Electronically delivered
November 29, 2022

Administrator
Edenbrook Of Rochester
1875 19th Street Northwest
Rochester, MN 55901

RE: CCN: 245409
Cycle Start Date: November 10, 2022

Dear Administrator:

On November 10, 2022, a survey was completed at your facility by the Minnesota Department(s) 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 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 December 14, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 14, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 14, 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.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

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 December 14, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Edenbrook Of Rochester will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 14, 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 May 10, 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:

Steven.Delich@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION (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

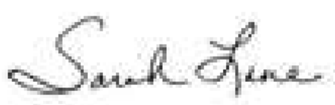
You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	C 11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 11/8/22, through 11/10/22, 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 complaints were found to be SUBSTANTIATED: H54095587C (MN88097), with a deficiency cited at F725, F686, and F880. H54095660C (MN85144) and H54095737C (MN84396) were substantiated with a deficiency cited at F755. The following complaints were found to be unsubstantiated: H54095525C (MN88056) and H54095736C (MN87021). 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	F 686		12/8/22

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

Electronically Signed | 12/01/2022

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 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a comprehensive pressure ulcer assessment, implement care plan interventions, follow physician orders to promote healing and/or reduce the risk of deterioration for 2 of 3 residents (R6 and R12) that had current pressure ulcers. The facility's failure resulted in harm to R6 who developed a stage 3 pressure ulcer after admission. Findings include: Stage 1 Pressure Injury: Non-blanchable erythema (redness) of intact skin Intact skin with a localized area of non-blanchable erythema (redness). Stage 2 Pressure Ulcer: Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis,	F 686	• Resident R6: placed back on an air mattress and new wheelchair cushion placed. • Resident R12: implemented floating heels. • Residents with Braden Scores less than 19 have the potential to be affected. • House wide skin sweep completed on 11/9/2022 to verify current wounds in the building. • Residents identified at risk (Braden Scores less than 19) were reviewed for surfaces to ensure surfaces in place to decrease the risk of obtaining a new pressure injury or of worsening an existing pressure injury. • Wound rounds completed on 12/2/2022 with wound nurse and wound provider to validate accurate staging of all current wounds. • Education: o Licensed nursing staff educated on the need to ensure preventative interventions are put into place for pressure injury prevention for residents at potential risk as defined by a Braden Score of less than 19, to ensure interventions are in place to decrease the	

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F 686	Continued From page 2 intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable PU/PI (pressure ulcer/pressure injury). Deep Tissue Pressure Injury (DTPI): Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure ulcer. Once a deep tissue injury opens to an ulcer, reclassify the ulcer into the appropriate stage. Skin Tears: acute wounds that result from a mechanical force such as shearing or friction or a traumatic injury such as from a fall.	F 686	risk of a pressure injury worsening and following provider orders. Validation of understanding of education completed with a quiz. • Audits: weekly audits of 5 residents per week to be completed x 3 months to ensure residents at risk for pressure injuries have interventions in place and provider orders are in place. • Responsible Party: Director of Nursing/designee	

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F 686	Continued From page 3 R6's face sheet dated 11/8/22, identified R6 had diagnoses of diabetes type II, chronic kidney disease, and heart failure. R6's significant change minimum data set (MDS) dated 10/12/22, indicated R6 was severely cognitively impaired, required extensive 1-2 person assist with most cares. MDS indicated R6 was total dependence on staff for hygiene and toileting, and was always incontinent of bowel and bladder. Further the MDS identified R6 was at risk for pressure ulcers, did not have pressure ulcers and/or any skin impairments. Skin treatments included pressure reducing cushions for chair and bed. No other interventions were identified. R6's progress note dated 10/14/22 indicated the physician was notified of the following: R6 had a new sacral injury that measured 1.3 cm x 1.0 cm., 100% epithelial tissue. Skin surrounding the wound was reddened, fragile with raised edges. Photo was obtained for monitoring. R6's MDS note dated 10/18/22, at 11:28 a.m., indicated R6 was completely incontinent of bowel and bladder, was currently checked and changed in bed. R2 had a stage 2 on his coccyx that had been noted on 10/14/22. R6's skin integrity care plan focus dated 10/27/22, identified R6 had alteration in skin integrity related to impaired mobility and bowel and bladder incontinence. Associated interventions dated 10/14/22 included: -Complete dressing changes as ordered -Position my body with pillows/support devices,	F 686		

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F 686	Continued From page 4 and protect bony prominence's -Turn and reposition every two hours per particular tolerance and schedule. On 10/18/22, intervention identified R6 had a ulcer to coccyx (stage not identified) see treatment administration record. On 10/24/22 intervention was air mattress to be added. R6 skin/wound note dated 10/27/22, at 4:32 p.m., Identified R6 had a skin tear to left buttock caused from full body mechanical lift sling removal. New interventions included put an air mattress on R6's bed. The note did not include measurements and/or further assessment of the skin impairment. Corresponding photo dated 10/27/22 identified a pink area on sacral/coccyx area which was identified as resolved. Left buttock had an open wound approximately size of quarter. The wound bed was deep red in color with no skin flap visible in the photo. The skin surrounding the wound was excoriated or consistent with moisture associated skin damage. R6's record lacked a comprehensive wound assessment of the skin impairment identified as a skin tear. Additionally R6's care plan was not revised to reflect the resolution of the stage 2 pressure ulcer. An additional skin integrity focus was added to the care plan that identified the left buttock skin tear. R6's care plan included additional skin integrity care plan focus dated 10/27/22, identified R6 had a skin tear to left buttock. Associated interventions dated 10/27/22 included: -Air mattress -Toileting program initiated : check change approximately every two hours during wake hours	F 686		

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F 686	Continued From page 5 and every 3 hours at night. -Turn and repositioning approximately every 2 hours when in bed, approximately every hour when in wheelchair. -Administer treatments as ordered. -Assess/monitor the alteration in skin integrity and document status weekly. -11/3/22 intervention; new dressing change orders received. R6's wound evaluation dated 11/3/22 identified R6 had a new skin tear to left buttock that measured 2.7 cm x 3.0 cm. with attached edges that appeared flush. Wound bed had slough (dead skin), 10% granulation tissue present (new connective tissue that forms on wound surfaces during healing process) and was pink or red. Surrounding wound was red, and fragile. Further identified wound as improving and healable. Interventions used included: mattress with pump, turning and repositioning program, and moisture barrier and control. R6's left buttock wound order dated 11/3/22, directed to clean wound with cleanser, pat dry, apply Medi honey (honey fiber) to wound bed. Then apply Duoderm to buttocks skin tear. The dressing was to be changed on the evening shift on Mondays and Fridays or sooner if it falls off or was soiled. During an observation on 11/8/22, at 8:27 a.m. R6 laid in his bed on his back. R6's mattress was not an air mattress in accordance with the care plan dated 10/27/22 or the skin evaluation dated 11/3/22. At 10:28 a.m. unknown staff members assisted R6 to his wheelchair. During a continuous observation on 11/8/22, that	F 686		

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F 686	Continued From page 6 began at 2:02 p.m. and ended at 3:17 p.m. R6 sat in his wheelchair without offers/attempts to reposition/offload R6 in accordance with the care plan. -At 2:02 p.m. R6 sat in his wheelchair, self-propelling down the hallway. -At 2:33 p.m. R6 continued to sit in his wheelchair in the same position in the sunroom at a table with a puzzle. -At 2:55 p.m. administrator pushed R6 back to his room. -At 2:57 p.m. R6 self-propelled his wheelchair out of his room and an unidentified staff member pushed R6 back to the sunroom. -At 3:12 p.m. R6 sat at the puzzle table and unidentified staff member put his glasses on. -From 3:15 p.m. to 3:17 p.m. R6 observed self-propelling around tables in the sunroom. During an interview on 11/8/22, at 3:24 p.m. NA-A indicated after R6 was up in his chair at 10:30, she had repositioned R6 after lunch, it was about two hours ago around 1:30 p.m. (three hours after R6 was up in his chair). NA-A explained she completed the repositioning by moving R6 around a little bit by the mechanical lift sling that he was sitting on. NA-A demonstrated the action with her arms; action was that of moving back and forth or side to side. NA-A's demonstration would not alleviate pressure to R6's buttock area. On 11/8/22, at 3:29 p.m. NA-A and NA-E observed doing personal cares on R6 in bed. NA-A stated she needed to apply barrier cream and stated she would go to the nurse and get the cream and be right back. R6's right sacral area of redness approximately size of quarter. Coccyx was excoriated with superficial open slit. Right outer gluteal fold (buttock) was excoriated	F 686		

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F 686	Continued From page 7 /peeling. Left buttock had an open wound between quarter and half dollar sized. Wound periphery was reddened with surrounding excoriation/peeling skin on the buttock/gluteal fold. R6 stated,"OWW, OWW!" as NA's cleaned the areas excoriation where the skin was peeling and red. When NA-A was done wiping, with same gloves on, she applied barrier cream to the wound. Then with the same gloves on she applied a bordered dressing to the wound. NA-E asked NA-A if she should be applying the dressing rather than the nurse. NA-A replied, "yes, the nurse told me to go ahead and put it on, so I am." Staff removed gloves, did not perform hand hygiene, and left room. R6's progress note dated 11/8/22, indicated as of 10/10/22, R6 wounds have resolved except a new wound found to right buttock-will await update to recommend supplementation. Registered dietician (RD) recommends increased magic cup to 4 ounces twice per due to decreased appetite. Discontinue Prostat (sugar free liquid protein often used for wound healing) due to resolved skin tears, pressure injury as of 10/6/22. R6's record did not identify measurements of the wound after 11/3/22. During an interview on 11/8/22, at 4:00 p.m., nurse manager (NM) indicated R6 had a history of wounds on his bottom. NM stated R6's wound on sacrum was first evaluated on 10/14/22 and had measurements 1.27cm x 1.03cm and had resolved on 10/27/22 by the physician. On 10/27/22 the new wound (skin tear) was identified however that measured 3.91 cm x 2.56 cm.; total surface area was 7.06 cm. On 11/3/22 measurements of wound were 2.73cm x 2.95cm;	F 686		

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F 686	Continued From page 8 total surface area 6.18 cm. NM stated staff should follow R6's care plan; he should be offloaded every hour when in a wheelchair by using a pillow or such. NM stated it was definitely not appropriate to shift a sling under a resident because it would not remove the pressure from the wound. NM stated nursing assistance (NA) were not to complete dressing changes as they do not have the education on assessing and it was out of their scope. During an interview on 11/9/22, at 9:34 a.m. administrator and director of nursing indicated they had identified the nurse had indeed delegated the task of wound care to the NA and had given the wrong directions. Education to staff was provided. Additionally, facility also provided job description to staff and what to do if they were directed to complete tasks out of their scope of practice. During an interview on 11/10/22, at 1:34 p.m. wound doctor (WD) stated R6 spent a lot of time in his wheelchair and R6 was bony and susceptible to pressure ulcers. WD stated he had not seen R6's wound last week but had seen the wound today; he debrided the wound as much as R6 would tolerate. Wound measured 0.1 and 1.4 cm, width was 1.8 cm. There was 80% slough, 10% granulation tissue, and 10% other with a little drainage. WD stated the wound had gotten smaller in the surface area than what he had seen previously. The skin impairment was caused by skin tear and the bias from that was pressure related as well as he (R6) did have fragile skin (shearing wound caused by pressure). WD stated the wound was (currently) stage III pressure ulcer because it had some depth to it. WD indicated treatment was xeroform (medicated	F 686		

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F 686	Continued From page 9 gauze dressing) and mepilex with border (foam dressing). WD explained R6 should be repositioned in his wheelchair every one hour and every two hours while in bed, additionally should have an air mattress. R12 R12's Admission record indicated R12 was admitted on 11/3/22, with diagnoses that included left femur fracture, diabetes with diabetic polyneuropathy (damage to nerves), and stage 3 pressure ulcer of the left heel. R12's admission Minimum Data Set (MDS) dated 11/9/22, identified R12 to be cognitively intact and had no rejection of cares exhibited. R12 required extensive assistance of two or more staff for toileting, bed mobility, transfers, and required extensive assistance of one staff for hygiene. MDS also identified R12 was at risk for pressure ulcers and had one stage 1 pressure ulcer. Skin and ulcer treatments included: pressure reducing device for chair and bed, along with pressure ulcer care. R12's hospital After Visit Summary (AVS) dated 11/3/22, identified R12 was admitted to the hospital with a femur fracture after a fall that required surgical intervention. Details of hospital stay identified R12 had a history of left heel ulcer from 8/8/22 hospitalization and indicated R12 had current left heel healing stage 3 that was treated with Santyl (enzymatic debrider ointment used for debriding dermal ulcers and aid in wound healing) to area covered with Mepilex (absorbent foam dressing) heel. Addition interventions were Prevalon boots (have a cushioned bottom that	F 686		

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F 686	Continued From page 10 floats the heel off the surface of the mattress, helping to reduce pressure) when lying or sitting to help protect. R12's right heel was intact but at risk (for skin breakdown) just like her left. Assessment and plan for pressure ulcer of left heel stage 3 included, "unable to assess today, nursing to evaluate upon admission." R12's medical record lacked a comprehensive skin assessment upon admission to the facility as directed by the hospital summary. Further even though the hospital summary directed to use Santyl, R12's physician orders directed to use zinc-based cream, which is not an enzymatic debrider. Physician order dated 11/4/22, indicated apply zinc-based cream to left posterior heel and change daily. R12's record did not identify an order to discontinue the Santyl and/or why there was a change to the treatment as identified by the hospital discharge summary. R12's Baseline care plan, signed 11/4/22, indicated R12 was at risk for alteration in skin integrity related to obesity, decreased mobility and dependence on staff. Interventions: float my heels or use heel suspension boots while I am in bed and keep my skin clean and dry. The baseline care plan indicated current skin integrity issues to include scratches/rash on right wrist, pressure injury left heel, surgical incision of left hip/thigh, and left shin scratches. R12's progress note, dated 11/4/22, at 8:44 p.m. indicated R12 complained of left heel pain. Mepilex applied. Skin dry and intact. R12's record did not include further assessment that identified source of pain, color, and texture (bogg/firm) of skin, and interventions used to relieve pain.	F 686		

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F 686	Continued From page 11 During observation and interview on 11/8/22, at 8:55 a.m. R12 laid in her bed on her back with both of her heels directly on the bed. Both heels had a dressing around the bottom wrapped with gauze and secured with tape; the dressings were undated. R12 stated she used to have a pressure ulcer on her left heel that she got in the hospital a while back. R12 explained she thought her dressings were supposed to be changed daily, however, no one had changed her dressing in a few days. She was not aware if the treatment had changed. R12 stated staff did not come in and help her to reposition in the bed and was not aware she was supposed to call for assistance and/or reposition. R12 indicated no one ever offers and/or puts her leg up on a pillow like they did in the hospital. R12 explained she usually just laid in bed; she worked with therapy and sometimes therapy would get her up. R12's November treatment administration record (TAR) identified physician order to apply zinc based cream to heel and cover with mepilex daily. The TAR indicated R12's treatment to heel was completed from 11/5/22 to 11/10/22, however did not include description of R12's heel or wound. Additionally, TAR identified R12 had diabetic foot check completed on the night shift from 11/3/22 to 11/10/22, however, did not address R12's skin integrity to her heel. During an observation and interview on 11/8/22, at 2:13 p.m. R12 laid in bed on her back covered with a sheet. R12 stated she did not get the dressing on her left heel changed yet. R12 stated she had been in bed all day, and no one had offered to reposition her or offer to put a pillow	F 686		

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F 686	Continued From page 12 under her leg. R12's heels were directly on the mattress and not floated. R12's pressure relieving boots were observed to be on the shelf at the end of her bed. During an observation and interview on 11/8/22, at 2:21 p.m. licensed practical nurse (LPN)-B stated because they were short staffed last night (11/7/22) she had not changed R12's heel dressing per physician orders. Instead, she reinforced the dressing with a gauze wrap. LPN-B walked to R12's room and verified R12's heels were not offloaded (floated) per the care plan. Further LPN-B did not offer and/or attempt to float R12's heels, place pressure relieving boots on her or offer to reposition. LPN-B indicated R12 refused to wear the pressure relieving boot because she thought it caused the pressure ulcer, no one has followed-up with therapy about the boot, and thought someone should do that. Although, R12's hospital discharge summary and base line care plan dated 11/4/22, directed to offload pressure from R12's heel and use pressure relieving boot, R12's TAR did not identify the directive or order until 11/10/22. The order included offload heel with Prevalon boots and wear Darco shoe outside. Float heel when sitting with pillows to keep heel pressure free every shift for pressure injury (ulcer) of left heel stage 3. A progress note dated 11/5/22 indicated R12 refused interventions, and on 11/9/22 identified R12's heels were offloaded, the facility did not consistently implement interverventions to prevent pressure ulcers. During an observation on 11/8/22, at 3:02 p.m. LPN-B removed R12's dressing to her left heel	F 686		

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F 686	Continued From page 13 and verified the dressing was not dated. The back of R12's left heel (Achilles tendon area) was observed; heel had a rectangular butterfly shaped open wound that had small red dots on the wound bed, approximately 1.0 inch by 2.5 inch, no surrounding redness. Above the wound there was an area of dry skin, no areas scabbing were observed over or surrounding the wound. LPN-B looked at the Mepilex and stated, there was a small amount of serous drainage (watery discharge that is pale yellow and transparent) on it. While LPN-B removed the dressing there was a distinct pungent foul odor which LPN-B verified. LPN-B looked at the wound on the back of left heel and stated it was open. LPN-B explained she did not think it was open before, but since there was drainage on the dressing it must have been open. LPN-B measured area on left heel; announced measurements of 5.0 cm x 3.0 cm. Stated she was going to clean the area with soap and water and have the wound nurse look at it prior to applying the zinc and Mepilex. During an observation and interview on 11/8/22, at 3:22 p.m. Nurse manager (NM) verified he was the wound nurse for the facility. NM explained a wound specialist (WD) was at the facility every Thursday. On Thursdays, residents were brought to the treatment room where they used a computer application to take pictures of the wound. WD would complete assessments, obtain measurements, and ensure treatments were appropriate. NM entered R12's room and looked at R12's left heel- Achilles tendon area. NM stated the left heel was definitely open with multiple red pinpoint areas located across the wound base. NM stated the wound was most likely from pressure. NM measured the wound; he reported results of 3.6 cm x 4.0 cm which	F 686		

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F 686	Continued From page 14 were inconsistent with LPN-B's measurements. NM explained there was nothing on her heel upon admission on 11/3/22. The area had some dry skin around it and was not open. As NM was touching R12's left heel he asked R12 if she could feel his hand. R12 closed her eyes and stated she could not feel it. NM stated for now he would cleanse the area with wound cleanser and apply a Mepilex and call the doctor to see what he wants to do with this. NM then put a pillow under R12's left leg so that the heel was off the bed. R12 allowed this without any rejection and/or refusals. R12's physician notification note, dated 11/8/22, at 4:46 p.m. included background of pressure ulcer to R12's left posterior (back) heel. Assessment included: posterior heel has a hard scab to previous pressure ulcer (documentation of a "hard scab" was inconsistent with observation at 3:22 p.m.). Upon evaluation on this day, the site measured 4.0 cm x 3.0 cm (Length x Width) to peri wound site appears with multiple pinpoint red areas. Old dressing had light serous drainage. Updated orders requested, currently using zinc barrier cream, site is dry. R12's progress note dated, 11/9/22, at 9:49 a.m. indicated a new order of Arginaid (Powder nutritional supplement drink mix that promotes the healing of pressure ulcers) two times a day to aid in wound healing related to pressure ulcer of the left heel. R12's progress note dated, 11/9/22, at 3:20 p.m. response from physician notification was, "continue to follow wound MD." R12's progress note dated 11/9/22, at 7:34 p.m.	F 686		

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F 686	Continued From page 15 included Mepilex to bilateral heels in place, left heel pressure injury present at this time. R12's admission MD visit dated 11/10/22, identified history of R12's left heel wound however, however did not identify current staging. The note included the following treatment orders and interventions: cleanse the wound with wound cleanser, pat dry, cover the wound bed with Mepilex. Change daily and as needed if soiled. [R12] to offload heel with Prevalon boots and wear Darco shoe outside. Float heel when sitting with pillows to keep heel pressure free. Nutritional consult with goal to improve nutritional status for wound healing. Any acute changes between visits should be documented and communicated ASAP (as soon as possible) to provider: a new wound or a change, if there is new or worsening drainage from a wound, redness, swollen or painful to the touch, if wound changes from pink or red to a tan or brown or black color, if development of fever or wound odor gets worse. Document and alert provider if patient declined repositioning or dressing change. During an observation and interview on 11/10/22, at 9:56 a.m. R12 laid on her back in her bed, heels were not offloaded/floated. R12's left heel had a Mepilex dressing placed underneath her heel but was not secured. R12 stated a doctor had just looked at her heel and no one has offered/attempted to offload her heel yet today. R12's weekly skin assessment dated 11/10/22, indicated left heel had blanchable redness measuring 6.5 cm x 4.0 cm. Further identified left heel pressure ulcer was a suspected deep tissue injury (SDTI) measuring 1.9 cm x 1.5 cm. Above blanchable redness surrounds the SDTI. The	F 686		

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F 686	Continued From page 16 SDTI area is non-blanchable purple appearance, skin intact. During a phone interview on 11/10/22, at 12:27 p.m. WD stated he had not had a chance to review R12's medical records yet. WD explained R12 had told him she had the pressure ulcer on her left heel since August. WD indicated he had assessed R12's wound today; measured 1.4 cm x 1.9 cm. The new treatment orders will be to apply Betadine (antiseptic liquid, put on minor wounds, cuts, abrasions or burns that helps reduce the risk of developing an infection) and a Mepilex dressing. WD further explained R12 would need to float her heels with a pillow or use the boots. Facility policy entitled, Pressure Injury Prevention and Wound care management, dated 8/26/2018, revised 4/27/21, stated that the policy was created for the facility to ensure that a resident who is admitted without a pressure injury does not develop a pressure injury, unless clinically unavoidable, a resident who has pressure injury will receive care and services to promote healing and to prevent additional ulcers. Policy indicates to refer to dressing change policy and procedure for dressing changes. Education provided to nursing staff on 11/8/22 and 11/9/22, indicated wound care MUST be performed by a licensed nurse. A licensed nurse cannot delegate wound care to certified nursing assistant (CNA) staff. This is outside their scope of practice. Any CNA staff being asked by a licensed nurse to complete wound care on a resident is to notify the Nurse Manager/Charge Nurse/Director of Nursing immediately and not follow the direction of the licensed nurse related	F 686		

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F 686	Continued From page 17 to the wound care.	F 686		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure sufficient staffing was available in order to provide timely assistance with personal cares according to the residents' assessed need and as directed by the	F 725	• Resident R12: validated that the call light is now working. • Resident R9: applied wrapping to legs as ordered. • Resident R16: offering to get up at	12/8/22

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F 725	Continued From page 18 care plan. This practice had to the potential to effect 4 of 4 residents (R12, R9, 16, R4) who interviewed. Findings include: See F686- Based on observation, interview and document review, the facility failed to complete a comprehensive pressure ulcer assessment, implement care plan interventions, follow physician orders to promote healing and/or reduce the risk of deterioration for 2 of 3 residents (R12 and R6) that had current pressure ulcers. The facility's failure resulted in harm to R6 who developed a stage 3 pressure ulcer after admission. Resident observations and interviews: R12 R12's admission Minimum Data Set (MDS) dated 11/9/22, identified R12 to be cognitively intact. R12 required extensive assistance of two or more staff for toileting, bed mobility, transfers, and required extensive assistance of one staff for hygiene. During observation and interview on the East Hall on 11/8/22, at 8:55 a.m. R12 laid in her bed on her back with both of her heels directly on the bed. Both heels had a dressing around the bottom wrapped with gauze and secured with tape; the dressings were undated. R12 explained she thought her dressings were supposed to be changed daily, however, no one had changed her dressing in a few days. R12 stated staff did not come in and help her to reposition in the bed and was not aware she was supposed to call for assistance and/or reposition. R12 explained she usually just laid in bed; she worked with therapy	F 725	preferred time as resident allows. • Resident R4: reviewed pain medication times with provider for any needed changes. • All residents have the potential to be affected by this deficient practice. • The Guardian Angel Program and Staff Rounding Program implemented by 12/7/2022. These programs proactively solicit feedback from residents and staff and checks patient / resident room for housekeeping, infection control, safety etc. These programs observe and follow up on issues. The facility will complete rounding with staff to identify any barriers to providing care for the residents and follow up on the concerns. • Facility is also actively hiring additional staff: Facility's staffing model continues to aim at what would be considered a 4 out of 5 stars per CMS 5-star rating for staffing. Most recent PBJ reporting included total nurse hours, RN hours, CNA hours, and total nurse staff per resident per day on the weekend hours at or above the national average. • Education: o IDT Managers have been educated on the guardian angel program and staff rounding program on 12/1/2022. o Facility staff have been educated on sufficient staffing and what it means to be aware of and meet all the residents' needs including but limited to person centered care ADL's, nail/shaving care, infection control safety, and call light timely response. Validation of understanding of education completed with a quiz.	

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F 725	Continued From page 19 and sometimes therapy would get her up. R12 stated sometimes staff would answer call lights right away, other times it would take 20 minutes or more. About three days ago, R12 had "to go in my diaper because it took them so long to get to me. I just couldn't wait anymore." During an observation and interview on 11/10/22, at 9:56 a.m. R12 was noted to be lying on her back in her bed, heels were not offloaded. R12 stated no one has offered to offload her heel yet today. R12 reported she had a tantrum this morning when her call light was on for way over 45 minutes. R12 stated she had to "pee" so bad. R12 put down her head, stated to make matters worse, she had started banging her cup on the table to get help. "I feel like I acted like a child". R12 indicated she felt ashamed and embarrassed and never thought she would have to resort to banging a cup on the table to get help. R12 explained she had thought her call light was not working so her roommate (R16) put on her call light too. R12 indicated she did make it to the bathroom in time; explained the aides run ragged but she should not have to wait that long. R9 R9's significant change MDS dated 10/12/22, identified R9 did not have cognitive impairment. R9 required extensive assistance from one staff for toileting and personal hygiene. During an interview on the West Hall, on 11/8/22, at 2:38 p.m. R9 stated the facility was short staffed. R9 pointed at her legs and stated her legs did not get wrapped like they were supposed and at least twice a week they were no wrapped. R9 explained when her legs were not wrapped, her legs feel heavy and get swollen. Both of R9's	F 725	• Audits: o Guardian Angel Interviews will be completed with 5 residents weekly x 3 months o Guardian Angel rounding sheets will be completed with 5 residents weekly x 3 months. o Staff rounding will be completed with 5 staff members weekly x 3 months. o Results of the interviews and rounding sheets (resident and staff) will be reviewed in the morning meeting to address any concerns identified. o Call light response time audits will be completed 5 x week x 1 month, then 3 x week x 2 months o The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs • Responsible Party: LNHA/designee	

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F 725	Continued From page 20 legs were observed to be swollen and without wraps on. R16 R16's significant change MDS dated 10/14/22 identified R9 did not have cognitive impairment. R16 required extensive assistance from one staff for transfers, dressing, toileting, and hygiene. During an interview on 11/10/22, at 9:56 a.m. R16 was noted to be lying in her bed in a facility gown. R16 stated she had to put her call light to help R12 because she had to go to the bathroom so bad. R16 stated it took them over 45 minutes to answer it. R16 explained there was not enough staff, there was usually only one aide working down this hallway. R16 further explained sometimes there was not an aide and the nurse had to do everything herself. R16 reported she liked to be up by 7:30 a.m. before she gets her breakfast, however, has not gotten out of bed yet today and still sitting in her night gown. R16 indicated she did not complain about getting up because she wanted to make sure residents who cannot speak for themselves gets the care, they need first. R16 stated maybe they need to start doing the 100-dollar bonuses for their staff like they did last year. "I don't know what the hell is going on here, but it is plain ridiculous." R4 R4's significant change MDS dated 10/17/22 identified R4 did not have cognitive impairment. R4 required extensive assistance from one staff for toileting and supervision for bed mobility, hygiene, and dressing. During an interview on 11/10/22, at 10:37 a.m. R4 was seated at the edge of her bed in her room.	F 725		

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F 725	Continued From page 21 R4 explained she used to be a nursing assistant and a staff coordinated for 25 years and was familiar with staffing patterns and problems. R4 thought there was approximately 18 other residents on the hallway she resided on. R4 stated the facility was lacking in staff really bad; that was probably a reason they gave her the wrong insulin. R4 reported when you guys (state surveyors) are in the building staffing is better, but then when surveyors leave it is bad. R4 explained her pain medication was usually an hour late but could tolerate it. She was more worried about other residents who could not speak for themselves. R4 stated on this hallway there was only one aide and one nurse with a lot of full body mechanical lift transfers that required two aides. R4 explained if there was only one aide working, then a nurse would have to be pulled from what she was doing and that was not good. R4 stated she had complained to the nurses about the staffing; the nurse's response was they will not schedule anymore and they were doing the best they could. Staff's concerns: During an interview on 11/8/22, at 8:31 a.m. nursing assistant (NA)-F, was observed to be passing out breakfast trays to rooms. NA-F stated she was the only aide scheduled for the North hallway and would be responsible for providing cares to all 16 residents. NA-F explained she needed to wash, toilet, reposition and transfer all the residents in addition to help anyone that that required assistants with eating. NA-F reported R14 and R15's call lights had been on for awhile (time unknown); she still needed to get them done yet. NA-F stated she did not always get everyone up that wanted to be up in their chair or out to the dining room for breakfast.	F 725		

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F 725	Continued From page 22 NA-F indicated there were always a lot of call lights going off and if there was another aide we could get everything done. During an interview on 11/8/22, at 10:18 a.m. NA-A stated the facility was short staffed. She was the only aide scheduled today for the East Hall wing for 18 residents. NA-A explained she was responsible to get all 18 residents cares done and get them all up. NA-A reported right now, the nurse for this hallway is on break along with the only NA scheduled for the West hallway. Making her responsible for watching over 30 residents and watching for call lights. She still had to get R6 up yet. NA-A further explained when there was only one aide schedule, she could not get the 9-10 residents that required repositioning done on time. During an interview on 11/8/22, at 2:03 pm, licensed practical nurse (LPN)-A stated, last night she worked her assigned unit by herself until 6:00 p.m. when a nurse manager was mandated to stay to work as an aide. LPN-A indicated when she worked by herself there were safety concerns. LPN-A reported because she had to work the hall by herself a lot of stuff did not get done and it was not fair to the residents. Subsequent interview at 2:28 p.m. LPN-A stated, she did not get R12's dressing on her heel changed last night, we were too short staffed, she did reinforce the dressing. During an interview on the East Hall on 11/8/22, at 2:45 p.m. licensed practical nurse (LPN)-A reported the day shift nurse did not have time to replace R12's lidocaine patch (pain patch) on her leg, so it was passed along to her. The patch should be put on early in the morning.	F 725		

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F 725	Continued From page 23 During an interview on 11/10/22, at 10:28 a.m. LPN-C stated there was only one aide on their wing with 18 residents to care for. It would be better with 2 aides. We do not have enough staff to care for the residents we have now, but they keep filling beds. LPN-C reported residents complained to her daily about staffing and long call lights. She has brought these concerns forward several times and nothing changed. Administration tells us there is adequate staff and are even overstaffed. LPN-C explained inadequate staff leads to medication errors, care was being rushed, cares like toileting and repositioning did not get completed according to the care plan. It's a safety hazard. During an interview on 11/8/22 at 9:53 a.m. registered nurse (RN)-A stated on this hallway most of the resident's required assistance from two staff to transfer; we only have one NA down here. Because of not having adequate staff, we can not get everyone out of bed at a normal time in the morning. RN-A stated she kept saying more staff were needed more staff, however the reply has been because of the number of residents, more staff hours could be cut. Call light logs were requested and not received. Staff schedule was requested from 11/8/22 to 11/10/22 and was not received. Facility Assessment that was provided was not current; last updated 4/20/21, and was last reviewed by quality assurance on 10/14/21. Further, the assessment was missing even pages, which included the facility staffing information.	F 725		

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F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure resident medication was not preset until the administration of medication for 5 of 5 residents (R7, R8, R9,	F 755	• Resident R7: nurse educated on not pre-setting medications. • Resident R8: nurse educated on not pre-setting medications.	12/8/22

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F 755	Continued From page 25 R10 and R11) who were observed during a medication pass. Findings include: During an observation on 11/8/22, at 9:18 a.m. licensed practical nurse (LPN)-A, pulled open the top drawer of the West Hall medication cart, where 5 clear plastic medication cups were stacked on top of each other and observed to have several pills in each cup with two different letters written in black marker on the side of each cup. LPN-A stated, she always presets the medications. LPN-A removed the top med cup with R7's initials; LPN-A was unable to articulate what medications were in the cup. LPN-A looked up the physician order on the medication administration record (MAR) and compared it with the R7's cards of medications in the lower drawer. The cup contained 10 pills: pantoprazole 40 milligrams (mg), risperidone 1 mg, venlafaxine extended release (ER) tablet 150 mg tablets (2 tablets) and 37.5 mg (1 tablets), metformin HCL tablet 500 mg (2), gabapentin 300 mg, and sennoside-docusate sodium tablet 8.6-50 mg (2 tablets). After verifying the medications LPN-A then walked to R7's room and administered the medications per physician's orders. During an observation on 11/8/22, at 9:25 a.m. LPN-A removed another med cup from cart drawer, stated these pills were for R8. LPN-A was unable to articulate what the medications in the cup were. LPN-A looked up the physician order on the medication administration record (MAR) and compared it with the R8's cards of medications in the lower drawer. The cup contained 5 pills: azithromycin 250 mg tablet, hydrochlorothiazide 12.5 mg tablet, metoprolol	F 755	• Resident R9: nurse educated on not pre-setting medications. • Resident R10: nurse educated on not pre-setting medications. • Resident R11: nurse educated on not pre-setting medications. • All residents have the potential to be affected by this deficient practice. • Education: o Licensed nurses and TMA staff educated on the need to ensure the 6 rights of Medication Administration are followed and ensure medications are not pre-set up. o New facility and agency licensed nurse and TMA staff will also be educated on the 6 rights of Medication Administration being followed and ensuring medications are not pre-set up. o Validation of understanding of education completed with a quiz. • Audits: Weekly audits will be completed x 3 months to ensure medications are not being pre-set up for residents. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs • Responsible party: Director of Nursing/Designee	

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F 755	Continued From page 26	F 755		

succinate ER 100 mg tablet, and hydralazine tablet two 10 mg tablets. After verifying the medications LPN-A walked into R8's room and administered the medications per physician order.

During an observation on 11/8/22, at 9:29 a.m. LPN-A removed another med cup from the cart drawer, stated these pills were for R9. LPN-A was unable to articulate what the medications in the cup were. LPN-A looked up the physician order on the MAR and compared it with the R9's cards of medications in the lower drawer. The cup contained 7 pills: atorvastatin calcium 20 mg tablet, calcium carbonate vitamin D3 500mg-200 international units (IU) tablet (2 tablets), coenzyme Q10 100 mg tablet (2 tablets), losartan potassium 25mg tablet, and duloxetine 30 mg delayed release capsule. After verifying the medications, LPN-A then walked into R9's room and administered the medications per physician order.

During an observation on 11/8/22, at 9:36 a.m. LPN-A removed another med cup from the med cart drawer, stated these pills are for R10, and was unable to articulate what the medications in the cup were. LPN-A looked up the physician order on the MAR and compared it with the R10's cards of medications in the lower drawer. The cup contained 6 pills: Centrum Silver 400mg-250 mcg chewable tablet, duloxetine 60 mg delayed release capsule, lisinopril 2.5 mg tablet, calcium carbonate vitamin D3 600mg-400 IU tablet, and acetaminophen 500 mg (2) tablets. After verifying the medications, LPN-A then walked into R10's room and administered the medications per physician order.

During an observation on 11/8/22, at 9:45 p.m.

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F 755	Continued From page 27	F 755		

LPN-A removed another med cup out of the med cart drawer, stated these pills are for R11, was unable to articulate what the medications in the cup were. LPN-A looked up the physician order on the MAR and compared it with the R10's cards of medications in the lower drawer. The cup contained 10 pills: escitalopram 20 mg tablet, glipizide 5mg tablet, prednisone 5 mg tablet, bupropion HCL ER 300 mg tablet, apixaban 5mg tablet, calcium carbonate 600 mg tablet, gabapentin 300 mg capsule (2 capsules), levetiracetam 1000 mg tablet, and buspirone 5mg tablet. After verifying the medications, LPN-A then walked into R11 ' s room and administered the medications per physician order.

During an interview on 11/8/22, at 9:52 a.m. LPN-A verified she should not have preset the resident medications and stated it can increase the risk of medication errors.

During an interview on 11/8/22, at 10:09 a.m. director of nursing (DON) stated it was not appropriate to preset medications as it increases the risk of medication errors.

During an interview on 11/10/22, at 11:32 a.m. consultant pharmacist (CP)-A stated, it is not good practice to preset medications as it increases the risk of medication errors. CP-A further stated they typically do a medication pass review once a year. CP-A could not remember the last time they did one and stated, it sounds like a good idea to do one now especially if they were presetting medications.

Facility policy, titled, "Policy and Procedure Administering Medications," revised 8/15/22, indicated a purpose to ensure safe and effective

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F 755	Continued From page 28 administration of medication in accordance with physician orders and state/federal regulations. 2. The director of nursing services is responsible for the supervision and direction of all personnel with medication administration duties and functions. 5. Medications may not be prepared in advance. Medications that are removed from their original packaging and not immediately administered must be destroyed in accordance with facility policy.	F 755		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		12/8/22

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F 880	Continued From page 29 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain infection control measures related to hand hygiene for 2 of 3 residents (R2, R6) reviewed during personal cares. In addition, the facility failed to perform hand hygiene in between residents receiving their medications for R7, R8, R9, R10 and R11. This deficient practice had the potential to affect all 48 residents residing in the facility. Findings included: During an observation on 11/8/22, at 8:26 a.m. nursing assistant (NA)-A was observed providing cares to R2 in R2's room. NA-A donned a pair of gloves and went to the bathroom to fill a pan to provide a bed bath. NA-A was observed leaving room and returning with same gloves. NA-A removed the gloves upon re-entering the room and applied clean gloves, without sanitizing or cleaning hands. NA-A provided full bed bath including peri cares with the same cloth and gloves. NA-A took the water basin to sink in bathroom rinsed it out and put it back on shelf. Took the dirty linens put them in a pile and moved the garbage container and left the room to inform the nurse she needed assistance. NA-A assisted to apply sling for mechanical lift with registered nurse (RN)-A while using the same gloves. NA-A and RN-A then transferred R1 to the wheelchair. RN-A removed gloves and sanitized hands before leaving the room. NA-A adjusted R1 in the wheelchair and removed the sling. NA-A removed soiled gloves and applied clean gloves without hand hygiene and proceeded to brush R1 teeth. NA-A again changed gloves without hand hygiene, bagged up garbage (removed bag from	F 880	" Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. o Resident R2: staff completed competencies for hand hygiene o Resident R6: staff completed competencies for hand hygiene o Resident R7: staff completed competencies for hand hygiene o Resident R8: staff completed competencies for hand hygiene o Resident R9: staff completed competencies for hand hygiene o Resident R10: staff completed competencies for hand hygiene o Resident R11: staff completed competencies for hand hygiene " Address how the facility will identify other residents having the potential to be affected by the same deficient practice o All residents have the potential to be affected by this deficient practice. " RCA completed (see attached) " The Infection Preventionist and Director of Nursing, shall complete the following: o Review hand hygiene policies and procedures to ensure they meet CDC guidance and CMS requirements and revise as needed. ¿ Policies were reviewed and currently meet CDC and CMS requirements. No revisions needed. " Training and Education: The Infection Preventionist, Director of Nursing and Clinical Education Coordinator must	

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F 880	Continued From page 31 container in the room), and bagged up the soiled linens and brought it to the soiled linen room in the hallway. Upon returning to the room NA-A brought in a clothing protector and applied it to R1. NA-A again left the room without preforming hand hygiene and went to the utility room to obtain a comb and combed R2's hair wearing the same gloves. NA-A then pushed R1 to the sunroom table and RN-1 stated she was going to check on R1's feeding status. NA-A then began to open containers on R1's tray and stir her food and offered bites of food to R1. NA-A then gave R1 the spoon and R1 began feeding herself. During an observation on 11/8/22, at 3:29 p.m. NA-A and NA-E provided peri cares to R6 using gloves. NA-A removed her gloves and stated she needed to go and get some barrier cream and left the room to go talk to nurse (no hand hygiene observed). NA-A returned and put on gloves from her pocket. She applied barrier cream to resident's peri-area, with same gloves on she then applied wound dressing, then placed clean incontinent brief in place. NA-A removed gloves and did not sanitize or wash hands. NA-A grabbed a pillow, raised the head of his bed, lowered the bed and covered R6, attaching his call light to the bed. NA-A left the room (no hand Hygiene) then entered room 3. NA-A left the room get a blanket. Upon returning to the room NA-A touched the TV remote and bedside table as she was conversing with the resident. NA-A then left room 3 and entered room 12, she grabbed a cup, walked to the kitchen, filled the cup and then returned to room 12. No hand hygiene was observed after NA-A left R3 ' s room. During an interview on 11/8/22, at 3:54 p.m. nurse manager (NM) stated the expectation for all staff was to wash hands or sanitize before and after all	F 880	implement competency assessments for staff on proper hand hygiene and develop a system to ensure all staff have received the training and are competent. o Hand hygiene competencies completed with all staff. " Monitoring and Auditing: The Director of Nursing, the Infection Preventionist and/or other facility leadership will conduct audits on all shifts, every day for one week, then may decrease the frequency based upon compliance. Audits should continue until 100% compliance is met. o Audits completed on all shifts, everyday x 1 week, then decreased to 3x week x 3 weeks. " The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program. o Ad hoc QAPI completed on 12/8/2022 and review of audits completed. " Responsible party: Director of Nursing/Infection Preventionist/designee	

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	245409	A. BUILDING _____ B. WING _____	C 11/10/2022

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F 880	Continued From page 32 cares of residents and when soiled. NM stated that if gloves were worn staff were still to sanitize and wash each time when changing gloves. During a medication pass on 11/8/22 from 9:18 a.m. until 9:45 a.m. licensed practical nurse (LPN)-A was observed to pass out medications to R7, R8, R9, R10 and R11 consecutively. During this medication pass LPN-A was not observed to perform any hand hygiene. During an interview on 11/8/22, at 9:45 a.m. LPN-A stated, I normally use hand sanitizer in between residents and after glove use. LPN-A verified that she did not perform any hand hygiene and stated she should have. During an observation on 11/8/22, 9:48 a.m. RN-A set up medications for residents in room 5 and went down to the room providing them with medications and returned to the cart to set up another resident's medications. No hand hygiene noted before or after this medication administration. During an interview on 11/8/22, at 10:09 a.m. director of nursing (DON) stated, I would expect handwashing to be done between residents with each medication pass and after the use of gloves. Hand hygiene is important to help decrease the risk of spreading infection and should be performed per our policy. Facility's Hand Hygiene Policy dated 8/1/15, revised 9/17/18, indicated the use of gloves does not replace hand hygiene. Hand hygiene is always the final step after removing and disposing of personal protective equipment (PPE.) Staff will perform hand hygiene by	F 880		

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F 880	Continued From page 33 washing hands for at least twenty seconds with antimicrobial or non-antimicrobial soap and water should be performed under the following conditions: when hands are visibly soiled with blood or other body substances: before entering and leaving an isolation room, before applying gloves and after removing gloves or other PPE; After contact with blood, body, secretions, mucous membranes, or non-intact skin; before moving from a contaminated body site to a clean body site during resident care: after providing peri-care, before applying moisture barrier or other treatments, before eating. Using Alcohol-Based Hand Gel 1. If hands are not visibly soiled; Before preparing or handling medications, after using the restroom. Facility's Policy titled, "Policy and Procedure Administering Medications," revised 8/15/22, indicated to ensure safe and effective administration of medication in accordance with physician orders and state/federal regulations. 12. Adherence to established facility infection control procedures shall be followed during the administration of medications. Hand hygiene per policy shall be required between residents.	F 880		

Electronically delivered
November 29, 2022

Administrator
Edenbrook Of Rochester
1875 19th Street Northwest
Rochester, MN 55901

Re: State Nursing Home Licensing Orders
Event ID: OPPX11

Dear Administrator:

The above facility was surveyed on November 8, 2022 through November 10, 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.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	11/10/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/8/22, to 11/10/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H54095587C (MN88097), with a licensing order issued at 0800, 0900 and 1390. H54095660C (MN85144) and H54095737C (MN84396) were substantiated with a licensing order issued at 1520. The following complaints were found to be unsubstantiated: H54095525C (MN88056) and H54095736C (MN87021). 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	2 000		

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2 000	Continued From page 2 available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure sufficient staffing was available in order to provide timely assistance with personal cares according to the residents' assessed need and as directed by the care plan. This practice had to the potential to effect 4 of 4 residents (R12, R9, 16, R4) who interviewed.	2 800	Corrected.	12/8/22

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2 800	Continued From page 3 Findings include: See F686- Based on observation, interview and document review, the facility failed to complete a comprehensive pressure ulcer assessment, implement care plan interventions, follow physician orders to promote healing and/or reduce the risk of deterioration for 2 of 3 residents (R12 and R6) that had current pressure ulcers. The facility's failure resulted in harm to R6 who developed a stage 3 pressure ulcer after admission. Resident observations and interviews: R12 R12's admission Minimum Data Set (MDS) dated 11/9/22, identified R12 to be cognitively intact. R12 required extensive assistance of two or more staff for toileting, bed mobility, transfers, and required extensive assistance of one staff for hygiene. During observation and interview on the East Hall on 11/8/22, at 8:55 a.m. R12 laid in her bed on her back with both of her heels directly on the bed. Both heels had a dressing around the bottom wrapped with gauze and secured with tape; the dressings were undated. R12 explained she thought her dressings were supposed to be changed daily, however, no one had changed her dressing in a few days. R12 stated staff did not come in and help her to reposition in the bed and was not aware she was supposed to call for assistance and/or reposition. R12 explained she usually just laid in bed; she worked with therapy and sometimes therapy would get her up. R12 stated sometimes staff would answer call lights right away, other times it would take 20 minutes or more. About three days ago, R12 had "to go in my diaper because it took them so long to get to	2 800		

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2 800	Continued From page 4 me. I just couldn't wait anymore." During an observation and interview on 11/10/22, at 9:56 a.m. R12 was noted to be lying on her back in her bed, heels were not offloaded. R12 stated no one has offered to offload her heel yet today. R12 reported she had a tantrum this morning when her call light was on for way over 45 minutes. R12 stated she had to "pee" so bad. R12 put down her head, stated to make matters worse, she had started banging her cup on the table to get help. "I feel like I acted like a child". R12 indicated she felt ashamed and embarrassed and never thought she would have to resort to banging a cup on the table to get help. R12 explained she had thought her call light was not working so her roommate (R16) put on her call light too. R12 indicated she did make it to the bathroom in time; explained the aides run ragged but she should not have to wait that long. R9 R9's significant change MDS dated 10/12/22, identified R9 did not have cognitive impairment. R9 required extensive assistance from one staff for toileting and personal hygiene. During an interview on the West Hall, on 11/8/22, at 2:38 p.m. R9 stated the facility was short staffed. R9 pointed at her legs and stated her legs did not get wrapped like they were supposed and at least twice a week they were no wrapped. R9 explained when her legs were not wrapped, her legs feel heavy and get swollen. Both of R9's legs were observed to be swollen and without wraps on. R16 R16's significant change MDS dated 10/14/22 identified R9 did not have cognitive impairment.	2 800		

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2 800	Continued From page 5 R16 required extensive assistance from one staff for transfers, dressing, toileting, and hygiene. During an interview on 11/10/22, at 9:56 a.m. R16 was noted to be lying in her bed in a facility gown. R16 stated she had to put her call light to help R12 because she had to go to the bathroom so bad. R16 stated it took them over 45 minutes to answer it. R16 explained there was not enough staff, there was usually only one aide working down this hallway. R16 further explained sometimes there was not an aide and the nurse had to do everything herself. R16 reported she liked to be up by 7:30 a.m. before she gets her breakfast, however, has not gotten out of bed yet today and still sitting in her night gown. R16 indicated she did not complain about getting up because she wanted to make sure residents who cannot speak for themselves gets the care, they need first. R16 stated maybe they need to start doing the 100-dollar bonuses for their staff like they did last year. "I don't know what the hell is going on here, but it is plain ridiculous." R4 R4's significant change MDS dated 10/17/22 identified R4 did not have cognitive impairment. R4 required extensive assistance from one staff for toileting and supervision for bed mobility, hygiene, and dressing. During an interview on 11/10/22, at 10:37 a.m. R4 was seated at the edge of her bed in her room. R4 explained she used to be a nursing assistant and a staff coordinated for 25 years and was familiar with staffing patterns and problems. R4 thought there was approximately 18 other residents on the hallway she resided on. R4 stated the facility was lacking in staff really bad; that was probably a reason they gave her the	2 800		

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2 800	Continued From page 6 wrong insulin. R4 reported when you guys (state surveyors) are in the building staffing is better, but then when surveyors leave it is bad. R4 explained her pain medication was usually an hour late but could tolerate it. She was more worried about other residents who could not speak for themselves. R4 stated on this hallway there was only one aide and one nurse with a lot of full body mechanical lift transfers that required two aides. R4 explained if there was only one aide working, then a nurse would have to be pulled from what she was doing and that was not good. R4 stated she had complained to the nurses about the staffing; the nurse's response was they will not schedule anymore and they were doing the best they could. Staff's concerns: During an interview on 11/8/22, at 8:31 a.m. nursing assistant (NA)-F, was observed to be passing out breakfast trays to rooms. NA-F stated she was the only aide scheduled for the North hallway and would be responsible for providing cares to all 16 residents. NA-F explained she needed to wash, toilet, reposition and transfer all the residents in addition to help anyone that that required assistants with eating. NA-F reported R14 and R15's call lights had been on for awhile (time unknown); she still needed to get them done yet. NA-F stated she did not always get everyone up that wanted to be up in their chair or out to the dining room for breakfast. NA-F indicated there were always a lot of call lights going off and if there was another aide we could get everything done. During an interview on 11/8/22, at 10:18 a.m. NA-A stated the facility was short staffed. She was the only aide scheduled today for the East Hall wing for 18 residents. NA-A explained she	2 800		

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2 800	Continued From page 7 was responsible to get all 18 residents cares done and get them all up. NA-A reported right now, the nurse for this hallway is on break along with the only NA scheduled for the West hallway. Making her responsible for watching over 30 residents and watching for call lights. She still had to get R6 up yet. NA-A further explained when there was only one aide schedule, she could not get the 9-10 residents that required repositioning done on time. During an interview on 11/8/22, at 2:03 pm, licensed practical nurse (LPN)-A stated, last night she worked her assigned unit by herself until 6:00 p.m. when a nurse manager was mandated to stay to work as an aide. LPN-A indicated when she worked by herself there were safety concerns. LPN-A reported because she had to work the hall by herself a lot of stuff did not get done and it was not fair to the residents. Subsequent interview at 2:28 p.m. LPN-A stated, she did not get R12's dressing on her heel changed last night, we were too short staffed, she did reinforce the dressing. During an interview on the East Hall on 11/8/22, at 2:45 p.m. licensed practical nurse (LPN)-A reported the day shift nurse did not have time to replace R12's lidocaine patch (pain patch) on her leg, so it was passed along to her. The patch should be put on early in the morning. During an interview on 11/10/22, at 10:28 a.m. LPN-C stated there was only one aide on their wing with 18 residents to care for. It would be better with 2 aides. We do not have enough staff to care for the residents we have now, but they keep filling beds. LPN-C reported residents complained to her daily about staffing and long call lights. She has brought these concerns	2 800		

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2 800	Continued From page 8 forward several times and nothing changed. Administration tells us there is adequate staff and are even overstaffed. LPN-C explained inadequate staff leads to medication errors, care was being rushed, cares like toileting and repositioning did not get completed according to the care plan. It's a safety hazard. During an interview on 11/8/22 at 9:53 a.m. registered nurse (RN)-A stated on this hallway most of the resident's required assistance from two staff to transfer; we only have one NA down here. Because of not having adequate staff, we can not get everyone out of bed at a normal time in the morning. RN-A stated she kept saying more staff were needed more staff, however the reply has been because of the number of residents, more staff hours could be cut. Call light logs were requested and not received. Staff schedule was requested from 11/8/22 to 11/10/22 and was not received. Facility Assessment that was provided was not current; last updated 4/20/21, and was last reviewed by quality assurance on 10/14/21. Further, the assessment was missing even pages, which included the facility staffing information. SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee should ensure adequate policy and programs are developed for sufficient staffing based on the resident population to staffing availability so residents received safe, adequate and timely assistance with toileting, bathing, repositioning, pressure ulcer care, medication administration, meals, and	2 800		

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	00916	A. BUILDING: _____ B. WING _____	11/10/2022

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2 800	Continued From page 9 eating assistance. The facility should educate staff on these policies and perform audits of resident care to ensure residents are receiving care and services with adequate staffing. The facility should report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a	2 900	Corrected.	12/8/22

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2 900	Continued From page 10 comprehensive pressure ulcer assessment, implement care plan interventions, follow physician orders to promote healing and/or reduce the risk of deterioration for 2 of 3 residents (R6 and R12) that had current pressure ulcers. The facility's failure resulted in harm to R6 who developed a stage 3 pressure ulcer after admission. Findings include: Stage 1 Pressure Injury: Non-blanchable erythema (redness) of intact skin Intact skin with a localized area of non-blanchable erythema (redness). Stage 2 Pressure Ulcer: Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage	2 900		

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2 900	Continued From page 11 and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable PU/PI (pressure ulcer/pressure injury). Deep Tissue Pressure Injury (DTPI): Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure ulcer. Once a deep tissue injury opens to an ulcer, reclassify the ulcer into the appropriate stage. Skin Tears: acute wounds that result from a mechanical force such as shearing or friction or a traumatic injury such as from a fall. R6's face sheet dated 11/8/22, identified R6 had diagnoses of diabetes type II, chronic kidney disease, and heart failure. R6's significant change minimum data set (MDS) dated 10/12/22, indicated R6 was severely cognitively impaired, required extensive 1-2 person assist with most cares. MDS indicated R6 was total dependence on staff for hygiene and toileting, and was always incontinent of bowel and bladder. Further the MDS identified R6 was at risk for pressure ulcers, did not have pressure ulcers and/or any skin impairments. Skin treatments included pressure reducing cushions	2 900		

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2 900	Continued From page 12 for chair and bed. No other interventions were identified. R6's progress note dated 10/14/22 indicated the physician was notified of the following: R6 had a new sacral injury that measured 1.3 cm x 1.0 cm., 100% epithelial tissue. Skin surrounding the wound was reddened, fragile with raised edges. Photo was obtained for monitoring. R6's MDS note dated 10/18/22, at 11:28 a.m., indicated R6 was completely incontinent of bowel and bladder, was currently checked and changed in bed. R2 had a stage 2 on his coccyx that had been noted on 10/14/22. R6's skin integrity care plan focus dated 10/27/22, identified R6 had alteration in skin integrity related to impaired mobility and bowel and bladder incontinence. Associated interventions dated 10/14/22 included: -Complete dressing changes as ordered -Position my body with pillows/support devices, and protect bony prominence's -Turn and reposition every two hours per particular tolerance and schedule. On 10/18/22, intervention identified R6 had a ulcer to coccyx (stage not identified) see treatment administration record. On 10/24/22 intervention was air mattress to be added. R6 skin/wound note dated 10/27/22, at 4:32 p.m., Identified R6 had a skin tear to left buttock caused from full body mechanical lift sling removal. New interventions included put an air mattress on R6's bed. The note did not include measurements and/or further assessment of the skin impairment. Corresponding photo dated 10/27/22 identified a pink area on sacral/coccyx	2 900		

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2 900	Continued From page 13 area which was identified as resolved. Left buttock had an open wound approximately size of quarter. The wound bed was deep red in color with no skin flap visible in the photo. The skin surrounding the wound was excoriated or consistent with moisture associated skin damage. R6's record lacked a comprehensive wound assessment of the skin impairment identified as a skin tear. Additionally R6's care plan was not revised to reflect the resolution of the stage 2 pressure ulcer. An additional skin integrity focus was added to the care plan that identified the left buttock skin tear. R6's care plan included additional skin integrity care plan focus dated 10/27/22, identified R6 had a skin tear to left buttock. Associated interventions dated 10/27/22 included: -Air mattress -Toileting program initiated : check change approximately every two hours during wake hours and every 3 hours at night. -Turn and repositioning approximately every 2 hours when in bed, approximately every hour when in wheelchair. -Administer treatments as ordered. -Assess/monitor the alteration in skin integrity and document status weekly. -11/3/22 intervention; new dressing change orders received. R6's wound evaluation dated 11/3/22 identified R6 had a new skin tear to left buttock that measured 2.7 cm x 3.0 cm. with attached edges that appeared flush. Wound bed had slough (dead skin), 10% granulation tissue present (new connective tissue that forms on wound surfaces during healing process) and was pink or red. Surrounding wound was red, and fragile. Further	2 900		

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2 900	Continued From page 14 identified wound as improving and healable. Interventions used included: mattress with pump, turning and repositioning program, and moisture barrier and control. R6's left buttock wound order dated 11/3/22, directed to clean wound with cleanser, pat dry, apply Medi honey (honey fiber) to wound bed. Then apply Duoderm to buttocks skin tear. The dressing was to be changed on the evening shift on Mondays and Fridays or sooner if it falls off or was soiled. During an observation on 11/8/22, at 8:27 a.m. R6 laid in his bed on his back. R6's mattress was not an air mattress in accordance with the care plan dated 10/27/22 or the skin evaluation dated 11/3/22. At 10:28 a.m. unknown staff members assisted R6 to his wheelchair. During a continuous observation on 11/8/22, that began at 2:02 p.m. and ended at 3:17 p.m. R6 sat in his wheelchair without offers/attempts to reposition/offload R6 in accordance with the care plan. -At 2:02 p.m. R6 sat in his wheelchair, self-propelling down the hallway. -At 2:33 p.m. R6 continued to sit in his wheelchair in the same position in the sunroom at a table with a puzzle. -At 2:55 p.m. administrator pushed R6 back to his room. -At 2:57 p.m. R6 self-propelled his wheelchair out of his room and an unidentified staff member pushed R6 back to the sunroom. -At 3:12 p.m. R6 sat at the puzzle table and unidentified staff member put his glasses on. -From 3:15 p.m. to 3:17 p.m. R6 observed self-propelling around tables in the sunroom.	2 900		

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2 900	Continued From page 15 During an interview on 11/8/22, at 3:24 p.m. NA-A indicated after R6 was up in his chair at 10:30, she had repositioned R6 after lunch, it was about two hours ago around 1:30 p.m. (three hours after R6 was up in his chair). NA-A explained she completed the repositioning by moving R6 around a little bit by the mechanical lift sling that he was sitting on. NA-A demonstrated the action with her arms; action was that of moving back and forth or side to side. NA-A's demonstration would not alleviate pressure to R6's buttock area. On 11/8/22, at 3:29 p.m. NA-A and NA-E observed doing personal cares on R6 in bed. NA-A stated she needed to apply barrier cream and stated she would go to the nurse and get the cream and be right back. R6's right sacral area of redness approximately size of quarter. Coccyx was excoriated with superficial open slit. Right outer gluteal fold (buttock) was excoriated /peeling. Left buttock had an open wound between quarter and half dollar sized. Wound periphery was reddened with surrounding excoriation/peeling skin on the buttock/gluteal fold. R6 stated,"OWW, OWW!" as NA's cleaned the areas excoriation where the skin was peeling and red. When NA-A was done wiping, with same gloves on, she applied barrier cream to the wound. Then with the same gloves on she applied a bordered dressing to the wound. NA-E asked NA-A if she should be applying the dressing rather than the nurse. NA-A replied, "yes, the nurse told me to go ahead and put it on, so I am." Staff removed gloves, did not perform hand hygiene, and left room. R6's progress note dated 11/8/22, indicated as of 10/10/22, R6 wounds have resolved except a new wound found to right buttock-will await update to recommend supplementation. Registered	2 900		

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2 900	Continued From page 16 dietician (RD) recommends increased magic cup to 4 ounces twice per due to decreased appetite. Discontinue Prostat (sugar free liquid protein often used for wound healing) due to resolved skin tears, pressure injury as of 10/6/22. R6's record did not identify measurements of the wound after 11/3/22. During an interview on 11/8/22, at 4:00 p.m., nurse manager (NM) indicated R6 had a history of wounds on his bottom. NM stated R6's wound on sacrum was first evaluated on 10/14/22 and had measurements 1.27cm x 1.03cm and had resolved on 10/27/22 by the physician. On 10/27/22 the new wound (skin tear) was identified however that measured 3.91 cm x 2.56 cm.; total surface area was 7.06 cm. On 11/3/22 measurements of wound were 2.73cm x 2.95cm; total surface area 6.18 cm. NM stated staff should follow R6's care plan; he should be offloaded every hour when in a wheelchair by using a pillow or such. NM stated it was definitely not appropriate to shift a sling under a resident because it would not remove the pressure from the wound. NM stated nursing assistance (NA) were not to complete dressing changes as they do not have the education on assessing and it was out of their scope. During an interview on 11/9/22, at 9:34 a.m. administrator and director of nursing indicated they had identified the nurse had indeed delegated the task of wound care to the NA and had given the wrong directions. Education to staff was provided. Additionally, facility also provided job description to staff and what to do if they were directed to complete tasks out of their scope of practice.	2 900		

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2 900	Continued From page 17 During an interview on 11/10/22, at 1:34 p.m. wound doctor (WD) stated R6 spent a lot of time in his wheelchair and R6 was bony and susceptible to pressure ulcers. WD stated he had not seen R6's wound last week but had seen the wound today; he debrided the wound as much as R6 would tolerate. Wound measured 0.1 and 1.4 cm, width was 1.8 cm. There was 80% slough, 10% granulation tissue, and 10% other with a little drainage. WD stated the wound had gotten smaller in the surface area than what he had seen previously. The skin impairment was caused by skin tear and the bias from that was pressure related as well as he (R6) did have fragile skin (shearing wound caused by pressure). WD stated the wound was (currently) stage III pressure ulcer because it had some depth to it. WD indicated treatment was xeroform (medicated gauze dressing) and mepilex with border (foam dressing). WD explained R6 should be repositioned in his wheelchair every one hour and every two hours while in bed, additionally should have an air mattress. R12 R12's Admission record indicated R12 was admitted on 11/3/22, with diagnoses that included left femur fracture, diabetes with diabetic polyneuropathy (damage to nerves), and stage 3 pressure ulcer of the left heel. R12's admission Minimum Data Set (MDS) dated 11/9/22, identified R12 to be cognitively intact and had no rejection of cares exhibited. R12 required extensive assistance of two or more staff for toileting, bed mobility, transfers, and required extensive assistance of one staff for hygiene. MDS also identified R12 was at risk for pressure ulcers and had one stage 1 pressure ulcer. Skin	2 900		

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2 900	Continued From page 18 and ulcer treatments included: pressure reducing device for chair and bed, along with pressure ulcer care. R12's hospital After Visit Summary (AVS) dated 11/3/22, identified R12 was admitted to the hospital with a femur fracture after a fall that required surgical intervention. Details of hospital stay identified R12 had a history of left heel ulcer from 8/8/22 hospitalization and indicated R12 had current left heel healing stage 3 that was treated with Santyl (enzymatic debrider ointment used for debriding dermal ulcers and aid in wound healing) to area covered with Mepilex (absorbent foam dressing) heel. Addition interventions were Prevalon boots (have a cushioned bottom that floats the heel off the surface of the mattress, helping to reduce pressure) when lying or sitting to help protect. R12's right heel was intact but at risk (for skin breakdown) just like her left. Assessment and plan for pressure ulcer of left heel stage 3 included, "unable to assess today, nursing to evaluate upon admission." R12's medical record lacked a comprehensive skin assessment upon admission to the facility as directed by the hospital summary. Further even though the hospital summary directed to use Santyl, R12's physician orders directed to use zinc-based cream, which is not an enzymatic debrider. Physician order dated 11/4/22, indicated apply zinc-based cream to left posterior heel and change daily. R12's record did not identify an order to discontinue the Santyl and/or why there was a change to the treatment as identified by the hospital discharge summary. R12's Baseline care plan, signed 11/4/22, indicated R12 was at risk for alteration in skin integrity related to obesity, decreased mobility	2 900		

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2 900	Continued From page 19 and dependence on staff. Interventions: float my heels or use heel suspension boots while I am in bed and keep my skin clean and dry. The baseline care plan indicated current skin integrity issues to include scratches/rash on right wrist, pressure injury left heel, surgical incision of left hip/thigh, and left shin scratches. R12's progress note, dated 11/4/22, at 8:44 p.m. indicated R12 complained of left heel pain. Mepilex applied. Skin dry and intact. R12's record did not include further assessment that identified source of pain, color, and texture (bogg/firm) of skin, and interventions used to relieve pain. During observation and interview on 11/8/22, at 8:55 a.m. R12 laid in her bed on her back with both of her heels directly on the bed. Both heels had a dressing around the bottom wrapped with gauze and secured with tape; the dressings were undated. R12 stated she used to have a pressure ulcer on her left heel that she got in the hospital a while back. R12 explained she thought her dressings were supposed to be changed daily, however, no one had changed her dressing in a few days. She was not aware if the treatment had changed. R12 stated staff did not come in and help her to reposition in the bed and was not aware she was supposed to call for assistance and/or reposition. R12 indicated no one ever offers and/or puts her leg up on a pillow like they did in the hospital. R12 explained she usually just laid in bed; she worked with therapy and sometimes therapy would get her up. R12's November treatment administration record (TAR) identified physician order to apply zinc based cream to heel and cover with mepilex daily. The TAR indicated R12's treatment to heel	2 900		

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2 900	Continued From page 20 was completed from 11/5/22 to 11/10/22, however did not include description of R12's heel or wound. Additionally, TAR identified R12 had diabetic foot check completed on the night shift from 11/3/22 to 11/10/22, however, did not address R12's skin integrity to her heel. During an observation and interview on 11/8/22, at 2:13 p.m. R12 laid in bed on her back covered with a sheet. R12 stated she did not get the dressing on her left heel changed yet. R12 stated she had been in bed all day, and no one had offered to reposition her or offer to put a pillow under her leg. R12's heels were directly on the mattress and not floated. R12's pressure relieving boots were observed to be on the shelf at the end of her bed. During an observation and interview on 11/8/22, at 2:21 p.m. licensed practical nurse (LPN)-B stated because they were short staffed last night (11/7/22) she had not changed R12's heel dressing per physician orders. Instead, she reinforced the dressing with a gauze wrap. LPN-B walked to R12's room and verified R12's heels were not offloaded (floated) per the care plan. Further LPN-B did not offer and/or attempt to float R12's heels, place pressure relieving boots on her or offer to reposition. LPN-B indicated R12 refused to wear the pressure relieving boot because she thought it caused the pressure ulcer, no one has followed-up with therapy about the boot, and thought someone should do that. Although, R12's hospital discharge summary and base line care plan dated 11/4/22, directed to offload pressure from R12's heel and use pressure relieving boot, R12's TAR did not identify	2 900		

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EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

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2 900	Continued From page 21 the directive or order until 11/10/22. The order included offload heel with Prevalon boots and wear Darco shoe outside. Float heel when sitting with pillows to keep heel pressure free every shift for pressure injury (ulcer) of left heel stage 3. A progress note dated 11/5/22 indicated R12 refused interventions, and on 11/9/22 identified R12's heels were offloaded, the facility did not consistently implement interverventions to prevent pressure ulcers. During an observation on 11/8/22, at 3:02 p.m. LPN-B removed R12's dressing to her left heel and verified the dressing was not dated. The back of R12's left heel (Achilles tendon area) was observed; heel had a rectangular butterfly shaped open wound that had small red dots on the wound bed, approximately 1.0 inch by 2.5 inch, no surrounding redness. Above the wound there was an area of dry skin, no areas scabbing were observed over or surrounding the wound. LPN-B looked at the Mepilex and stated, there was a small amount of serous drainage (watery discharge that is pale yellow and transparent) on it. While LPN-B removed the dressing there was a distinct pungent foul odor which LPN-B verified. LPN-B looked at the wound on the back of left heel and stated it was open. LPN-B explained she did not think it was open before, but since there was drainage on the dressing it must have been open. LPN-B measured area on left heel; announced measurements of 5.0 cm x 3.0 cm. Stated she was going to clean the area with soap and water and have the wound nurse look at it prior to applying the zinc and Mepilex. During an observation and interview on 11/8/22, at 3:22 p.m. Nurse manager (NM) verified he was the wound nurse for the facility. NM explained a wound specialist (WD) was at the facility every	2 900		

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2 900	Continued From page 22 Thursday. On Thursdays, residents were brought to the treatment room where they used a computer application to take pictures of the wound. WD would complete assessments, obtain measurements, and ensure treatments were appropriate. NM entered R12's room and looked at R12's left heel- Achilles tendon area. NM stated the left heel was definitely open with multiple red pinpoint areas located across the wound base. NM stated the wound was most likely from pressure. NM measured the wound; he reported results of 3.6 cm x 4.0 cm which were inconsistent with LPN-B's measurements. NM explained there was nothing on her heel upon admission on 11/3/22. The area had some dry skin around it and was not open. As NM was touching R12's left heel he asked R12 if she could feel his hand. R12 closed her eyes and stated she could not feel it. NM stated for now he would cleanse the area with wound cleanser and apply a Mepilex and call the doctor to see what he wants to do with this. NM then put a pillow under R12's left leg so that the heel was off the bed. R12 allowed this without any rejection and/or refusals. R12's physician notification note, dated 11/8/22, at 4:46 p.m. included background of pressure ulcer to R12's left posterior (back) heel. Assessment included: posterior heel has a hard scab to previous pressure ulcer (documentation of a "hard scab" was inconsistent with observation at 3:22 p.m.). Upon evaluation on this day, the site measured 4.0 cm x 3.0 cm (Length x Width) to peri wound site appears with multiple pinpoint red areas. Old dressing had light serous drainage. Updated orders requested, currently using zinc barrier cream, site is dry. R12's progress note dated, 11/9/22, at 9:49 a.m.	2 900		

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2 900	Continued From page 23 indicated a new order of Arginaid (Powder nutritional supplement drink mix that promotes the healing of pressure ulcers) two times a day to aid in wound healing related to pressure ulcer of the left heel. R12's progress note dated, 11/9/22, at 3:20 p.m. response from physician notification was, "continue to follow wound MD." R12's progress note dated 11/9/22, at 7:34 p.m. included Mepilex to bilateral heels in place, left heel pressure injury present at this time. R12's admission MD visit dated 11/10/22, identified history of R12's left heel wound however, however did not identify current staging. The note included the following treatment orders and interventions: cleanse the wound with wound cleanser, pat dry, cover the wound bed with Mepilex. Change daily and as needed if soiled. [R12] to offload heel with Prevalon boots and wear Darco shoe outside. Float heel when sitting with pillows to keep heel pressure free. Nutritional consult with goal to improve nutritional status for wound healing. Any acute changes between visits should be documented and communicated ASAP (as soon as possible) to provider: a new wound or a change, if there is new or worsening drainage from a wound, redness, swollen or painful to the touch, if wound changes from pink or red to a tan or brown or black color, if development of fever or wound odor gets worse. Document and alert provider if patient declined repositioning or dressing change. During an observation and interview on 11/10/22, at 9:56 a.m. R12 laid on her back in her bed, heels were not offloaded/floated. R12's left heel had a Mepilex dressing placed underneath her	2 900		

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2 900	Continued From page 24 heel but was not secured. R12 stated a doctor had just looked at her heel and no one has offered/attempted to offload her heel yet today. R12's weekly skin assessment dated 11/10/22, indicated left heel had blanchable redness measuring 6.5 cm x 4.0 cm. Further identified left heel pressure ulcer was a suspected deep tissue injury (SDTI) measuring 1.9 cm x 1.5 cm. Above blanchable redness surrounds the SDTI. The SDTI area is non-blanchable purple appearance, skin intact. During a phone interview on 11/10/22, at 12:27 p.m. WD stated he had not had a chance to review R12's medical records yet. WD explained R12 had told him she had the pressure ulcer on her left heel since August. WD indicated he had assessed R12's wound today; measured 1.4 cm x 1.9 cm. The new treatment orders will be to apply Betadine (antiseptic liquid, put on minor wounds, cuts, abrasions or burns that helps reduce the risk of developing an infection) and a Mepilex dressing. WD further explained R12 would need to float her heels with a pillow or use the boots. Facility policy entitled, Pressure Injury Prevention and Wound care management, dated 8/26/2018, revised 4/27/21, stated that the policy was created for the facility to ensure that a resident who is admitted without a pressure injury does not develop a pressure injury, unless clinically unavoidable, a resident who has pressure injury will receive care and services to promote healing and to prevent additional ulcers. Policy indicates to refer to dressing change policy and procedure for dressing changes. Education provided to nursing staff on 11/8/22 and 11/9/22, indicated wound care MUST be	2 900		

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2 900	Continued From page 25 performed by a licensed nurse. A licensed nurse cannot delegate wound care to certified nursing assistant (CNA) staff. This is outside their scope of practice. Any CNA staff being asked by a licensed nurse to complete wound care on a resident is to notify the Nurse Manager/Charge Nurse/Director of Nursing immediately and not follow the direction of the licensed nurse related to the wound care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of	21385		12/8/22

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21385	Continued From page 26 the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain infection control measures related to hand hygiene for 2 of 3 residents (R2, R6) reviewed during personal cares. In addition, the facility failed to perform hand hygiene in between residents receiving their medications for R7, R8, R9, R10 and R11. This deficient practice had the potential to affect all 48 residents residing in the facility. Findings included: During an observation on 11/8/22, at 8:26 a.m. nursing assistant (NA)-A was observed providing cares to R2 in R2's room. NA-A donned a pair of gloves and went to the bathroom to fill a pan to provide a bed bath. NA-A was observed leaving room and returning with same gloves. NA-A removed the gloves upon re-entering the room and applied clean gloves, without sanitizing or cleaning hands. NA-A provided full bed bath including peri cares with the same cloth and gloves. NA-A took the water basin to sink in bathroom rinsed it out and put it back on shelf. Took the dirty linens put them in a pile and moved the garbage container and left the room to inform the nurse she needed assistance. NA-A assisted to apply sling for mechanical lift with registered nurse (RN)-A while using the same gloves. NA-A and RN-A then transferred R1 to the wheelchair. RN-A removed gloves and sanitized hands before leaving the room. NA-A adjusted R1 in the wheelchair and removed the sling. NA-A removed	21385	Corrected.	

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21385	Continued From page 27 soiled gloves and applied clean gloves without hand hygiene and proceeded to brush R1 teeth. NA-A again changed gloves without hand hygiene, bagged up garbage (removed bag from container in the room), and bagged up the soiled linens and brought it to the soiled linen room in the hallway. Upon returning to the room NA-A brought in a clothing protector and applied it to R1. NA-A again left the room without preforming hand hygiene and went to the utility room to obtain a comb and combed R2's hair wearing the same gloves. NA-A then pushed R1 to the sunroom table and RN-1 stated she was going to check on R1's feeding status. NA-A then began to open containers on R1's tray and stir her food and offered bites of food to R1. NA-A then gave R1 the spoon and R1 began feeding herself. During an observation on 11/8/22, at 3:29 p.m. NA-A and NA-E provided peri cares to R6 using gloves. NA-A removed her gloves and stated she needed to go and get some barrier cream and left the room to go talk to nurse (no hand hygiene observed). NA-A returned and put on gloves from her pocket. She applied barrier cream to resident's peri-area, with same gloves on she then applied wound dressing, then placed clean incontinent brief in place. NA-A removed gloves and did not sanitize or wash hands. NA-A grabbed a pillow, raised the head of his bed, lowered the bed and covered R6, attaching his call light to the bed. NA-A left the room (no hand Hygiene) then entered room 3. NA-A left the room get a blanket. Upon returning to the room NA-A touched the TV remote and bedside table as she was conversing with the resident. NA-A then left room 3 and entered room 12, she grabbed a cup, walked to the kitchen, filled the cup and then returned to room 12. No hand hygiene was observed after NA-A left R3 ' s room.	21385		

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21385	Continued From page 28 During an interview on 11/8/22, at 3:54 p.m. nurse manager (NM) stated the expectation for all staff was to wash hands or sanitize before and after all cares of residents and when soiled. NM stated that if gloves were worn staff were still to sanitize and wash each time when changing gloves. During a medication pass on 11/8/22 from 9:18 a.m. until 9:45 a.m. licensed practical nurse (LPN)-A was observed to pass out medications to R7, R8, R9, R10 and R11 consecutively. During this medication pass LPN-A was not observed to perform any hand hygiene. During an interview on 11/8/22, at 9:45 a.m. LPN-A stated, I normally use hand sanitizer in between residents and after glove use. LPN-A verified that she did not perform any hand hygiene and stated she should have. During an observation on 11/8/22, 9:48 a.m. RN-A set up medications for residents in room 5 and went down to the room providing them with medications and returned to the cart to set up another resident's medications. No hand hygiene noted before or after this medication administration. During an interview on 11/8/22, at 10:09 a.m. director of nursing (DON) stated, I would expect handwashing to be done between residents with each medication pass and after the use of gloves. Hand hygiene is important to help decrease the risk of spreading infection and should be performed per our policy. Facility's Hand Hygiene Policy dated 8/1/15, revised 9/17/18, indicated the use of gloves does not replace hand hygiene. Hand hygiene is always the final step after removing and	21385		

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21385	Continued From page 29 disposing of personal protective equipment (PPE.) Staff will perform hand hygiene by washing hands for at least twenty seconds with antimicrobial or non-antimicrobial soap and water should be performed under the following conditions: when hands are visibly soiled with blood or other body substances: before entering and leaving an isolation room, before applying gloves and after removing gloves or other PPE; After contact with blood, body, secretions, mucous membranes, or non-intact skin; before moving from a contaminated body site to a clean body site during resident care: after providing peri-care, before applying moisture barrier or other treatments, before eating. Using Alcohol-Based Hand Gel 1. If hands are not visibly soiled; Before preparing or handling medications, after using the restroom. Facility's Policy titled, "Policy and Procedure Administering Medications," revised 8/15/22, indicated to ensure safe and effective administration of medication in accordance with physician orders and state/federal regulations. 12. Adherence to established facility infection control procedures shall be followed during the administration of medications. Hand hygiene per policy shall be required between residents. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they	21385		

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21385	Continued From page 30 contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21385		
21520	MN Rule 4658.1300 Subp. 1-4 Medications and Pharmacy Services; Definition Subpart 1. Controlled substances. "Controlled substances" has the meaning given in Minnesota Statutes, section 152.01, subdivision 4. Subp. 2. Schedule II drugs. "Schedule II drugs" means drugs with a high potential for abuse that have established medical uses as defined in Minnesota Statutes, section 152.02, subdivision 3. Subp. 3. Pharmacy services. "Pharmacy services" means services to ensure the accurate acquiring, receiving, and administering of all drugs to meet the needs of each resident. Subp. 4. Drug regimen. "Drug regimen" means all prescribed and over-the-counter medications a resident is taking. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure resident	21520	Correct.	12/8/22

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21520	Continued From page 31 medication was not preset until the administration of medication for 5 of 5 residents (R7, R8, R9, R10 and R11) who were observed during a medication pass. Findings include: During an observation on 11/8/22, at 9:18 a.m. licensed practical nurse (LPN)-A, pulled open the top drawer of the West Hall medication cart, where 5 clear plastic medication cups were stacked on top of each other and observed to have several pills in each cup with two different letters written in black marker on the side of each cup. LPN-A stated, she always presets the medications. LPN-A removed the top med cup with R7's initials; LPN-A was unable to articulate what medications were in the cup. LPN-A looked up the physician order on the medication administration record (MAR) and compared it with the R7's cards of medications in the lower drawer. The cup contained 10 pills: pantoprazole 40 milligrams (mg), risperidone 1 mg, venlafaxine extended release (ER) tablet 150 mg tablets (2 tablets) and 37.5 mg (1 tablets), metformin HCL tablet 500 mg (2), gabapentin 300 mg, and sennoside-docusate sodium tablet 8.6-50 mg (2 tablets). After verifying the medications LPN-A then walked to R7's room and administered the medications per physician's orders. During an observation on 11/8/22, at 9:25 a.m. LPN-A removed another med cup from cart drawer, stated these pills were for R8. LPN-A was unable to articulate what the medications in the cup were. LPN-A looked up the physician order on the medication administration record (MAR) and compared it with the R8's cards of medications in the lower drawer. The cup contained 5 pills: azithromycin 250 mg tablet,	21520		

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21520	Continued From page 32 hydrochlorothiazide 12.5 mg tablet, metoprolol succinate ER 100 mg tablet, and hydralazine tablet two 10 mg tablets. After verifying the medications LPN-A walked into R8's room and administered the medications per physician order. During an observation on 11/8/22, at 9:29 a.m. LPN-A removed another med cup from the cart drawer, stated these pills were for R9. LPN-A was unable to articulate what the medications in the cup were. LPN-A looked up the physician order on the MAR and compared it with the R9's cards of medications in the lower drawer. The cup contained 7 pills: atorvastatin calcium 20 mg tablet, calcium carbonate vitamin D3 500mg-200 international units (IU) tablet (2 tablets), coenzyme Q10 100 mg tablet (2 tablets), losartan potassium 25mg tablet, and duloxetine 30 mg delayed release capsule. After verifying the medications, LPN-A then walked into R9's room and administered the medications per physician order. During an observation on 11/8/22, at 9:36 a.m. LPN-A removed another med cup from the med cart drawer, stated these pills are for R10, and was unable to articulate what the medications in the cup were. LPN-A looked up the physician order on the MAR and compared it with the R10's cards of medications in the lower drawer. The cup contained 6 pills: Centrum Silver 400mg-250 mcg chewable tablet, duloxetine 60 mg delayed release capsule, lisinopril 2.5 mg tablet, calcium carbonate vitamin D3 600mg-400 IU tablet, and acetaminophen 500 mg (2) tablets. After verifying the medications, LPN-A then walked into R10's room and administered the medications per physician order. During an observation on 11/8/22, at 9:45 p.m.	21520		

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21520	Continued From page 33 LPN-A removed another med cup out of the med cart drawer, stated these pills are for R11, was unable to articulate what the medications in the cup were. LPN-A looked up the physician order on the MAR and compared it with the R10's cards of medications in the lower drawer. The cup contained 10 pills: escitalopram 20 mg tablet, glipizide 5mg tablet, prednisone 5 mg tablet, bupropion HCL ER 300 mg tablet, apixaban 5mg tablet, calcium carbonate 600 mg tablet, gabapentin 300 mg capsule (2 capsules), levetiracetam 1000 mg tablet, and buspirone 5mg tablet. After verifying the medications, LPN-A then walked into R11's room and administered the medications per physician order. During an interview on 11/8/22, at 9:52 a.m. LPN-A verified she should not have preset the resident medications and stated it can increase the risk of medication errors. During an interview on 11/8/22, at 10:09 a.m. director of nursing (DON) stated it was not appropriate to preset medications as it increases the risk of medication errors. During an interview on 11/10/22, at 11:32 a.m. consultant pharmacist (CP)-A stated, it is not good practice to preset medications as it increases the risk of medication errors. CP-A further stated they typically do a medication pass review once a year. CP-A could not remember the last time they did one and stated, it sounds like a good idea to do one now especially if they were presetting medications. Facility policy, titled, "Policy and Procedure Administering Medications," revised 8/15/22, indicated a purpose to ensure safe and effective administration of medication in accordance with	21520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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
21520	Continued From page 34 physician orders and state/federal regulations. 2. The director of nursing services is responsible for the supervision and direction of all personnel with medication administration duties and functions. 5. Medications may not be prepared in advance. Medications that are removed from their original packaging and not immediately administered must be destroyed in accordance with facility policy. SUGGESTED METHOD OF CORRECTION: The administrator, DON, and consulting pharmacist could review and revise policies and procedures for appropriate medication administration and educate staff. The DON or designee, could audit medication administration and take those results to the Quality Assurance Performance Improvement (QAPI) committee for a set amount of time to determine compliance and the need for further monitoring. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21520		