skin inspection dated 9/22/22 indicated no skin concerns. R4's record lacked weekly monitoring of the skin to ensure the area remained healed. R4's record lacked a comprehensive pressure ulcer assessment that identified risk factors including decreased mobility, medication that impaired healing, co-morbities, refusals/rejection of care and treatment, cognitive status, incontinence status, nutrition and hydration, and pressure points for turning and reposition needs. Continuous observation on 9/27/22 that started at 10:20 a.m. and ended 1:20 p.m. identified R3 was not turned/repositioned for almost 3 hours with a resulting red area on his right hip.	2 900		

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2 900	Continued From page 9 -At 10:20 a.m. R4 was laid in his bed on his right side with his call light within reach. Head of bed elevated to approximately 60 degrees. -At 10:35 a.m. R4 continued to lay in the same position. -At 11:05 a.m. R4 put his call light on. Nursing assistant (NA)-C entered R4's room, emptied the urinal, and provided gave R4 a pack of crackers. NA-C did not offer or encourage R4 to change positions. -At 11:20 a.m. R4 continued to lay in the same position. -At 11:35 a.m. R4 continued to lay in the same position as he talked on his cell phone. -At 11:44 a.m. R4 continued to lay in the same position on his right side. NA-D entered R4's room and emptied R4's urinal. NA-D did not prompt, offer, or encourage R4 to reposition -At 12:00 p.m. unknown housekeeper entered R4's room. R4 conversed with the housekeeper while remaining on his right side. Between 12:01 p.m. and 12:27 p.m. R4 continued to lay on his right side in the same position. -At 12:27 p.m. NA-D took lunch tray into R4's room and placed the tray on the bedside table. NA-D asked R4 if he needed anything else. After R4 stated "no", NA-D left the room without attempting or offering to reposition R4 off his right side. R4 laid on his right side while eating his lunch. -At 12:45 p.m. R4 was done eating his lunch. At 12:55 p.m. unknown kitchen staff member entered R4's room and removed the tray. -At 1:15 p.m. NA-D was not aware of when R4 had last been repositioned. NA-D entered R4's room, NA-D asked R4 to reposition to his back which he was able to do. NA-D pulled the pillow out from right hip area. R4's right hip had a red area the size of a softball. The red area had	2 900		

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2 900	Continued From page 10 indentations about ¼ inch deep where he had been laying on the wrinkles of his bedding. During an interview on 9/26/22, at 1:05 p.m. R4 stated he did not think he had been out of bed in the past year because he had bad hips and knees that were painful. R4 indicated he laid on his right side because his left hip and knee hurt worse than the right. R4 stated he was able to turn himself with the assist of the positioning bar over his bed. R4 stated that he has had open areas on his bottom in the past, but did not think he had any open areas currently. R4 indicated that staff did not prompt or remind him to reposition, he would use the positioning bar when he wanted to move. During an interview on 9/27/22, at 11:08 a.m. NA-C stated staff would wash R4 up daily, turn and reposition him every two hours, and empty his urinal. NA-C indicated R4 would sometimes refuse cares but staff would go back and re-approach. During an interview on 9/27/22, at 11:45 a.m. NA-D stated R4 was supposed to be repositioned every two to three hours. NA-D stated sometimes they would put calmoseptime lotion on his bottom; he did not have any open areas. During an interview on 9/27/22, at 3:40 p.m. licensed practical nurse (LPN)-A indicated R4 was at risk for pressure ulcers. R4 sometimes refused cares, but staff would go back and re-approach R4. LPN-A stated R4 usually would allow staff to perform tasks o the second approach. LPN-A indicated refusals were supposed to be documented. During an interview on 9/28/22, at 1:30 p.m.	2 900		

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2 900	Continued From page 11 RN-B indicated a tissue tolerance test was completed on R4 today; RN-B indicated the reddened area to R4's right hip had resolved since identified yesterday (9/27/22). During an interview on 9/27/22, at 4:00 p.m. director of nursing (DON) reviewed R4's record and verified that R4 was missing some weekly skin assessments. It was her expectation that they were completed. DON also indicated that she usually reviews the weekly skin inspection documentation weekly but did not keep a record of her audits. When asked about how they get the time frame for repositioning DON stated from the Tissue Tolerance Test (TTT) done yearly. DON stated that R4 was already on an air mattress and that R4 did not always cooperate with his cares, but expected staff to attempt and document refusals. Facility policy Skin Assessment and Wound Management policy dated 5/27/22, included 5) a weekly skin inspection will be completed by licensed staff. Pressure Wounds, New Skin Problem: when a pressure ulcer is identified, the following actions will be taken; 1) notify MD/treatment ordered, 3) complete education with resident/resident representative including risks and benefits, 4) initiate weekly pressure wound evaluation, update care plan. The policy did not address modality's for pressure ulcer prevention, did not addressing identification or staging, following physician orders, wound vacs, nor direction for completing comprehensive assessments. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure	2 900		

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2 900	Continued From page 12 ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		