Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 11, 2025

Administrator
Parkview Care Center
55 Tenth Street Southeast
Wells, MN 56097

RE: CCN: 245436
Cycle Start Date: April 24, 2025

Dear Administrator:

On May 14, 2025, we notified you a remedy was imposed. On June 9, 2025 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 9, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 29, 2025 be discontinued as of June 9, 2025. (42 CFR 488.417 (b))

In our letter of May 14, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 29, 2025. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 11, 2025

Administrator
Parkview Care Center
55 Tenth Street Southeast
Wells, MN 56097

Re: Reinspection Results
Event ID: HUL512

Dear Administrator:

On June 9, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 24, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

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Electronically delivered
May 14, 2025

Administrator
Parkview Care Center
55 Tenth Street Southeast
Wells, MN 56097

RE: CCN: 245436
Cycle Start Date: April 24, 2025

Dear Administrator:

On April 24, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted 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 location for imposition. The CMS location 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 May 29, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 29, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 29, 2025.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 $13,343; 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 May 29, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Parkview Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 29, 2025. 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)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
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

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 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 location and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 24, 2025 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:

Stamika.brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

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 tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245436	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER	55 TENTH STREET SOUTHEAST WELLS, MN 56097

(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 4/22/25 to 4/24/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H54363269C (MN00112416), with a deficiency cited at F684 and F686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 684	Preparation and/or execution of this plan	5/26/25

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

Electronically Signed | 05/21/2025

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 684	Continued From page 1 facility failed to comprehensively assess and monitor for change in condition following computer tomography with contrast dye to ensure appropriate and prompt treatment for 1 of 1 residents (R1) who was at risk for acute renal failure. Additionally based on observation, interview, and record review the facility failed to comprehensively assess, monitor, and treat wounds for 1 of 1 residents (R2) reviewed for non-pressure skin concerns. Findings include: R1's quarterly minimum data set (MDS) dated 2/25/25, indicated R1 had intact cognition and was dependent on staff for all dressing, toileting, personal hygiene, transfers, and mobility with wheelchair. Further identified R1 had diagnoses that included hemiplegia following a cerebral vascular accident (CVA), heart failure, renal (kidney) failure, diabetes mellitus (inability to regulate blood sugars), dementia, and morbid obesity. The MDS also identified R1 was at risk for pressure ulcers. R1's care plan dated 10/2/2024, identified R1 had a provider order for life sustaining treatment (POLST) which include a do not resuscitate (DNR) and do not intubate (DNI) but did accept intravenous, oral, and intramuscular antibiotics. R1's care plan identified R1 was at risk for infections; had a self-care deficit requiring staff assistance; was resistive to care at times; had behavior problems toward staff; was at risk for falls; at risk for constipation; high risk for respiratory infections; on antidepressant medications; on anticoagulant (blood thinning) therapy; potential nutritional problem; an ulcer between 3rd and 4th toes; at risk for pain; high	F 684	does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and the plan of correction. This plan of correction is submitted as the facilitys credible allegation of compliance. Deficiency: The facility failed to comprehensively assess and monitor for change in condition following computer tomography with contrast dye to ensure appropriate and prompt treatment for 1 of 1 residents (R1) who was at risk for acute renal failure. Additionally, the facility failed to comprehensively assess, monitor, and treat wounds for 1 of 1 residents (R2) reviewed for non-pressure skin concerns. F684 Quality of Care Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents choices. 1 Corrective Action for Resident Affected: R1 Went to the hospital on 04/10/2025 and did not return to the facility due to death at the hospital. R2 A. R2s wound was comprehensively	

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F 684	Continued From page 2 risk for skin breakdown; bladder incontinence; and at risk for potential abuse and neglect. R1's care plan did not identify management and/or risk of congestive heart failure or renal failure A physician order dated 3/13/25, identified R1 to drink 5 six to eight ounce glasses of water daily in preparation for a dye study to protect the kidneys. R1's Medication Administration Record (MAR) for April 2025 indicated on 3/14/25 an order was entered to "encourage" resident to drink at least 5-6 eight-ounce glasses of water daily in preparation for a dye study to protect his kidneys. The MAR did not contain any monitoring of oral fluid intake. The MAR also noted, and order started on 4/4/25 and discontinued on 4/8/25, to monitor VS two times a day; if O2 sat not maintained above 90% or fever develops patient needs to be seen. The MAR also identified an order entered on 3/9/25 to monitor for vitals two times a day for infection. This order entry identified R1 had an elevated temperature of 99.3 degrees (F). R1's record did not identify a physician was notified of an elevated temperature. R1's physician order dated 11/22/22, included weight one time daily for congestive hear failure. The order did not identify parameters in which the physician was to be notified for weight gain/weight loss. R1's daily weight log indicated R1 weighted 325 pounds on 3/8/25 and 334.5 pounds on 4/8/25 which was an increase of 9.5 pounds in a month	F 684	assessed on 04/15/25 by RN-A. 1. The physician was notified of RN-As concern about the possible involvement of the right hip prosthesis by RN-A. 2. Orders were received. 3. An order was given for a CT of the right hip. Notification and education were provided to the family contact. The family agreed for R2 to have CT of the right. 4. CT was completed on 04/17/2025 5. R2 was added to the facility provider rounds for 04/17/25. 6. Antibiotics were ordered for R2 on 04/17/25. B. R2s wound was assessed on 04/22/25, and the provider was faxed for request for new treatment order due to worsening of wound depth and continued purulent drainage. 1. Treatment to add a 1/4 inch packing strip to the wound. C. A future appointment was scheduled with R2s Orthopedic provider at Mayo Clinic, Rochester for June 2025. This appointment was scheduled by a family member. RN-A has placed a call to the provider to see if a sooner appointment is recommended. Awaiting return call from provider. D. The Care Plan was updated with person-centered care to identify specific wound and providers dictation stating possibly a draining sinus tract and goals and interventions. J. Education and training, as listed below, was completed by staff and logged by DON.	

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F 684	Continued From page 3 with no documentation of physician notification of the increased weight and no evidence of further assessment of the weight gain to identify if the gain was related to fluid or nutritional related. R1's progress notes identified the following: 4/2/25 and 4/3/25, indicated R1 was out for appointments and returned with diagnoses of recurrent renal cell carcinoma with level two tumor thrombus (tumor extension into a vessel). 4/4/25 at 12:15 p.m., sent a physician request form to provider to request Mucinex and (as needed) prn neb [nebulizer]. [R1] present cough with mucus and complains of chest pain. COVID was negative. 4/4/25 at 2:03 p.m., family member (FM)-A would like [R1] watched closely to see if he needs an antibiotic. Mucus clear and does not have a fever. 4/4/25 at 3:10 p.m., received orders for DuoNebs (inhaler) and Mucinex (loosens congestion) prn and monitor VS (vital signs) and needs to be seen if fever or [oxygen] sats (saturations) below 90%. 4/5/25 at 5:30 a.m., temp. (temperature) 100.1 [degrees F]; oxygen sats 90% when lying down and 95% when sitting up on room air. Cough very loose. 7:39 a.m., called daughter and she wanted provider contacted. R1 was swabbed for RSV (respiratory syncytial virus) and FLU (influenza). 7:16 p.m., R1 tested negative for RSV, FLU, and COVID. 4/6/26 at 11:19 p.m., updated provider and received order for Zpak (used to treat bacterial infections).	F 684	K. Policies related to the alleged deficiency were reviewed, revised or newly drafted as needed. 2 Corrective Action for Other Residents It was determined that all residents have the potential to be affected by this alleged deficient practice. A. Comprehensive chart reviews were completed by RN-A on 5/4/25 and 5/5/25 for all residents to determine if they have had any change of condition, and if concerns or changes were noted, they were reported to the DON, assessed and monitored accordingly. B. In addition, the facility will conduct a facility-wide review to identify any residents who have undergone CT scans with contrast dye in the past 30 days that are at risk of acute renal failure. These residents will be assessed for renal function and monitored for any noted changes. C. Comprehensive chart reviews for diagnoses of heart failure, renal failure, and/or edema were completed for all residents, and person-centered care plans were updated as appropriate. D. Vital signs and weight parameters were received from the medical director for addressing abnormal vital signs and weight gain or loss to ensure proper assessments and timely provider notification occur. Assessment and monitoring will be completed if vitals or weight parameters are outside the norms. E. Written education was provided to	

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F 684	Continued From page 4 4/8/25 at 11:45 a.m., R1 does not have as frequent of a cough and cough is not as moist and congested, afebrile (no fever). 4/9/25 at 8:11 a.m., writer reported to the nurse that she thought resident was full of fluid and needed to go to the hospital. 4/9/25 11:31 a.m., resident awake since 4am [4:00 a.m.]; at 7 am R1 asked to lie down in bed and indicated not feeling well; temperature 99.3 [F], did not want breakfast, had chills, lungs [sounds] slightly diminished in bases. Documentation did not indicate provider was notified of change in condition and no further progress notes on 4/9/25. 4/10/25 at 5:38 a.m. R1 awake at 1a.m., taken CPAP (continuous positive airway pressure machine to treat sleep apnea) off and refused to allow it back on, oxygen sats 93% on room air. 4/10/25 at 10:35 a.m., [R1] assessed as "he seems to be worse"; audible wheezing and "wet" non-productive cough. O2 (oxygen) sats 89-90% on room air. R1 stated he feels "like shit and just might die". R1 had been eating and drinking minimally. Family in agreement to sent to ED. 4/10/25 at 7:14 p.m. R1 going to ICU (intensive care unit). R1's kidneys are shutting down and there is acid in his blood. R1's hospital Admission Note dated 4/10/25 at 11:23 p.m., identified R1 transferred to higher level of care hospital due to severe Acute Kidney Injury (AKI) and concern for need of urgent dialysis (filters waste and excess fluid from the	F 684	licensed nursing that lung sounds will be required with weekly vitals on any resident with CHF, and/or CKD. If abnormal, the provider and care contact are to be notified. Proper monitoring, assessments, and documentation is required. F. Any change of condition for a resident will require a nurse assessment, monitoring, notifications to family and provider, care plan revisions, and nursing documentation. G. A medication transcription error report was completed for the order to drink 5-6 8-ounce glasses of fluid daily, and education was provided to the DON by the corporate RN. H. Implementation has begun for all licensed nurses to document in PCC Progress Notes on all residents, every shift. I. New methods of communication between managers, charge nurses, and CNAs have been implemented, with expectations for proper and timely follow-up. J. DON spoke with the Medical Director on 05/21/2025 to explore options to get supplemental in-house provider coverage for acute care needs. The Medical Director and Administrator will propose the possibility of CNP coverage weekly through Mayo Clinic Fairmont and/or an MD from UHD Blue Earth twice a month. It was determined that all residents with non-pressure-related wounds have the potential to be affected. All residents were	

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F 684	Continued From page 5 blood). The Admission Note further indicated the etiology for R1's AKI differential includes mainly contrast [dye]-induced, and R1's cough and dyspnea are likely consequences of the fluid overload caused by the renal [kidney] failure. R1's death certificate indicated R1 died on 4/22/25, in the hospital due to acute and chronic kidney failure. During an interview on 4/23/25 at 5:00 p.m., FM-A identified R1 had at CT with dye contrast on both 4/2/25 and 4/3/24 and was told that R1 should have adequate fluid before and after the procedures to prevent kidney damage but, was not aware of the fluid order that was written on 3/13/24, and did not know if the facility was monitoring it. FM-A further identified R1 had a CT scan with dye on 4/2/25 and because of the findings, was asked to return for a second CT scan on 4/3/25 and R1 was "already feeling sick" by then. Reported R1 became "really sick" by the weekend (two days after the CT scan). FM-A asked RN-C to send him to the emergency department for evaluation but was told by RN-C that R1 did not have a fever, and they would not do anything for him until R1 developed one. FM-A stated during a visit on 4/9/25, a facility nurse (unsure which one) reported R1 was "better" and decided to wait one more day to have R1 seen by a provider. The next day, a different nurse called and stated R1 needed to be sent to the ED for evaluation and treatment. FM-A indicated she expected facility staff to be monitoring R1 more closely than they were. During an interview on 4/23/25 at 12:15 p.m., nursing assistant (NA)-A identified working with R1 the days prior to R1's hospitalization. On	F 684	assessed for skin-related concerns and/or wounds. A. Full body skin assessments of all residents were conducted by RN-A on 04/30/25 and 05/01/25 to determine if a resident had any undocumented skin concerns and/or wounds. B. A comprehensive review of all residents with non-pressure skin concerns/wounds and pressure-related wounds was completed to ensure care plans, notifications, comprehensive assessments, continued monitoring, and appropriate treatment plans are in place. C. All residents with wounds were evaluated for nutritional supplement needs, and provider requests for orders were obtained as deemed appropriate. D. Education for wound care, skin care, prevention of, observation, assessment, etiology, monitoring, reporting, documentation, and treatment was provided to licensed nursing, CNAs/TMAs, Administrator, and Dietary Supervisor via online, written, and instructor-led training. 3 Systemic Changes Made to Ensure Deficient Practice Will Not Recur: Policies The following policies were reviewed and revised as needed: A. CT Scan (with contrast dye) B. Change of Condition and Assessments	

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F 684	Continued From page 6 those days, R1 was "wheezing a lot" but was told R1 "had a cold or something". NA-A was not aware R1 had any wounds or pressure areas for R1. During an interview on 4/24/25 at 9:30 a.m., NA-B identified R1 was "more rude and disrespectful" then normal for a couple of days before he went to the hospital. NA-B stated he was "not feeling well, was more wheezy, appetite had decreased, not sleeping well, and was hard for us [staff] to get him to eat or drink anything." NA-B further identified she notified nursing staff and thinks they were checking on him more frequently but was not sure what the nurses were doing for R1. NA-B indicated staff were not monitoring R1's fluid intake or urine output. During an interview on 4/23/25 at 12:41 p.m., NA-C identified the nurses did not communicate to any of the staff about any need to increase R1's fluids and did not know that R1 should have had fluid intake monitored before and after the CT scan, and did not know that the CT scan could have put R1's health at risk further. R1 got sick with cold symptoms right after the CT scan. On 4/9/25, NA-C reported to RN-B that R1 was full of fluid, chest was full, stomach felt like "rubber" and was tight. RN-B told her the ED would not do anything for R1 because R1 was already on an antibiotic and nebulizer treatments. NA-C did not know whether RN-B further assessed R1 or not but in the morning of 4/10/25, R1 looked even worse and further described R1 was full of fluid, chest was rattling, having a hard time breathing, and appeared in a lot of pain. NA-C further reported that R1 told her that he had never felt that bad. NA-C then reported to RN-A and then RN-A assessed R1 and sent him to the	F 684	C. Wound Treatment Management D. Skin Assessment All survey deficiency-related new and/or revised policies will be reviewed by the QAPI team members on May 22, 2025. Process Changes A. Oral fluid monitoring will be completed when ordered by the provider or as a nurse order if concerns are noted. 1. Communication with nursing and dietary staff will be conducted per orders to ensure oral fluid orders are understood. 2. Documentation will be required to account for all fluid intake or restrictions. 3. If the order is to prevent acute kidney injury due to contrast dye procedures, the ordering provider will be notified of fluid intake prior to the scheduled test date. B. Monitoring and assessments for all residents who are scheduled for or who have completed a CT scan with contrast dye will be done. C. Any new orders and/or order changes that are received for a resident will be communicated to the resident and/or residents care contact and documented in the PCC resident progress notes. D. New process changes were implemented on how management will communicate with the nurses and CNAs for pertinent care-related information regarding residents and the expectations for each discipline to share care-related information with each other. 1. All licensed nurses now have email access and will be used as the primary	

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F 684	Continued From page 7 ED. During an interview on 4/22/25 at 1:40 p.m., licensed practical nurse (LPN)-C indicated if a resident is on a physician ordered fluid intake or restriction, it should be on the MAR and would be measured and monitored but did not know of any resident's that the facility had been monitoring for fluid intake or restriction within the past few months. If there is a change in condition, the nurse should immediately assess and document in the progress notes that the nurse notified the family and provider of the change. LPN-C denied working with R1 during the days prior to his hospitalization so was not sure of R1's condition. During an interview on 4/23/24 at 9:40 a.m., LPN-B identified being familiar with R1's cares but did not know he was to be monitored for fluid intake and did not know anything about R1 having CT scans done. LPN-B further identified R1's cough did not get any better so notified family and they requested antibiotics, the physician was notified and ordered antibiotics and did infection monitoring on R1 every shift (included monitoring temperature, pulse, respirations, pain, and oxygen level) but although R1's vital signs were stable, R1 did not get any better and one of the RN's from the office sent R1 to the ED, R1 was hospitalized, and died. During an interview on 4/23/25 at 11:32 a.m., social service designee (SSD) indicated [nurse] charting could be better so everyone could know what is happening with the residents. During an interview on 4/22/25 at 3:05 p.m., registered nurse (RN)-A indicated not seeing R1 for a week prior to 4/10/25 and was asked to	F 684	form of communication, along with the PCC communication board. 2. Nurse end-of/start-of-shift report will be given to CNAs. 3. Stop and Watch forms will be used by all departments. E. A new form will be drafted, reviewed, and approved to be filled out by licensed nurses of resident care-related concerns to be given to the provider when he is making facility rounds, instead of relying on word of mouth. F. All education that is provided, whether written, verbal, or online, will be logged and documented in personnel files and/or filed in the DONs education files. A. A wound care treatment protocol was drafted to include pressure injury and non-pressure wound treatments. It will be presented to the medical director and will be used as standing wound treatment orders. These protocols will need to be reviewed and signed off annually and PRN by the medical director. These protocols will allow nurses to treat a wound immediately upon discovery of a wound, which will be in the residents best interest for wound healing without delay. B. DON plans to assign ADON to the resident's weekly comprehensive wound assessments, and the DON will be the backup wound RN. The anticipated date for ADON to transition to the Wound RN is in approximately 6 months. Training and Education:	

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F 684	Continued From page 8 assess R1 for change of condition. RN-A noted R1 to have respiratory wheezing that was audible immediately entering the doorway and was dusky in color, with R1 stating he felt like he was going to die. RN-A notified family and arranged for ED transfer. RN-A also indicated an order was entered into the computer as "encourage to drink" instead of "drink" and no documentation was entered for tracking how much fluid R1 had consumed prior to or after the CT scans. During an interview on 4/23/25 at 3:45 p.m., the director of nursing (DON) indicated she received and transcribed R1's order for on 3/13/25 but instead of "drink" five 6-8 ounce glasses of water a day prior to the CT scan, transcribed the order as "encourage" five 6-8 ounce glasses of water a day and verified there was a difference in the interpretation of "drink" and "encourage". The DON also stated she should have transcribed the order exactly as written, monitored the amount of fluids R1 had consumed, and communicated that amount to the provider that ordered the CT scan. The protocol for recognizing a change in condition is the nursing assistants (NA)'s inform the nurse and then nurse is to do an assessment of vital signs, oxygen level, lung sounds for respiratory, overall condition. If needed, the nurse would call the family to see if the resident should go in [clinic or ED] to be evaluated. If not, we would call or fax the doctor. The DON indicated R1 had a "big change" in condition on 4/5/25-4/6/25, when R1 developed a fever and lung sounds slightly diminished. We [facility nurse] got an order for nebulizer and Mucinex and he should have been monitored daily. The DON indicated vital signs were put in R1's MAR but lung sounds, or edema is not routinely checked unless the nurse "felt it was something	F 684	A. Mandatory online Educare modules that have been assigned to all licensed nursing staff for completion prior to the correction date: 1. Clinical Competency-RN & LPN-Skin & Wound Care 2. Documenting, Observing, & Reporting 3. Medication & Treatment-Wound Care 4. Pressure Ulcer Prevention & Skin Care 5. Clinical Competency-RN & LPN-Dressing Change B. Impact Medical in-house/in-person mandatory wound training was completed for all licensed nursing staff, administrators, and dietary supervisor. It was also offered to CNAs. C. Nurse Wound Education was provided in written form. D. Charge Nurse Wound Education was provided in written form. C. Miscellaneous Education that was provided: * PCC Connect and Nursing Advantage education was done with all nurses. * Any orders that are received will be entered as a provider order into the MAR. Prior to the discontinuation of any order, a DC order will be requested from the provider. 1. Nursing will not DC orders without a provider-written or telephone order. * Notification to the provider will be done with a resident change of conditions. * Lung sounds to be included in weekly vitals monitoring for all residents with CHF and/or CKD. * Wounds and dressings must be	

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F 684	Continued From page 9 that needed to be done". The DON further identified R1 asked to go to the ED on 4/9/25 but R1 seemed to be the same as the day before so did not send him. The DON confirmed there was no documentation about R1's condition change until the next day (4/10/25) when R1 transferred to the ED. The DON stated she would have expected to see more [progress] notes than there were. R2 R2's face sheet dated 4/23/25, identified diagnoses of presence of right artificial hip joint (replacement of artificial parts for bone), and infection and inflammatory reaction due to internal right hip prosthesis (infection and inflammatory reaction that occurs around a joint replacement implant). R2's quarterly Minimum Data Set (MDS) dated 4/11/25, identified R2 had some cognition issues, no behaviors, independent with activities of daily living, and used a walker for mobility. R2's care plan dated 11/20/24, identified potential for skin breakdown. Interventions included weekly treatment documentation to include measurement of each area of skin breakdowns width, length, depth, type of tissue and exudate and any other notable changes or observations. R2's care plan did not identify any specific areas of skin concern. R2's physician notification form with approved order dated 9/19/24, identified R2 had an open wound on back of right hip that measured 2.0 cm x 1.0 cm. looked like a pressure sore from hip	F 684	monitored daily and wounds assessed every 7 days. * Post-contrast dye procedures require monitoring, especially if a resident has renal failure. * Monitoring and documenting any provider or nursing oral fluid orders will be required. * New wound treatment protocols as standard orders. * Change of Condition assessment, monitoring, reporting, notifications, documentation. * Resident Rights- Right to go to ED if requesting. * When nurses receive reports for care concerns of our residents from CNAs, they must follow up timely and be addressed appropriately. * EBP re-education review was provided to all nursing staff. D. All staff will be re-educated on the Stop and Watch forms that are available at the nurses stations on the west and east halls, the maintenance room, dietary, and therapy department. E. Educare Module: Documenting, Observing, Reporting was assigned to all CNAs/TMAs. 4 Monitoring and Quality Assurance: The DON will be responsible for identifying trends and areas for continued improvement, overseeing the implementation of corrective actions, and ensuring compliance. All nursing staff will be responsible for	

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F 684	Continued From page 10 being pressed on side of recliner. Orders to clean and cover with mepilex (name brand of a foam absorbent dressing) until resolved. R2's progress note dated 1/4/25, identified R2 took off mepilex and noted drainage coming from gluteal fold. Serosanguineous drainage, wound edges intact, wound bed is reddish surrounding yellow/whitish in the middle of the wound. Measurements are 1.5 cm x 1.0 cm x upper part of the wound 0.8 cm depth and lower part is 0.5 cm depth. Cleansed, applied mepilex with hydrogel. R2 had no pain with the only complaint being itchiness. At 10:42 a.m., R2 stated he did not want a big dressing on his wound. Informed R2 he had more drainage at night and the bigger foam should help. Refused hot pack prior to dressing change. R2's skin observation tool dated 1/4/25, identified a skin abnormality to right gluteal fold, type of wound was pressure stage III with measurements of 1.5 cm x 1.0 cm x depth of 0.5 cm and 0.8 cm. Applied hydrogel and mepilex after cleansing. R2's progress note dated 1/6/25 at 8:30 a.m., identified there are no wounds on buttocks or gluteal fold. Only wounds are on right hip area. The lower wound is located at the top of an old hip surgery incision, area is a hole which the wound bed is located at the base of the hole and the skin up the edges of the hole and top of the hole are normal color, intact skin with no maceration. Wound bed which only covers the base of the hole measured 1.0 cm x 1.5 cm and 0.1 cm depth. 85% red beefy tissue and 15% yellow slough. The other wound which is located about 1.0-1.5 inches above the other wound is 0.5 cm x 1.0 cm and 0.2 cm depth with	F 684	adhering to all policies and procedures. The DON, ADON, or licensed nurse designee will complete A. 2 audits weekly (for each of the 8 concerns) for 4 weeks (3 of these audits per concern, 1-5 will be for R2) B. Then 3 audits per month (for each of the 8 concerns) for 3 months (2 of these audits per concern 1-5 will be for R2) C. Then, 1 audit monthly (for each of the 8 concerns) for the next 3 months (1 of these audits for each concern 1-5 will be for R2) D. Ongoing audits as needed until compliance is met for each of the following concerns. 1. Audit care plans for all residents with CHF, CKD, edema, and/or wounds to ensure appropriate problems, goals, and interventions are written and person-centered for the identified resident. 2. Change of Conditions- Audit the 24-hour report in PCC for any resident with significant changes, and if any change of condition is noted, was assessment, monitoring, notifications, documentation, and care plans completed? 3. Audit for new wound concerns- Was assessment, monitoring, notifications, reporting, documentation, and care plans completed? Proper etiology and treatment documented? 4. Audit existing wounds- Is the wound progressing? If not, was the provider notified and a new treatment order	

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F 684	Continued From page 11 yellow/pink wound bed. R2 did not have the wounds covered and stated he took it off because it bothers him and makes him itch. Noted an area of serous drainage on pants about the size of an orange. Will fax MD-A for change in treatment as there is too much drainage for silver hydrogel to be effective. At 11:14 a.m., order obtained to change treatment to calcium alginate to wound bed, after cleansing with wound cleanser apply skin protectant to surrounding skin and cover with mepilex daily. R2's physician notification form with approved order dated 1/6/25, identified R2 continues to have a large amount of drainage to wound on right outer buttock. May we change to calcium alginate after cleansing with wound cleanser and skin protectant to surrounding skin and cover with mepilex. Response was ok to wound treatment changes. R2's skin observation tool dated 2/26/25, identified open area on right buttocks still has small pinpoint opening below skin bubble that sticks out. Dressing was saturated with sanguineous (blood mixed with yellow liquid) fluid. No redness or signs of infection. No measurements provided. R2's record did not identify weekly skin evaluations with measurements on 3/5/25. R2's skin observation tool dated 3/12/25, identified wound care being done to right hip region. No measurements, type of wound or drainage provided. R2's progress note dated 3/2/25 at 9:40 p.m., identified changed dressing to ulcer on buttocks.	F 684	received? 5. Any new orders- Were they transcribed as written? Were resident and care contact notified? 6. Audit vital signs and weights- Were abnormal vitals and/or weights that are outside the physician-recommended parameters reported to the provider? Was monitoring and assessments started? 7. Audit all oral fluid orders. 8. Audit any CT scans with contrast dye orders. Was policy and procedure followed? Audits will include the above questions listed but not limited to. If any negative findings are noted, corrections will be completed. Completed audit forms will be reviewed and discussed with the QAPI committee during the weekly QAPI meetings. If necessary, an action plan will be written by the QAPI committee. Any written action plan will be monitored by the Administrator weekly until an acceptable resolution is obtained. All new and/or revised policies, as listed above, will be reviewed by the QAPI committee for approval. Additional revisions will be added as needed and readdressed. The survey deficiencies were discussed during the facility QAPI meeting on May 1, 2025. Policies and procedures will be discussed	

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F 684	Continued From page 12 Continues to be the same, not healing but not worse. R2's skin observation tool dated 3/13/25, identified pinpoint open area that drains serous fluid on right hip has 0.4 cm high skin growth next to open area. No measurements or type of wound provided. R2's progress note dated 3/15/25, identified dressing change to right hip area after a warm pack for 15 minutes. Small amount of drainage with no odor. R2's skin observation tool dated 3/18/25, identified pinpoint area that drains serous fluid on right hip has 0.4 cm high skin growth next to open area. No measurements or type of wound provided. R2's record did not identify weekly skin evaluations with measurements on 3/26/25, and 4/2/25. R2's progress note dated 4/8/25 at 11:36 a.m., identified wound on right hip is no longer open, is fully covered with normal color skin and no drainage. R2's progress note dated 4/14/25 at 12:15 p.m., identified area on right hip that was resolved is now open again and measured 0.2 cm x 0.3 cm x 0.3 cm water blister noted below open area. Moderate amount of serous drainage from area. Will inquire with family if they would like to take R2 to wound clinic as this was closed and now is open again and took a long time to heal. Family requested to continue treatment at facility. At 2:32 p.m., upon inspection of wound again noted that	F 684	and approved by the QAPI committee on May 22, 2025. POC completion will be reviewed and discussed on May 22, 2025. The survey results and plan of correction with completed audits will be reported to QAA on July 17, 2025. Completion date: 05/26/2025	

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F 684	Continued From page 13 wound is 2.5 cm depth and about the size of the wooden end of a Q-Tip. R2's weekly skin observation dated 4/15/25, identified location was healed surgical scar on right hip/buttock with unknown etiology. Impression was worsening. Slough tissue and unable to visualize wound base due to minimal opening at top layer of skin. Moderate amount of yellow, tacky drainage with no odor. Depth measured 5.2 cm. Scar tissue around wound macerated and irregular. No suspected infection or inflammation present. Orders for CT of hip. Cover with absorbent dressing. MD-A does not feel packing the wound is needed currently. R2's progress note dated 4/15/25 at 10:15 a.m., identified wound is directly on the healed surgical scar from right hip revision. No peri wound redness, no pain or discomfort. Wound has very small opening at surface of epidermal layer. Able to probe Q-Tip into wound 5.2 cm depth but may be deeper. Unable to determine if wound tracts or undermines and unable to measure length and width due to small opening. Drainage is yellow and tacky. Packed with one fourth inch packing strip and covered with absorbent bordered dressing. Notified family and they are willing to get treatment and be seen at a wound clinic. Will contact MD-A for wound dressing change and wound clinic referral. At 12:25 p.m., spoke with MD-A to get referral for dressing order and wound clinic appointment. MD-A felt that this may involve the right hip prosthesis, and the first step should be a right hip CT. if there is prosthesis involvement, dressings are irrelevant at this time. Family aware. R2's progress note dated 4/16/25 at 11:01 a.m.,	F 684		

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F 684	Continued From page 14 identified area on buttocks still open 0.25 cm round with serosanguineous drainage, dressing changed. R2's progress note dated 4/17/25 at 11:05 a.m., identified MD-A examined wound on right hip by palpation and movement and discussed getting the CT scan. The physician visit note dated 4/17/25, identified the biggest concern was R2's hip wound and concern for an underlying infected hip replacement. R2 denied pain in that area interestingly. Area over the right hip shows a depressed area that is red, somewhat irritated, with an open area in the center that medical director (MD)-A was unable to express any purulent (thick, milky discharge that typically indicates an infection) material out of but does appear as though it has been draining. Possibly a draining sinus. Ordered at computed tomography (CT) scan of pelvis and hip to observe how deep the area of infection over the right hip was. Nursing staff stated it has been draining and this is a concern given R2's history of infected prosthetic. Certainly, prudent to look at a referral to orthopedic department for their thoughts. If R2 does have an infected right hip replacement that is not going to heal without removal, spacer, antibiotics, etc. this would likely result ultimately in R2 not really doing well at all. R2's CT with IV contrast dated 4/17/25, identified diagnoses of septic arthritis (painful infection in a joint), arthritis pyogenic hip (serious painful infection of joint often caused by bacteria). A small quantity of fluid is seen along the lateral incision within the proximal superficial subcutaneous tissue (layer of skin) of right thigh	F 684		

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F 684	Continued From page 15 measured approximately 5.4 cm x 3.2 cm x 4.4 cm in size. R2's progress note dated 4/17/25 at 5:04 p.m., identified MD-A reviewed CT results. Fluid collection increased in size and ordered Keflex and doxycycline. Also, arginaid ordered. At 5:53 p.m., changed dressing to right hip. Light tan colored drainage noted on old mepilex. No signs of infection noted to area. R2's physician notification form dated 4/17/25, identified MD-A reviewed the CT results per radiology and it appeared the fluid collection has increased in size some from previously. MD-A recommended these findings be reviewed by orthopedic team that worked on R2. In the interim, start R2 on an antibiotic. Keflex 500 mg three times per day for 10 days and doxycycline 100 mg twice daily for 14 days. R2's physician notification form dated 4/22/25, identified wound on right buttock/old surgical scar continues to close over and fill with yellow, tacky fluid. Depth almost at 6 cm. May we add one fourth packing strip to wound with current orders and wondering if R2 should be seen by orthopedics. Reply was ok for packing of wound and recommended being seen by orthopedics to determine need for additional imaging and intervention. R2's weekly skin observation dated 4/22/25, identified location as healed surgical scar right hip/buttock with unknown etiology. Unchanged. Slough tissue present, moist. Very small opening with deep tract. Unable to visualize base. Large amount of purulent drainage with no odor. 0.1 cm x 0.1 cm x 5.8 cm depth. Indurated, scar tissue	F 684		

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F 684	Continued From page 16 on peri wound. No infection suspected and no inflammation present. Cover with absorbent dressing. Sent fax to MD-A about packing wound. No evidence of healing, continued to drain large amount of tacky, yellow fluid. R2's progress note dated 4/22/25 at 6:09 p.m., identified fax sent to MD-A for order to pack right buttock wound with one fourth inch packing, as it continues to close over the tiny opening and fill with thick, tacky yellow drainage. Wound measured 6+ cm depth. Also questioned if follow-up with orthopedics was needed. R2's care plan dated 4/23/25, identified potential for skin breakdown. Has an open area on right hip. Interventions included treatment to open area on right hip as ordered by doctor, pack with packing after cleansing and cover with dressing daily, use only a continuous strip and leave a tail of 2-3 inches on outer side of wound to prevent packing getting left in wound. R2's skin observation tool dated 4/23/25, identified skin abnormality to right trochanter (hip), type is listed as other. Measurement 1.0 cm x 0.5 cm x 5.0 cm depth. Currently just covering wound with dressing per provider, pending an updated wound care order. R2's progress note dated 4/23/25 at 12:48 p.m., identified an orthopedic appointment for right hip had been made. During an interview on 4/23/25 at 11:22 a.m., licensed practical nurse (LPN)-A stated the nurse would check every resident's skin when they had a bath. The nurse would assess skin issues, bruises, dressings that are in place. For new skin issues the doctor, director of nursing (DON), and	F 684		

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F 684	Continued From page 17 family are notified. During an interview on 4/23/25 at 11:30 a.m., LPN-B stated she had measured the length and width of R2's wound but not the depth on 4/23/25 after he had a bath. R2 did not currently have a dressing in place on his right hip wound. Registered Nurse (RN)-A had been measuring the depth. They were waiting for new orders from the doctor for packing the wound. During an interview on 4/23/25 at 11:39 a.m., RN-A stated she had taken over wound management the week of 4/14/25. During an observation on 4/23/25 at 12:50 p.m., LPN-B and RN-A applied enhanced barrier precautions (EBP) prior to entering R2's room. R2 had been seated on the edge of his bed and stood up with a walker upon LPN-B and RN-A entering the room. LPN-B placed a clean towel over R2's overbed table and moved the garbage close to the overbed table. LPN-B removed needed wound care supplies from R2's closet and placed on towel. RN-A described the process for packing the wound with a tail to LPN-B. RN-A stated R2 had a CT scan last week. The wound would close over with fluid. The packing is to keep the wound open and wick out the fluid. The wound opening is the size of a Q-tip and does not have pain with it. The wound has been an on-going issue since 9/24. RN-A lifted up R2's skin as the wound site was not visible without lifting the skin up with a hand. RN-A pointed out that proud flesh dimpled skin was at the end of the right hip surgical scar and the opening to the wound was not really visible. RN-A took took the wooden end of a Q-tip and placed it inside the wound opening and moved the Q-tip around.	F 684		

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F 684	Continued From page 18 RN-A stated the wound felt boggy against the Q-tip. Removed Q-tip and measured the Q-tip with red-tinged drainage on it at 4.8 cm depth. Red liquid dripped from the wound down R2's leg. RN-A used a new Q-tip, after measuring out packing for the wound, and began to insert packing in the wound bed. R2 made noises and winced during this process. RN-A stated it was very difficult to pack the wound as it was such a tiny opening. Packed the wound with a tail hanging out and placed a mepilex over the area. Both nurses removed EBP when care was complete. During an interview on 4/23/25 at 1:39 p.m., LPN-B stated she was unsure how long it would take a boil to heal. Pressure sores occur from not having blood circulate to an area from a point that has pressure on it and did not feel that R2's wound was from pressure. Wounds should be measured a minimum of once a week and if a wound is not healing or does not have any change to it, the doctor should address every one to two weeks. During a phone interview on 4/29/25 at 12:50 p.m., MD-A stated if he had been aware that the 'boil' area that was being treated was on the right hip surgical site he would have ordered a CT sooner and consulted with R2's surgeon. One of the reasons MD-A ordered the CT scan was because he was under the impression that this was a new wound that had popped up. During an interview on 4/24/25 at 9:05 a.m., RN-A stated she had first observed R2's hip wound on 4/15/25. Prior to observing the wound, RN-A was under the impression that R2's wound was a boil. The charge nurses are in charge of the	F 684		

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F 684	Continued From page 19 day-to-day wound treatments and RN-A would complete a weekly skin wound assessment that would include assessing for changes, notifying the doctor for wound treatments and updating with changes, notifying family as needed. RN-A had completed wound training with licensed nursing staff within the past year but did not include nursing assistants (NA)'s in the education. Medical doctor (MD)-A would have to be notified and requested to look at wounds during his monthly rounds if a wound needed to be looked at. RN-A had addressed with MD-A the extent of R2's wound on 4/15/25 and that is when the CT was ordered. MD-A was not aware that R2 still had a wound on his right hip. Moving forward MD-A and family will be informed when wounds heal and the site will be monitored for a week afterwards. RN-A was completing the weekly wound assessments in the interim until the facility determined who would be in charge of them. During an interview on 4/24/25 at 10:36a.m., DON stated a wound resource binder is located at each nursing station. Wounds should have a weekly comprehensive assessment completed. DON was unable to articulate the amount of time a treatment should be completed before re-evaluation but if there was no change for a while would reach out to MD-A to request new treatment orders. There is no protocol for monitoring a healed wound and it would just be part of the nurses responsibility to assess weekly on bath days. The braden assessment is completed to determine a residents risk for pressure ulcers and pressure reducing mattresses and wheelchair cushions are interventions that would be put in place. MD-A would address wounds on residents whenever necessary. DON would go with on rounds and	F 684		

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F 684	Continued From page 20 have handwritten notes of items that needed to be addressed and tell MD-A while in the room with the residents. DON did not have any wound care audits or confirmatory training paperwork on specific wounds with nursing staff completed, any education was only verbal. DON could not recall if she had assessed R2's wound at the initial evaluation. DON did not feel that a boil would remain from September until April and had only assessed the wound when she was working as the floor nurse. There had not been any discussion or concern that the wound could be infected and/or have something to do with his right hip prosthesis even though R2 admitted to the facility with a diagnosis of infection and inflammatory reaction from the right hip prosthesis. Treatment for wounds are determined by review of the nurse resource manual, review from DON or RN-A and the request faxed to MD-A with what orders the facility would like for treatment. The expectation is that wounds are measured, documented, complete assessment and weekly review completed and addressed with MD-A on monthly rounds or as needed for wound worsening or healing and needing new treatment orders. The DON was in charge of completing and comprehensively reviewing weekly wounds but currently RN-A had begun completing them in the interim. The goal is to have the assistant director of nursing (ADON) complete them (after orientation) and DON would be the back-up. The facility Wound Treatment Management policy revised 4/2025, identified to promote wound healing of various types of wounds, the facility would provide evidence-based treatments in accordance with current standards of practice and physician orders. The effectiveness of treatments will be monitored through ongoing	F 684		

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F 684	Continued From page 21 assessment of the wound. Considerations for needed modifications include lack of progression towards healing, changes in wound characteristics, and changes in resident goals and preference. The facility policy titled Change of Condition and Assessments Policy and Procedure last reviewed 4/17/25, indicated the policy establishes standardized procedures for registered nurses (RNs) to assess and manage changes in condition among residents. The goal is to ensure timely detection, documentation, and intervention for any significant alteration in a resident's baseline status, safeguarding resident health and well-being. The policy defines change in condition as major decline or improvement in a resident's baseline status that will not normally resolve without intervention by staff, will not normally resolve by implementing standard disease related clinical intervention, and the decline is not considered self-limiting. Indicates a focused assessment is a targeted approach to assessing a resident for a specific health concern or area of care. This type of assessment is used to evaluate the resident's immediate needs, symptoms, or risk factors related to a particular condition, system, or issue. The purpose of a nursing-focused assessment is to collect and compare data to normal findings and the individual patient's current health status, and reporting changes and responses to interventions in an ongoing manner to a registered nurse or the appropriate licensed health care provider. The LPN may not initiate any new plan of care items; they may only update existing care plans. The procedure is as follows: If the LPN determines there is as change from normal findings and the individual patient's current health status, the LPN	F 684		

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F 684	Continued From page 22 will communicate to the RN if in the building. If not, should be communicated to MD (medical doctor) or on call physician (if unable to contact the MD). The RN will determine whether they need to complete further assessment. When a resident experiences a change in condition the RN will complete a comprehensive assessment and, if appropriate, update the care plan. A RN will complete a nursing assessment when there is a potential status change to determine if the resident is experiencing a change in condition. The nurse must assess the resident and, if the resident remains at baseline, the assessment completed should be documented. If the resident is experiencing a change of condition, the RN will complete a comprehensive assessment. The Facility Assessment policy last revised 4/2025, indicates the facility provides management of medical conditions with assessment, early identification of problems/deterioration, management of medical and psychiatric symptoms such as heart failure, diabetes, chronic obstructive pulmonary disease (COPD), and infections.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		5/26/25

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F 686	Continued From page 23 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess, monitor, and provide interventions to prevent pressure ulcer development, promote healing, and prevent deterioration for 1 of 3 residents (R3) who had pressure ulcers. The facility's failures resulted in harm when R3 developed a stage 2 pressure ulcer (PU) that deteriorated to a stage 3. Findings include: STAGING Staging of a PU/PI is performed to indicate the characteristics and extent of tissue injury, and should be conducted according to professional standards of practice. Determining whether damage to the skin and underlying tissue is a PI or PU depends on the staging of the damaged tissue. Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis 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	F 686	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facilitys credible allegation of compliance. Deficiency: The facility failed to comprehensively assess, monitor, and provide interventions to prevent pressure ulcer development, promote healing, and prevent deterioration for 1 of 3 residents (R3) who had pressure ulcers. The facility's failures resulted in harm when R3 developed a stage 2 pressure ulcer (PU) that deteriorated to a stage 3. F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates	

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F 686	Continued From page 24 folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Ulcer: Full-thickness skin loss 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 UP/PI. R3's face sheet dated 4/23/25, identified diagnoses of edema (swelling caused by excess fluid). R3's quarterly Minimum Data Set (MDS) dated 3/19/25, identified R2 had no memory issues, did not reject cares, was dependent on staff for putting on and taking off footwear, R2 was at-risk for pressure injuries but did not have any. R3's care plan dated 3/25/25, identified R3 had a whirlpool bath weekly and required 1-2 staff to assist with bathing. The care plan identified a potential for skin impairment dated 10/13/23, identified interventions of Braden risk assessment, keep skin clean and dry, report any signs of skin breakdown, weekly treatment documentation to include measurement of each area of skin breakdowns width, length, depth, type of tissue and exudate and any other notable changes or observations.	F 686	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. 1 Corrective Action for Resident Affected Immediate Assessment: During an in house podiatry evaluation visit, R3 was found to have a stage III pressure injury on her right foot between the 3rd and 4th toe. 1. Immediately upon being notified, RN-A spoke with MD-B, RN-A assessed and treated the wound as ordered. 2. During the nurse assessment, it was found that R3 had significant edema (+4) in the right foot and edema (3+) of the right leg. Compression wraps were removed and reapplied, paying attention to protecting the foot with soft padding, starting at toes and finishing just below the knee. 3. R3 did not offer any complaints of pain during wound dressing application. 4. After direct care for R3s pressure ulcer: a. Comprehensive wound assessment was completed in PCC. b. Progress note created. c. Risk management incident report filled out. d. Notification to primary provider, family, administrator, and director of nursing. e. The care plan was updated with a	

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F 686	Continued From page 25 R3's podiatry evaluation dated 12/17/24, identified there was a small stage II ulceration to the right medial 4th toe. An offloading pad/dressing was applied. Keep the right foot dry in the shower and sponge bathe for now. Offload the area, keep dressing intact. If dressing falls off apply iodine, gauze and kling daily. Return to clinic in 3-4 weeks or sooner if problems arise. An addendum to the note on 12/17/24, identified R3's family did not want to transport R3 to the clinic and preferred the facility to treat the wound. Therefore, requested the nurse dressing daily, (but) wait to removal of initial dressing for two weeks. Then cleanse the ulcer daily and apply iodine, gauze, kling and paper tape. Keep the foot dry in the shower and sponge bathe until the ulcer is healed. Call the office with any questions of if the ulcer is getting worse or not healing for an appointment or go to the nearest hospital. Review of R3's progress notes dated 12/17/24 through 12/31/25 did not identify the dressing was left in place for two weeks as ordered. According to R3's treatment administration record the order for daily wound care dated 1/1/25 was discontinued on 1/2/25; R3's record did not include an assessment and/or documentation the wound had healed. During an interview on 4/23/25 at 1:39 p.m., licensed practical nurse (LPN)-B stated she could not remember if she discontinued the treatment on 1/2/25 but recalled that a dressing had been in place between the 3rd and 4th toes. They were told to monitor and after a couple of days to take the dressing off and discontinue the order. LPN-A stated when the order was discontinued on 1/2/25, the area did not appear healed. The area was scabbed over but not macerated. R3's toes	F 686	person-centered pressure injury problem, goal and interventions. f. Education provided to nursing staff regarding pressure ulcer, keeping foot dry and edema. g. Corrective action and re-education were completed with the nurse RM-LPN for failure to properly assess/monitor, document, and notify the provider and family care contact when she was notified of pressure injury on 4/18/25 by NA-D. Treatment Plan: 1. A comprehensive treatment plan was ordered by MD-B on 4/22/2025 and implemented immediately by RN-A. 2. The order was transcribed that included to keep the right foot dry during showering. 3. New compression wraps were used for B/L legs. 4. Education on proper wrap techniques was provided to nursing staff via the communication board on PCC. 5. Due to the significant degree of edema, a referral was requested and received from the primary provider for OT to evaluate and treat R3s edema. New wrap orders have been received and are being used currently. 6. Plastic waterproof leg/foot protectors were ordered and should arrive by 5/22/25. Family Notification: R3's family contact was informed of the pressure injury, MD-Bs request to see the resident in the clinic in 4 weeks, and the steps to address the pressure ulcer.	

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	245436	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER	55 TENTH STREET SOUTHEAST WELLS, MN 56097

(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 686	Continued From page 26 were always puffy and so was her foot so ace wraps were used. R3 had a weekly bath and the NA's (nurse aides) got her feet in there to let them soak. LPN-B observed her skin after the bath but had not looked between the toes where the UP/PI was located. R3's bath skin assessment dated 1/8/25, identified a handwritten note that stated "toe" in parenthesis. R3's record did not identify a wound assessment was completed on the pressure ulcer between the 3rd and 4th toes of right foot between 12/17/24-4/21/25. R3's podiatry evaluation dated 4/22/25, identified stage III pressure ulcer to the medial right 4th toe, with maceration, no signs of infection. Debrided the ulcer at visit. Orders included to cleanse ulcer daily with saline damp gauze, dress daily with iodine, gauze, kling, and paper tape. Keep dry in the shower. Follow-up in the office in four weeks, call with questions or concerns. Add one package of Arginade per day. R3's progress note dated 4/22/25 at 9:01 a.m., identified podiatry was in house and ordered right medial 4th toe ulcer to cleanse daily with saline damp gauze, apply iodine, gauze, kling, and paper tape. Keep dry in the shower and follow up in four weeks. Add one packet of Arginade daily. At 9:59 a.m., spoke with family member (FM)-B in regards to the pressure injury worsening and the risks involved with wounds of the sort and difficulty of healing. Daughter requested to continue treating at facility. R3's care plan dated 4/23/25, identified pressure	F 686	Daughter declined to have an appointment made in the podiatry clinic for R3 despite RN-As education that was given, describing risks. 2 Corrective Action for Other Residents It was determined that all residents who are at risk of developing a pressure injury have the potential to be affected by this alleged deficient practice. A. Full body skin assessments of all residents were conducted by RN-A on 04/30/25 and 05/01/25 to determine if a resident had any undocumented skin concerns and/or pressure injury wounds. Skin assessment findings were documented in resident charts. B. A comprehensive review of all residents with pressure-related wounds and also non-pressure skin concerns was completed to ensure that their care plans, notifications, comprehensive assessments, continued monitoring, and appropriate treatment plans are in place, including pressure-reducing surfaces and repositioning plans. C. All residents with wounds were evaluated for nutritional supplement needs, and provider requests for orders were obtained as deemed appropriate. D. Education for wound care, skin care, prevention of, observation, assessment, etiology, monitoring, reporting, documentation, and treatment was provided to licensed nursing, CNAs/TMAs, Administrator, and Dietary Supervisor via online, written, and	

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F 686	Continued From page 27 ulcer on the medial aspect of right 4th toe related to immobility and edema. Interventions included to measure length, width, and depth where possible, document wound perimeter, wound bed and healing progress. Report improvements and declines to medical doctor. Due to difficulty of visualizing the wound for proper assessment, do dressing change and assessment when lying in recliner or bed. If unable to get right toe gauze to stay in place, apply lambs wool between 4th and 5th toes of right foot instead but it is important to cushion with one or the other. R3's weekly wound observation tool dated 4/23/25, identified pressure ulcer stage III to right 4th toe webbing acquired at facility. Wound had begun as a stage II. Wound tissue was moist with 100% slough (dead tissue presents soft, yellow, or white) present. No odor or drainage present. Wound measured 0.3 centimeters (cm) x 0.4 cm x 0.2 cm depth, depth approximate due to slough covering wound and unable to see base of wound. Surrounding skin is macerated (moist) and erythematosus (red). 4+ edema on top of right foot, fluid filled thin skin, 3+ edema in right mid-calf to knee. Inflammation is present with redness and discomfort at wound site. Treatment included to cleanse the ulcer with saline damp gauze, apply iodine, gauze, cling, and secure with paper tape. Keep dry in the shower. Updated order included that iodosorb (iodine gel primarily used to clean wounds and promote healing) could be applied to wound bed and lambs wool in between toes if gauze does not stay in place. Do not wrap multiple toes together to avoid added pressure. R3's progress note dated 4/23/25, identified right foot 4th digit wound assessed and dressing	F 686	instructor-led training. E. All residents who are at risk for pressure-related skin injury were identified, and ensured that preventative measures were in place as appropriate. F. DON spoke with the Medical Director on 05/21/2025 to explore options to get supplemental in-house provider coverage for acute care needs. The Medical Director and Administrator will propose the possibility of CNP coverage weekly through Mayo Clinic Fairmont and/or an MD from UHD Blue Earth twice a month. 3 Systemic Changes Made to Ensure Deficient Practice Will Not Recur: Policies The following policies were reviewed and revised as needed: A. Wound Treatment Management B. Skin Assessment C. Skin Integrity-Foot Care D. Pressure Injuries All survey deficiency related new and/or revised policies will be reviewed by the QAPI team members on May 22, 2025. Process Changes A. A wound care treatment protocol was drafted to include pressure injury and non-pressure wounds treatments. It will be presented to the medical director and will be used as a standing wound	

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F 686	Continued From page 28 completed. Wound is in the web of fourth and fifth digit, difficult to dress. Notified podiatry of difficulty dressing and ease of unintentional removal of dressing with sock, ace wraps, and slippers on/off. Do not wrap toes together as this could compromise wound be adding additional pressure. Additional orders received for wounds and tentative appointment scheduled. Dressing changed to bedtime so foot is not dependent and wound would be easier to visualize. During an interview on 4/23/25 at 11:18 a.m., R3 was sitting in her wheelchair with her feet on the floor and wearing slippers. R3 stated she had her toes looked at on 4/22/25 by podiatry and they saw a sore on her toe. R3 thought she had the sore for awhile. R3 did not think the nurse had changed the dressing today. During an interview on 4/23/25 at 11:22 a.m., licensed practical nurse (LPN)-A stated skin is checked weekly after showers. The nurse will look at bruises, open skin, and dressings. LPN-A reviewed R3's medical record and did not see anything identified as a pressure ulcer. During am interview on 4/23/25 at 11:28 a.m., nursing assistant (NA)-B stated R3 had the toe wound since 4/18/25. The dressing is not on right now since R3 just had a bath. NA-B would notify the charge nurse for any wounds. During an observation on 4/23/25 at 1:14 p.m., registered nurse (RN)-A entered R3's room to complete wound care. R3 was sitting in a wheelchair with her feet dependent on the floor. R3 stated the wound does not hurt. RN-A removed the ace wrap that was on R3's leg from toes to calf. There was +4 pocketed edema on	F 686	treatment order. These protocols will need to be reviewed and signed off annually and PRN by the medical director. These protocols will allow nurses to treat a wound immediately upon discovery of a wound, which will be in the residents best interest for wound healing without delay. B. Wounds will be monitored for one week after it is healed to ensure it does not open again. C. Wound Checklist will be required for all licensed nursing staff to complete to ensure all tasks are completed for new wounds. This worksheet will be initialed off and returned to RN-A when complete. D. Re-education was done with nursing staff to monitor and assess for wounds between toes during daily cares and weekly skin assessments. If the skin between toes is fragile, the nurse to get the order to separate toes with lambswool. E. The Director of Nursing plans to assign the ADON to the resident's weekly comprehensive wound assessments, and the DON will be the backup wound RN. The anticipated date for ADON to transition to the Wound RN is in approximately 6 months. F. New process changes were implemented on how management will communicate with the nurses and CNAs for pertinent care-related information regarding residents and the expectations for each discipline to share care-related information with each other. 1. All licensed nurses now have email access and will be used as the primary form of communication, along with the	

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F 686	Continued From page 29 the top of right foot. No dressing was on the pressure ulcer to remove. The 4th toe was red and the wound is located inside on the web of the toe in between the middle toe and fourth toe and going up a little of the 4th toe. It measured 0.3 cm x 0.4 cm. unable to determine depth as the wound was covered in a white substance. RN-A stated she could smell an odor during the dressing change. R3 stated it tickled but did not hurt. RN-A explained all of R3's toes had a large amount of edema and were pressed together and difficult to separate to see between. During an interview on 4/23/25 at 3:44 p.m., NA-D stated she discovered R3's toe on 4/18/25. The wound was between the toes. The toes were really red, swollen, and warm to touch. NA-D had not noticed it before. The nurse put triple antibiotic ointment on the wound and NA-D reported the area in the shift to shift report and told the oncoming staff about it. During a subsequent interview on 4/24/25 at 8:42 a.m., NA-B stated R3's sore had been there but it had not been open like it was currently. It opened again on 4/18/25. NA-B described the wound as a scab prior to 4/18/25. During an interview on 4/23/25 at 5:06 p.m., RN-B could not recall a pressure ulcer on R3's 4th toe. RN-B stated most of the wound treatments are done on the day shift and if a treatment is required the TAR would reflect it. During an interview on 4/24/25 at 9:05 a.m., RN-A stated a stage II pressure ulcer presenting with a scab over it would not be considered healed and would be troublesome as it would be eschar tissue. RN-A took over the wound treatments for	F 686	PCC communication board. 2. Nurse end-of/start-of-shift report will be given to CNAs. 3. Stop and Watch forms will be used by all departments. D. A new form will be drafted, reviewed and approved to be filled out by licensed nursing of resident care-related concerns to be given to the provider when he is making the facility rounds instead of relying on word of mouth. E. All education that is provided, whether written, verbal, or online, will be logged and documented in personnel files and/or filed in the DONs education files. Training and Education: A. Mandatory online Educare modules that have been assigned to all licensed nursing staff for completion prior to correction date: 1. Clinical Competency-RN & LPN-Skin & Wound Care 2. Documenting, Observing, & Reporting 3. Medication & Treatment-Wound Care 4. Pressure Ulcer Prevention & Skin Care 5. Clinical Competency-RN & LPN-Dressing Change B. Impact Medical in house/in person mandatory wound training was completed for all licensed nursing staff, administrator, and dietary supervisor. It was also offered to CNAs. C. Nurse Wound Education was provided in written form. D. Charge Nurse Wound Education	

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F 686	Continued From page 30 the facility the week of 4/15/25, and had not been aware of the pressure ulcer until the podiatry noted it on 4/22/25 during their rounds. During a follow-up phone interview on 4/29/25 at 1:56 p.m., RN-A verified that R3's pressure ulcer is between the third and fourth toes, not the fourth and fifth toes as was documented. During a phone interview on 4/29/25 at 8:44 a.m., medical doctor (MD)-B stated the stage II pressure ulcer is the same location as the stage III pressure ulcer. The wound is the same width and diameter but appeared a little bit deeper on examination 4/22/25 compared to 12/17/24, when MD-B last saw it. There were no dressings on the wound prior to MD-B's examination. MD-B's expectation was that the facility would follow the order to not get the foot wet. The water just gets trapped between the toes due to the size of her toes. MD-B had not had any communication with the facility on R3's pressure ulcer in between 12/17/24 and 4/22/25. During an interview on 4/24/25 at 10:36 a.m., director of nursing (DON) stated wounds should be assessed at a minimum weekly and measurements included. If a wound was healed it would be documented in the progress notes, weekly wound assessment or the skin assessment tool. There was not a protocol in place to monitor a wound for any specific amount of time after it healed, only that the floor nurses should be aware of the healed wound and lay eyes on the location on weekly bath assessments. It was determined that R3's pressure ulcer had healed in January, but no documentation on the wound being healed. If the wound had a scab over it, the wound would be considered unstageable and not healed. The	F 686	was provided in written form. C. Miscellaneous Education that was provided: * PCC Connect and Nursing Advantage education was done with all nurses. * Any orders that are received, will be entered as a provider order into the MAR. Prior to the discontinuation of any order, a DC order will be requested from the provider. 1. Nursing will not DC orders without a provider-written or telephone order. * Wounds and dressings must be monitored daily, and wounds assessed every 7 days. * New wound treatment protocols as standard orders. * When nurses receive reports for care concerns of our residents from CNAs, they must Follow up timely and be addressed appropriately. * EBP re-education review was provided to all nursing staff. * All orders to keep feet dry will be followed. Use of waterproof leg and foot protectors will be applied prior to showering or bathing. D. All staff will be re-educated on the Stop and Watch forms that are available at the nurses stations on the west and east halls, the maintenance room, the dietary and therapy department. E. Educare Module: Documenting, Observing, Reporting was assigned to all CNAs/TMAs to be completed no later than 5/26/2025. 4 Monitoring and Quality Assurance:	

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F 686	Continued From page 31 nurses were to communicate to the NA's that R3's right foot was not to get wet. It is the expectation that nurses look between resident toes on bath days. The facility Wound Treatment Management policy revised 4/2025, identified to promote wound healing of various types of wounds, the facility would provide evidence-based treatments in accordance with current standards of practice and physician orders. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include lack of progression towards healing, changes in wound characteristics, and changes in resident goals and preference. The facility Foot Care Skin Integrity policy dated 4/2025, identified the residents receive proper treatment and care to maintain mobility and good foot health. The risk assessment will include a comprehensive assessment to identify additional risk factors or conditions that increase risk for impaired foot skin integrity. Medical conditions will be managed and interventions implemented in accordance with professional standards of practice to prevent complications of medical conditions. The attending physician will be notified of the presence, progression towards healing, or lack of healing of any foot ulcers, or any changes in a residents medical condition.	F 686	The DON will be responsible for identifying trends and areas for continued improvement, overseeing the implementation of corrective actions and ensuring compliance. All nursing staff will be responsible for adhering to all policies and procedures. The DON, ADON or licensed nurse designee will complete A. 2 audits weekly (for each of the 3 concerns) for 4 weeks (3 of these audits for each concern will be for R3) B. Then 3 audits per month (for each of the 3 concern) for 3 months (2 of these audits for each concern will be for R3) C. Then, 1 audit monthly (for each of the 3 concerns) for the next 3 months (1 of these audits for each concern will be for R3) D. Ongoing audits as needed until compliance is met for each of the following concerns. 1. Audit care plans for all residents with wounds to ensure appropriate problems, goals, and interventions are written and person-centered for the identified resident. 2. Audit for new wound concerns- Was assessment, monitoring, notifications, reporting, documentation, risk management, and care plans completed? Was proper etiology and treatment documented? 3. Audit existing wounds- Is the wound progressing? If not, was the provider notified and a new treatment order	

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F 686	Continued From page 32	F 686	received? Is the wound healed? If so, was the provider and family notified? Was an order received to DC treatment? Audits will include the above questions listed but not limited to. If any negative findings are noted, corrections will be completed. Completed audit forms will be reviewed and discussed with the QAPI committee during the weekly QAPI meetings. If necessary, an action plan will be written by the QAPI committee. Any written action plan will be monitored by the Administrator weekly until an acceptable resolution is obtained. All new and/or revised policies, as listed above, will be reviewed by the QAPI committee for approval. Additional revisions will be added as needed and readdressed. The survey deficiencies were discussed during the facility QAPI meeting on May 1, 2025. Policies and procedures will be discussed and approved by the QAPI committee on May 22, 2025. POC completion will be reviewed and discussed on May 22, 2025. The survey results and plan of correction with completed audits will be reported to QAA on July 17, 2025. Completion date: 05/26/2025	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 14, 2025

Administrator
Parkview Care Center
55 Tenth Street Southeast
Wells, MN 56097

Re: State Nursing Home Licensing Orders
Event ID: HUL511

Dear Administrator:

The above facility was surveyed on April 22, 2025 through April 24, 2025 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, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

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

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2 000	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 4/22/25 to 4/24/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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PARKVIEW CARE CENTER	55 TENTH STREET SOUTHEAST WELLS, MN 56097

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaint was reviewed: H54363269C (MN00112416) with a licensing order issued at 0830 and 0900. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and monitor for change in condition following computer tomography (CT) with contrast dye to ensure appropriate and prompt treatment for 1 of 1 residents (R1) who was at risk for acute renal failure. Additionally based on observation, interview, and record review the facility failed to comprehensively assess, monitor, and treat wounds for 1 of 1 residents (R2) reviewed for non-pressure skin concerns.	2 830	Corrected.	5/26/25

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2 830	Continued From page 3 Findings include: R1's quarterly minimum data set (MDS) dated 2/25/25, indicated R1 had intact cognition and was dependent on staff for all dressing, toileting, personal hygiene, transfers, and mobility with wheelchair. Further identified R1 had diagnoses that included hemiplegia following a cerebral vascular accident (CVA), heart failure, renal (kidney) failure, diabetes mellitus (inability to regulate blood sugars), dementia, and morbid obesity. The MDS also identified R1 was at risk for pressure ulcers. R1's care plan dated 10/2/2024, identified R1 had a provider order for life sustaining treatment (POLST) which include a do not resuscitate (DNR) and do not intubate (DNI) but did accept intravenous, oral, and intramuscular antibiotics. R1's care plan identified R1 was at risk for infections; had a self-care deficit requiring staff assistance; was resistive to care at times; had behavior problems toward staff; was at risk for falls; at risk for constipation; high risk for respiratory infections; on antidepressant medications; on anticoagulant (blood thinning) therapy; potential nutritional problem; an ulcer between 3rd and 4th toes; at risk for pain; high risk for skin breakdown; bladder incontinence; and at risk for potential abuse and neglect. R1's care plan did not identify management and/or risk of congestive heart failure or renal failure A physician order dated 3/13/25, identified R1 to drink 5 six to eight ounce glasses of water daily in preparation for a dye study to protect the kidneys.	2 830		

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2 830	Continued From page 4 R1's Medication Administration Record (MAR) for April 2025 indicated on 3/14/25 an order was entered to "encourage" resident to drink at least 5-6 eight-ounce glasses of water daily in preparation for a dye study to protect his kidneys. The MAR did not contain any monitoring of oral fluid intake. The MAR also noted, and order started on 4/4/25 and discontinued on 4/8/25, to monitor VS two times a day; if O2 sat not maintained above 90% or fever develops patient needs to be seen. The MAR also identified an order entered on 3/9/25 to monitor for vitals two times a day for infection. This order entry identified R1 had an elevated temperature of 99.3 degrees (F). R1's record did not identify a physician was notified of an elevated temperature. R1's physician order dated 11/22/22, included weight one time daily for congestive hear failure. The order did not identify parameters in which the physician was to be notified for weight gain/weight loss. R1's daily weight log indicated R1 weighted 325 pounds on 3/8/25 and 334.5 pounds on 4/8/25 which was an increase of 9.5 pounds in a month with no documentation of physician notification of the increased weight and no evidence of further assessment of the weight gain to identify if the gain was related to fluid or nutritional related. R1's progress notes identified the following: 4/2/25 and 4/3/25, indicated R1 was out for appointments and returned with diagnoses of recurrent renal cell carcinoma with level two tumor thrombus (tumor extension into a vessel). 4/4/25 at 12:15 p.m., sent a physician request	2 830		

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2 830	Continued From page 5 form to provider to request Mucinex and (as needed) prn neb [nebulizer]. [R1] present cough with mucus and complains of chest pain. COVID was negative. 4/4/25 at 2:03 p.m., family member (FM)-A would like [R1] watched closely to see if he needs an antibiotic. Mucus clear and does not have a fever. 4/4/25 at 3:10 p.m., received orders for DuoNebs (inhaler) and Mucinex (loosens congestion) prn and monitor VS (vital signs) and needs to be seen if fever or [oxygen] sats (saturations) below 90%. 4/5/25 at 5:30 a.m., temp. (temperature) 100.1 [degrees F]; oxygen sats 90% when lying down and 95% when sitting up on room air. Cough very loose. 7:39 a.m., called daughter and she wanted provider contacted. R1 was swabbed for RSV (respiratory syncytial virus) and FLU (influenza). 7:16 p.m., R1 tested negative for RSV, FLU, and COVID. 4/6/26 at 11:19 p.m., updated provider and received order for Zpak (used to treat bacterial infections). 4/8/25 at 11:45 a.m., R1 does not have as frequent of a cough and cough is not as moist and congested, afebrile (no fever). 4/9/25 at 8:11 a.m., writer reported to the nurse that she thought resident was full of fluid and needed to go to the hospital. 4/9/25 11:31 a.m., resident awake since 4am [4:00 a.m.]; at 7 am R1 asked to lie down in bed and indicated not feeling well; temperature 99.3 [F], did not want breakfast, had chills, lungs	2 830		

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2 830	Continued From page 6 [sounds] slightly diminished in bases. Documentation did not indicate provider was notified of change in condition and no further progress notes on 4/9/25. 4/10/25 at 5:38 a.m. R1 awake at 1a.m., taken CPAP (continuous positive airway pressure machine to treat sleep apnea) off and refused to allow it back on, oxygen sats 93% on room air. 4/10/25 at 10:35 a.m., [R1] assessed as "he seems to be worse"; audible wheezing and "wet" non-productive cough. O2 (oxygen) sats 89-90% on room air. R1 stated he feels "like shit and just might die". R1 had been eating and drinking minimally. Family in agreement to sent to ED. 4/10/25 at 7:14 p.m. R1 going to ICU (intensive care unit). R1's kidneys are shutting down and there is acid in his blood. R1's hospital Admission Note dated 4/10/25 at 11:23 p.m., identified R1 transferred to higher level of care hospital due to severe Acute Kidney Injury (AKI) and concern for need of urgent dialysis (filters waste and excess fluid from the blood). The Admission Note further indicated the etiology for R1's AKI differential includes mainly contrast [dye]-induced, and R1's cough and dyspnea are likely consequences of the fluid overload caused by the renal [kidney] failure. R1's death certificate indicated R1 died on 4/22/25, in the hospital due to acute and chronic kidney failure. During an interview on 4/23/25 at 5:00 p.m., FM-A identified R1 had at CT with dye contrast on both 4/2/25 and 4/3/24 and was told that R1 should have adequate fluid before and after the	2 830		

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2 830	Continued From page 7 procedures to prevent kidney damage but, was not aware of the fluid order that was written on 3/13/24, and did not know if the facility was monitoring it. FM-A further identified R1 had a CT scan with dye on 4/2/25 and because of the findings, was asked to return for a second CT scan on 4/3/25 and R1 was "already feeling sick" by then. Reported R1 became "really sick" by the weekend (two days after the CT scan). FM-A asked RN-C to send him to the emergency department for evaluation but was told by RN-C that R1 did not have a fever, and they would not do anything for him until R1 developed one. FM-A stated during a visit on 4/9/25, a facility nurse (unsure which one) reported R1 was "better" and decided to wait one more day to have R1 seen by a provider. The next day, a different nurse called and stated R1 needed to be sent to the ED for evaluation and treatment. FM-A indicated she expected facility staff to be monitoring R1 more closely than they were. During an interview on 4/23/25 at 12:15 p.m., nursing assistant (NA)-A identified working with R1 the days prior to R1's hospitalization. On those days, R1 was "wheezing a lot" but was told R1 "had a cold or something". NA-A was not aware R1 had any wounds or pressure areas for R1. During an interview on 4/24/25 at 9:30 a.m., NA-B identified R1 was "more rude and disrespectful" then normal for a couple of days before he went to the hospital. NA-B stated he was "not feeling well, was more wheezy, appetite had decreased, not sleeping well, and was hard for us [staff] to get him to eat or drink anything." NA-B further identified she notified nursing staff and thinks they were checking on him more frequently but was not sure what the nurses were doing for R1.	2 830		

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2 830	Continued From page 8 NA-B indicated staff were not monitoring R1's fluid intake or urine output. During an interview on 4/23/25 at 12:41 p.m., NA-C identified the nurses did not communicate to any of the staff about any need to increase R1's fluids and did not know that R1 should have had fluid intake monitored before and after the CT scan, and did not know that the CT scan could have put R1's health at risk further. R1 got sick with cold symptoms right after the CT scan. On 4/9/25, NA-C reported to RN-B that R1 was full of fluid, chest was full, stomach felt like "rubber" and was tight. RN-B told her the ED would not do anything for R1 because R1 was already on an antibiotic and nebulizer treatments. NA-C did not know whether RN-B further assessed R1 or not but in the morning of 4/10/25, R1 looked even worse and further described R1 was full of fluid, chest was rattling, having a hard time breathing, and appeared in a lot of pain. NA-C further reported that R1 told her that he had never felt that bad. NA-C then reported to RN-A and then RN-A assessed R1 and sent him to the ED. During an interview on 4/22/25 at 1:40 p.m., licensed practical nurse (LPN)-C indicated if a resident is on a physician ordered fluid intake or restriction, it should be on the MAR and would be measured and monitored but did not know of any resident's that the facility had been monitoring for fluid intake or restriction within the past few months. If there is a change in condition, the nurse should immediately assess and document in the progress notes that the nurse notified the family and provider of the change. LPN-C denied working with R1 during the days prior to his hospitalization so was not sure of R1's condition.	2 830		

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2 830	Continued From page 9 During an interview on 4/23/24 at 9:40 a.m., LPN-B identified being familiar with R1's cares but did not know he was to be monitored for fluid intake and did not know anything about R1 having CT scans done. LPN-B further identified R1's cough did not get any better so notified family and they requested antibiotics, the physician was notified and ordered antibiotics and did infection monitoring on R1 every shift (included monitoring temperature, pulse, respirations, pain, and oxygen level) but although R1's vital signs were stable, R1 did not get any better and one of the RN's from the office sent R1 to the ED, R1 was hospitalized, and died. During an interview on 4/23/25 at 11:32 a.m., social service designee (SSD) indicated [nurse] charting could be better so everyone could know what is happening with the residents. During an interview on 4/22/25 at 3:05 p.m., registered nurse (RN)-A indicated not seeing R1 for a week prior to 4/10/25 and was asked to assess R1 for change of condition. RN-A noted R1 to have respiratory wheezing that was audible immediately entering the doorway and was dusky in color, with R1 stating he felt like he was going to die. RN-A notified family and arranged for ED transfer. RN-A also indicated an order was entered into the computer as "encourage to drink" instead of "drink" and no documentation was entered for tracking how much fluid R1 had consumed prior to or after the CT scans. During an interview on 4/23/25 at 3:45 p.m., the director of nursing (DON) indicated she received and transcribed R1's order for on 3/13/25 but instead of "drink" five 6-8 ounce glasses of water a day prior to the CT scan, transcribed the order as "encourage" five 6-8 ounce glasses of water a	2 830		

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2 830	Continued From page 10 day and verified there was a difference in the interpretation of "drink" and "encourage". The DON also stated she should have transcribed the order exactly as written, monitored the amount of fluids R1 had consumed, and communicated that amount to the provider that ordered the CT scan. The protocol for recognizing a change in condition is the nursing assistants (NA)'s inform the nurse and then nurse is to do an assessment of vital signs, oxygen level, lung sounds for respiratory, overall condition. If needed, the nurse would call the family to see if the resident should go in [clinic or ED] to be evaluated. If not, we would call or fax the doctor. The DON indicated R1 had a "big change" in condition on 4/5/25-4/6/25, when R1 developed a fever and lung sounds slightly diminished. We [facility nurse] got an order for nebulizer and Mucinex and he should have been monitored daily. The DON indicated vital signs were put in R1's MAR but lung sounds, or edema is not routinely checked unless the nurse "felt it was something that needed to be done". The DON further identified R1 asked to go to the ED on 4/9/25 but R1 seemed to be the same as the day before so did not send him. The DON confirmed there was no documentation about R1's condition change until the next day (4/10/25) when R1 transferred to the ED. The DON stated she would have expected to see more [progress] notes than there were. R2 R2's face sheet dated 4/23/25, identified diagnoses of presence of right artificial hip joint (replacement of artificial parts for bone), and infection and inflammatory reaction due to internal right hip prosthesis (infection and inflammatory reaction that occurs around a joint	2 830		

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2 830	Continued From page 11 replacement implant). R2's quarterly Minimum Data Set (MDS) dated 4/11/25, identified R2 had some cognition issues, no behaviors, independent with activities of daily living, and used a walker for mobility. R2's care plan dated 11/20/24, identified potential for skin breakdown. Interventions included weekly treatment documentation to include measurement of each area of skin breakdowns width, length, depth, type of tissue and exudate and any other notable changes or observations. R2's care plan did not identify any specific areas of skin concern. R2's physician notification form with approved order dated 9/19/24, identified R2 had an open wound on back of right hip that measured 2.0 cm x 1.0 cm. looked like a pressure sore from hip being pressed on side of recliner. Orders to clean and cover with mepilex (name brand of a foam absorbent dressing) until resolved. R2's progress note dated 1/4/25, identified R2 took off mepilex and noted drainage coming from gluteal fold. Serosanguineous drainage, wound edges intact, wound bed is reddish surrounding yellow/whitish in the middle of the wound. Measurements are 1.5 cm x 1.0 cm x upper part of the wound 0.8 cm depth and lower part is 0.5 cm depth. Cleansed, applied mepilex with hydrogel. R2 had no pain with the only complaint being itchiness. At 10:42 a.m., R2 stated he did not want a big dressing on his wound. Informed R2 he had more drainage at night and the bigger foam should help. Refused hot pack prior to dressing change.	2 830		

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2 830	Continued From page 12 R2's skin observation tool dated 1/4/25, identified a skin abnormality to right gluteal fold, type of wound was pressure stage III with measurements of 1.5 cm x 1.0 cm x depth of 0.5 cm and 0.8 cm. Applied hydrogel and mepilex after cleansing. R2's progress note dated 1/6/25 at 8:30 a.m., identified there are no wounds on buttocks or gluteal fold. Only wounds are on right hip area. The lower wound is located at the top of an old hip surgery incision, area is a hole which the wound bed is located at the base of the hole and the skin up the edges of the hole and top of the hole are normal color, intact skin with no maceration. Wound bed which only covers the base of the hole measured 1.0 cm x 1.5 cm and 0.1 cm depth. 85% red beefy tissue and 15% yellow slough. The other wound which is located about 1.0-1.5 inches above the other wound is 0.5 cm x 1.0 cm and 0.2 cm depth with yellow/pink wound bed. R2 did not have the wounds covered and stated he took it off because it bothers him and makes him itch. Noted an area of serous drainage on pants about the size of an orange. Will fax MD-A for change in treatment as there is too much drainage for silver hydrogel to be effective. At 11:14 a.m., order obtained to change treatment to calcium alginate to wound bed, after cleansing with wound cleanser apply skin protectant to surrounding skin and cover with mepilex daily. R2's physician notification form with approved order dated 1/6/25, identified R2 continues to have a large amount of drainage to wound on right outer buttock. May we change to calcium alginate after cleansing with wound cleanser and skin protectant to surrounding skin and cover with mepilex. Response was ok to wound treatment changes.	2 830		

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2 830	Continued From page 13 R2's skin observation tool dated 2/26/25, identified open area on right buttocks still has small pinpoint opening below skin bubble that sticks out. Dressing was saturated with sanguineous (blood mixed with yellow liquid) fluid. No redness or signs of infection. No measurements provided. R2's record did not identify weekly skin evaluations with measurements on 3/5/25. R2's skin observation tool dated 3/12/25, identified wound care being done to right hip region. No measurements, type of wound or drainage provided. R2's progress note dated 3/2/25 at 9:40 p.m., identified changed dressing to ulcer on buttocks. Continues to be the same, not healing but not worse. R2's skin observation tool dated 3/13/25, identified pinpoint open area that drains serous fluid on right hip has 0.4 cm high skin growth next to open area. No measurements or type of wound provided. R2's progress note dated 3/15/25, identified dressing change to right hip area after a warm pack for 15 minutes. Small amount of drainage with no odor. R2's skin observation tool dated 3/18/25, identified pinpoint area that drains serous fluid on right hip has 0.4 cm high skin growth next to open area. No measurements or type of wound provided. R2's record did not identify weekly skin	2 830		

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2 830	Continued From page 14 evaluations with measurements on 3/26/25, and 4/2/25. R2's progress note dated 4/8/25 at 11:36 a.m., identified wound on right hip is no longer open, is fully covered with normal color skin and no drainage. R2's progress note dated 4/14/25 at 12:15 p.m., identified area on right hip that was resolved is now open again and measured 0.2 cm x 0.3 cm x 0.3 cm water blister noted below open area. Moderate amount of serous drainage from area. Will inquire with family if they would like to take R2 to wound clinic as this was closed and now is open again and took a long time to heal. Family requested to continue treatment at facility. At 2:32 p.m., upon inspection of wound again noted that wound is 2.5 cm depth and about the size of the wooden end of a Q-Tip. R2's weekly skin observation dated 4/15/25, identified location was healed surgical scar on right hip/buttock with unknown etiology. Impression was worsening. Slough tissue and unable to visualize wound base due to minimal opening at top layer of skin. Moderate amount of yellow, tacky drainage with no odor. Depth measured 5.2 cm. Scar tissue around wound macerated and irregular. No suspected infection or inflammation present. Orders for CT of hip. Cover with absorbent dressing. MD-A does not feel packing the wound is needed currently. R2's progress note dated 4/15/25 at 10:15 a.m., identified wound is directly on the healed surgical scar from right hip revision. No peri wound redness, no pain or discomfort. Wound has very small opening at surface of epidermal layer. Able to probe Q-Tip into wound 5.2 cm depth but may	2 830		

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2 830	Continued From page 15 be deeper. Unable to determine if wound tracts or undermines and unable to measure length and width due to small opening. Drainage is yellow and tacky. Packed with one fourth inch packing strip and covered with absorbent bordered dressing. Notified family and they are willing to get treatment and be seen at a wound clinic. Will contact MD-A for wound dressing change and wound clinic referral. At 12:25 p.m., spoke with MD-A to get referral for dressing order and wound clinic appointment. MD-A felt that this may involve the right hip prosthesis, and the first step should be a right hip CT. if there is prosthesis involvement, dressings are irrelevant at this time. Family aware. R2's progress note dated 4/16/25 at 11:01 a.m., identified area on buttocks still open 0.25 cm round with serosanguineous drainage, dressing changed. R2's progress note dated 4/17/25 at 11:05 a.m., identified MD-A examined wound on right hip by palpation and movement and discussed getting the CT scan. The physician visit note dated 4/17/25, identified the biggest concern was R2's hip wound and concern for an underlying infected hip replacement. R2 denied pain in that area interestingly. Area over the right hip shows a depressed area that is red, somewhat irritated, with an open area in the center that medical director (MD)-A was unable to express any purulent (thick, milky discharge that typically indicates an infection) material out of but does appear as though it has been draining. Possibly a draining sinus. Ordered at computed tomography (CT) scan of pelvis and hip to observe how deep the area of infection over the right hip was.	2 830		

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2 830	Continued From page 16 Nursing staff stated it has been draining and this is a concern given R2's history of infected prosthetic. Certainly, prudent to look at a referral to orthopedic department for their thoughts. If R2 does have an infected right hip replacement that is not going to heal without removal, spacer, antibiotics, etc. this would likely result ultimately in R2 not really doing well at all. R2's CT with IV contrast dated 4/17/25, identified diagnoses of septic arthritis (painful infection in a joint), arthritis pyogenic hip (serious painful infection of joint often caused by bacteria). A small quantity of fluid is seen along the lateral incision within the proximal superficial subcutaneous tissue (layer of skin) of right thigh measured approximately 5.4 cm x 3.2 cm x 4.4 cm in size. R2's progress note dated 4/17/25 at 5:04 p.m., identified MD-A reviewed CT results. Fluid collection increased in size and ordered Keflex and doxycycline. Also, arginaid ordered. At 5:53 p.m., changed dressing to right hip. Light tan colored drainage noted on old mepilex. No signs of infection noted to area. R2's physician notification form dated 4/17/25, identified MD-A reviewed the CT results per radiology and it appeared the fluid collection has increased in size some from previously. MD-A recommended these findings be reviewed by orthopedic team that worked on R2. In the interim, start R2 on an antibiotic. Keflex 500 mg three times per day for 10 days and doxycycline 100 mg twice daily for 14 days. R2's physician notification form dated 4/22/25, identified wound on right buttock/old surgical scar continues to close over and fill with yellow, tacky	2 830		

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2 830	Continued From page 17 fluid. Depth almost at 6 cm. May we add one fourth packing strip to wound with current orders and wondering if R2 should be seen by orthopedics. Reply was ok for packing of wound and recommended being seen by orthopedics to determine need for additional imaging and intervention. R2's weekly skin observation dated 4/22/25, identified location as healed surgical scar right hip/buttock with unknown etiology. Unchanged. Slough tissue present, moist. Very small opening with deep tract. Unable to visualize base. Large amount of purulent drainage with no odor. 0.1 cm x 0.1 cm x 5.8 cm depth. Indurated, scar tissue on peri wound. No infection suspected and no inflammation present. Cover with absorbent dressing. Sent fax to MD-A about packing wound. No evidence of healing, continued to drain large amount of tacky, yellow fluid. R2's progress note dated 4/22/25 at 6:09 p.m., identified fax sent to MD-A for order to pack right buttock wound with one fourth inch packing, as it continues to close over the tiny opening and fill with thick, tacky yellow drainage. Wound measured 6+ cm depth. Also questioned if follow-up with orthopedics was needed. R2's care plan dated 4/23/25, identified potential for skin breakdown. Has an open area on right hip. Interventions included treatment to open area on right hip as ordered by doctor, pack with packing after cleansing and cover with dressing daily, use only a continuous strip and leave a tail of 2-3 inches on outer side of wound to prevent packing getting left in wound. R2's skin observation tool dated 4/23/25, identified skin abnormality to right trochanter	2 830		

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2 830	Continued From page 18 (hip), type is listed as other. Measurement 1.0 cm x 0.5 cm x 5.0 cm depth. Currently just covering wound with dressing per provider, pending an updated wound care order. R2's progress note dated 4/23/25 at 12:48 p.m., identified an orthopedic appointment for right hip had been made. During an interview on 4/23/25 at 11:22 a.m., licensed practical nurse (LPN)-A stated the nurse would check every resident's skin when they had a bath. The nurse would assess skin issues, bruises, dressings that are in place. For new skin issues the doctor, director of nursing (DON), and family are notified. During an interview on 4/23/25 at 11:30 a.m., LPN-B stated she had measured the length and width of R2's wound but not the depth on 4/23/25 after he had a bath. R2 did not currently have a dressing in place on his right hip wound. Registered Nurse (RN)-A had been measuring the depth. They were waiting for new orders from the doctor for packing the wound. During an interview on 4/23/25 at 11:39 a.m., RN-A stated she had taken over wound management the week of 4/14/25. During an observation on 4/23/25 at 12:50 p.m., LPN-B and RN-A applied enhanced barrier precautions (EBP) prior to entering R2's room. R2 had been seated on the edge of his bed and stood up with a walker upon LPN-B and RN-A entering the room. LPN-B placed a clean towel over R2's overbed table and moved the garbage close to the overbed table. LPN-B removed needed wound care supplies from R2's closet and placed on towel. RN-A described the process for packing the wound with a tail to LPN-B. RN-A	2 830		

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2 830	Continued From page 19 stated R2 had a CT scan last week. The wound would close over with fluid. The packing is to keep the wound open and wick out the fluid. The wound opening is the size of a Q-tip and does not have pain with it. The wound has been an on-going issue since 9/24. RN-A lifted up R2's skin as the wound site was not visible without lifting the skin up with a hand. RN-A pointed out that proud flesh dimpled skin was at the end of the right hip surgical scar and the opening to the wound was not really visible. RN-A took took the wooden end of a Q-tip and placed it inside the wound opening and moved the Q-tip around. RN-A stated the wound felt boggy against the Q-tip. Removed Q-tip and measured the Q-tip with red-tinged drainage on it at 4.8 cm depth. Red liquid dripped from the wound down R2's leg. RN-A used a new Q-tip, after measuring out packing for the wound, and began to insert packing in the wound bed. R2 made noises and winced during this process. RN-A stated it was very difficult to pack the wound as it was such a tiny opening. Packed the wound with a tail hanging out and placed a mepilex over the area. Both nurses removed EBP when care was complete. During an interview on 4/23/25 at 1:39 p.m., LPN-B stated she was unsure how long it would take a boil to heal. Pressure sores occur from not having blood circulate to an area from a point that has pressure on it and did not feel that R2's wound was from pressure. Wounds should be measured a minimum of once a week and if a wound is not healing or does not have any change to it, the doctor should address every one to two weeks. During a phone interview on 4/29/25 at 12:50 p.m., MD-A stated if he had been aware that the	2 830		

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2 830	Continued From page 20 'boil' area that was being treated was on the right hip surgical site he would have ordered a CT sooner and consulted with R2's surgeon. One of the reasons MD-A ordered the CT scan was because he was under the impression that this was a new wound that had popped up. During an interview on 4/24/25 at 9:05 a.m., RN-A stated she had first observed R2's hip wound on 4/15/25. Prior to observing the wound, RN-A was under the impression that R2's wound was a boil. The charge nurses are in charge of the day-to-day wound treatments and RN-A would complete a weekly skin wound assessment that would include assessing for changes, notifying the doctor for wound treatments and updating with changes, notifying family as needed. RN-A had completed wound training with licensed nursing staff within the past year but did not include nursing assistants (NA)'s in the education. Medical doctor (MD)-A would have to be notified and requested to look at wounds during his monthly rounds if a wound needed to be looked at. RN-A had addressed with MD-A the extent of R2's wound on 4/15/25 and that is when the CT was ordered. MD-A was not aware that R2 still had a wound on his right hip. Moving forward MD-A and family will be informed when wounds heal and the site will be monitored for a week afterwards. RN-A was completing the weekly wound assessments in the interim until the facility determined who would be in charge of them. During an interview on 4/24/25 at 10:36a.m., DON stated a wound resource binder is located at each nursing station. Wounds should have a weekly comprehensive assessment completed. DON was unable to articulate the amount of time a treatment should be completed before re-evaluation but if there was no change for a	2 830		

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2 830	Continued From page 21 while would reach out to MD-A to request new treatment orders. There is no protocol for monitoring a healed wound and it would just be part of the nurses responsibility to assess weekly on bath days. The braden assessment is completed to determine a residents risk for pressure ulcers and pressure reducing mattresses and wheelchair cushions are interventions that would be put in place. MD-A would address wounds on residents whenever necessary. DON would go with on rounds and have handwritten notes of items that needed to be addressed and tell MD-A while in the room with the residents. DON did not have any wound care audits or confirmatory training paperwork on specific wounds with nursing staff completed, any education was only verbal. DON could not recall if she had assessed R2's wound at the initial evaluation. DON did not feel that a boil would remain from September until April and had only assessed the wound when she was working as the floor nurse. There had not been any discussion or concern that the wound could be infected and/or have something to do with his right hip prosthesis even though R2 admitted to the facility with a diagnosis of infection and inflammatory reaction from the right hip prosthesis. Treatment for wounds are determined by review of the nurse resource manual, review from DON or RN-A and the request faxed to MD-A with what orders the facility would like for treatment. The expectation is that wounds are measured, documented, complete assessment and weekly review completed and addressed with MD-A on monthly rounds or as needed for wound worsening or healing and needing new treatment orders. The DON was in charge of completing and comprehensively reviewing weekly wounds but currently RN-A had begun completing them in the interim. The goal is to have the assistant	2 830		

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2 830	Continued From page 22 director of nursing (ADON) complete them (after orientation) and DON would be the back-up. The facility Wound Treatment Management policy revised 4/2025, identified to promote wound healing of various types of wounds, the facility would provide evidence-based treatments in accordance with current standards of practice and physician orders. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include lack of progression towards healing, changes in wound characteristics, and changes in resident goals and preference. The facility policy titled Change of Condition and Assessments Policy and Procedure last reviewed 4/17/25, indicated the policy establishes standardized procedures for registered nurses (RNs) to assess and manage changes in condition among residents. The goal is to ensure timely detection, documentation, and intervention for any significant alteration in a resident's baseline status, safeguarding resident health and well-being. The policy defines change in condition as major decline or improvement in a resident's baseline status that will not normally resolve without intervention by staff, will not normally resolve by implementing standard disease related clinical intervention, and the decline is not considered self-limiting. Indicates a focused assessment is a targeted approach to assessing a resident fora specific health concern or area of care. This type of assessment is used to evaluate the resident's immediate needs, symptoms, or risk factors related to a particular condition, system, or issue. The purpose of a nursing-focused assessment is to collect and compare data to normal findings and the	2 830		

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2 830	Continued From page 23 individual patient's current health status, and reporting changes and responses to interventions in an ongoing manner to a registered nurse or the appropriate licensed health care provider. The LPN may not initiate any new plan of care items; they may only update existing care plans. The procedure is as follows: If the LPN determines there is as change from normal findings and the individual patient's current health status, the LPN will communicate to the RN if in the building. If not, should be communicated to MD (medical doctor) or on call physician (if unable to contact the MD). The RN will determine whether they need to complete further assessment. When a resident experiences a change in condition the RN will complete a comprehensive assessment and, if appropriate, update the care plan. A RN will complete a nursing assessment when there is a potential status change to determine if the resident is experiencing a change in condition. The nurse must assess the resident and, if the resident remains at baseline, the assessment completed should be documented. If the resident is experiencing a change of condition, the RN will complete a comprehensive assessment. The Facility Assessment policy last revised 4/2025, indicates the facility provides management of medical conditions with assessment, early identification of problems/deterioration, management of medical and psychiatric symptoms such as heart failure, diabetes, chronic obstructive pulmonary disease (COPD), and infections. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents with impaired skin integrity, to assure they are receiving ongoing monitoring and	2 830		

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2 830	Continued From page 24 assessment of the skin along with the necessary treatment/services to promote improvement. The director of nursing or designee, could conduct random audits of the delivery of care; review nursing assessments; to ensure appropriate care and services are implemented and reduce the risk of edema not being cared for properly. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess, monitor, and provide interventions to prevent pressure ulcer development, promote healing, and prevent deterioration for 1 of 3	2 900	Corrected.	5/26/25

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 25 residents (R3) who had pressure ulcers. The facility's failures resulted in harm when R3 developed a stage 2 pressure ulcer (PU) that deteriorated to a stage 3. Findings include: STAGING Staging of a PU/PI is performed to indicate the characteristics and extent of tissue injury, and should be conducted according to professional standards of practice. Determining whether damage to the skin and underlying tissue is a PI or PU depends on the staging of the damaged tissue. Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis 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 skin loss 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	2 900		

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2 900	Continued From page 26 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 UP/PI. R3's face sheet dated 4/23/25, identified diagnoses of edema (swelling caused by excess fluid). R3's quarterly Minimum Data Set (MDS) dated 3/19/25, identified R2 had no memory issues, did not reject cares, was dependent on staff for putting on and taking off footwear, R2 was at-risk for pressure injuries but did not have any. R3's care plan dated 3/25/25, identified R3 had a whirlpool bath weekly and required 1-2 staff to assist with bathing. The care plan identified a potential for skin impairment dated 10/13/23, identified interventions of Braden risk assessment, keep skin clean and dry, report any signs of skin breakdown, weekly treatment documentation to include measurement of each area of skin breakdowns width, length, depth, type of tissue and exudate and any other notable changes or observations. R3's podiatry evaluation dated 12/17/24, identified there was a small stage II ulceration to the right medial 4th toe. An offloading pad/dressing was applied. Keep the right foot dry in the shower and sponge bathe for now. Offload the area, keep dressing intact. If dressing falls off apply iodine, gauze and kling daily. Return to clinic in 3-4 weeks or sooner if problems arise. An addendum to the note on 12/17/24, identified R3's family did not want to transport R3 to the clinic and preferred the facility to treat the wound. Therefore, requested the nurse dressing daily, (but) wait to removal of initial dressing for two	2 900		

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2 900	Continued From page 27 weeks. Then cleanse the ulcer daily and apply iodine, gauze, kling and paper tape. Keep the foot dry in the shower and sponge bathe until the ulcer is healed. Call the office with any questions of if the ulcer is getting worse or not healing for an appointment or go to the nearest hospital. Review of R3's progress notes dated 12/17/24 through 12/31/25 did not identify the dressing was left in place for two weeks as ordered. According to R3's treatment administration record the order for daily wound care dated 1/1/25 was discontinued on 1/2/25; R3's record did not include an assessment and/or documentation the wound had healed. During an interview on 4/23/25 at 1:39 p.m., licensed practical nurse (LPN)-B stated she could not remember if she discontinued the treatment on 1/2/25 but recalled that a dressing had been in place between the 3rd and 4th toes. They were told to monitor and after a couple of days to take the dressing off and discontinue the order. LPN-A stated when the order was discontinued on 1/2/25, the area did not appear healed. The area was scabbed over but not macerated. R3's toes were always puffy and so was her foot so ace wraps were used. R3 had a weekly bath and the NA's (nurse aides) got her feet in there to let them soak. LPN-B observed her skin after the bath but had not looked between the toes where the UP/PI was located. R3's bath skin assessment dated 1/8/25, identified a handwritten note that stated "toe" in parenthesis. R3's record did not identify a wound assessment was completed on the pressure ulcer between the 3rd and 4th toes of right foot between	2 900		

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2 900	Continued From page 28 12/17/24-4/21/25. R3's podiatry evaluation dated 4/22/25, identified stage III pressure ulcer to the medial right 4th toe, with maceration, no signs of infection. Debrided the ulcer at visit. Orders included to cleanse ulcer daily with saline damp gauze, dress daily with iodine, gauze, kling, and paper tape. Keep dry in the shower. Follow-up in the office in four weeks, call with questions or concerns. Add one package of Arginade per day. R3's progress note dated 4/22/25 at 9:01 a.m., identified podiatry was in house and ordered right medial 4th toe ulcer to cleanse daily with saline damp gauze, apply iodine, gauze, kling, and paper tape. Keep dry in the shower and follow up in four weeks. Add one packet of Arginade daily. At 9:59 a.m., spoke with family member (FM)-B in regards to the pressure injury worsening and the risks involved with wounds of the sort and difficulty of healing. Daughter requested to continue treating at facility. R3's care plan dated 4/23/25, identified pressure ulcer on the medial aspect of right 4th toe related to immobility and edema. Interventions included to measure length, width, and depth where possible, document wound perimeter, wound bed and healing progress. Report improvements and declines to medical doctor. Due to difficulty of visualizing the wound for proper assessment, do dressing change and assessment when lying in recliner or bed. If unable to get right toe gauze to stay in place, apply lambs wool between 4th and 5th toes of right foot instead but it is important to cushion with one or the other. R3's weekly wound observation tool dated 4/23/25, identified pressure ulcer stage III to right	2 900		

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2 900	Continued From page 29 4th toe webbing acquired at facility. Wound had begun as a stage II. Wound tissue was moist with 100% slough (dead tissue presents soft, yellow, or white) present. No odor or drainage present. Wound measured 0.3 centimeters (cm) x 0.4 cm x 0.2 cm depth, depth approximate due to slough covering wound and unable to see base of wound. Surrounding skin is macerated (moist) and erythematosus (red). 4+ edema on top of right foot, fluid filled thin skin, 3+ edema in right mid-calf to knee. Inflammation is present with redness and discomfort at wound site. Treatment included to cleanse the ulcer with saline damp gauze, apply iodine, gauze, cling, and secure with paper tape. Keep dry in the shower. Updated order included that iodosorb (iodine gel primarily used to clean wounds and promote healing) could be applied to wound bed and lambs wool in between toes if gauze does not stay in place. Do not wrap multiple toes together to avoid added pressure. R3's progress note dated 4/23/25, identified right foot 4th digit wound assessed and dressing completed. Wound is in the web of fourth and fifth digit, difficult to dress. Notified podiatry of difficulty dressing and ease of unintentional removal of dressing with sock, ace wraps, and slippers on/off. Do not wrap toes together as this could compromise wound be adding additional pressure. Additional orders received for wounds and tentative appointment scheduled. Dressing changed to bedtime so foot is not dependent and wound would be easier to visualize. During an interview on 4/23/25 at 11:18 a.m., R3 was sitting in her wheelchair with her feet on the floor and wearing slippers. R3 stated she had her toes looked at on 4/22/25 by podiatry and they saw a sore on her toe. R3 thought she had the	2 900		

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2 900	Continued From page 30 sore for awhile. R3 did not think the nurse had changed the dressing today. During an interview on 4/23/25 at 11:22 a.m., licensed practical nurse (LPN)-A stated skin is checked weekly after showers. The nurse will look at bruises, open skin, and dressings. LPN-A reviewed R3's medical record and did not see anything identified as a pressure ulcer. During am interview on 4/23/25 at 11:28 a.m., nursing assistant (NA)-B stated R3 had the toe wound since 4/18/25. The dressing is not on right now since R3 just had a bath. NA-B would notify the charge nurse for any wounds. During an observation on 4/23/25 at 1:14 p.m., registered nurse (RN)-A entered R3's room to complete wound care. R3 was sitting in a wheelchair with her feet dependent on the floor. R3 stated the wound does not hurt. RN-A removed the ace wrap that was on R3's leg from toes to calf. There was +4 pocketed edema on the top of right foot. No dressing was on the pressure ulcer to remove. The 4th toe was red and the wound is located inside on the web of the toe in between the middle toe and fourth toe and going up a little of the 4th toe. It measured 0.3 cm x 0.4 cm. unable to determine depth as the wound was covered in a white substance. RN-A stated she could smell an odor during the dressing change. R3 stated it tickled but did not hurt. RN-A explained all of R3's toes had a large amount of edema and were pressed together and difficult to separate to see between. During an interview on 4/23/25 at 3:44 p.m., NA-D stated she discovered R3's toe on 4/18/25. The wound was between the toes. The toes were really red, swollen, and warm to touch. NA-D had	2 900		

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2 900	Continued From page 31 not noticed it before. The nurse put triple antibiotic ointment on the wound and NA-D reported the area in the shift to shift report and told the oncoming staff about it. During a subsequent interview on 4/24/25 at 8:42 a.m., NA-B stated R3's sore had been there but it had not been open like it was currently. It opened again on 4/18/25. NA-B described the wound as a scab prior to 4/18/25. During an interview on 4/23/25 at 5:06 p.m., RN-B could not recall a pressure ulcer on R3's 4th toe. RN-B stated most of the wound treatments are done on the day shift and if a treatment is required the TAR would reflect it. During an interview on 4/24/25 at 9:05 a.m., RN-A stated a stage II pressure ulcer presenting with a scab over it would not be considered healed and would be troublesome as it would be eschar tissue. RN-A took over the wound treatments for the facility the week of 4/15/25, and had not been aware of the pressure ulcer until the podiatry noted it on 4/22/25 during their rounds. During a follow-up phone interview on 4/29/25 at 1:56 p.m., RN-A verified that R3's pressure ulcer is between the third and fourth toes, not the fourth and fifth toes as was documented. During a phone interview on 4/29/25 at 8:44 a.m., medical doctor (MD)-B stated the stage II pressure ulcer is the same location as the stage III pressure ulcer. The wound is the same width and diameter but appeared a little bit deeper on examination 4/22/25 compared to 12/17/24, when MD-B last saw it. There were no dressings on the wound prior to MD-B's examination. MD-B's expectation was that the facility would follow the order to not get the foot wet. The water just gets	2 900		

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2 900	Continued From page 32 trapped between the toes due to the size of her toes. MD-B had not had any communication with the facility on R3's pressure ulcer in between 12/17/24 and 4/22/25. During an interview on 4/24/25 at 10:36 a.m., director of nursing (DON) stated wounds should be assessed at a minimum weekly and measurements included. If a wound was healed it would be documented in the progress notes, weekly wound assessment or the skin assessment tool. There was not a protocol in place to monitor a wound for any specific amount of time after it healed, only that the floor nurses should be aware of the healed wound and lay eyes on the location on weekly bath assessments. It was determined that R3's pressure ulcer had healed in January, but no documentation on the wound being healed. If the wound had a scab over it, the wound would be considered unstageable and not healed. The nurses were to communicate to the NA's that R3's right foot was not to get wet. It is the expectation that nurses look between resident toes on bath days. The facility Wound Treatment Management policy revised 4/2025, identified to promote wound healing of various types of wounds, the facility would provide evidence-based treatments in accordance with current standards of practice and physician orders. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include lack of progression towards healing, changes in wound characteristics, and changes in resident goals and preference. The facility Foot Care Skin Integrity policy dated	2 900		

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2 900	Continued From page 33 4/2025, identified the residents receive proper treatment and care to maintain mobility and good foot health. The risk assessment will include a comprehensive assessment to identify additional risk factors or conditions that increase risk for impaired foot skin integrity. Medical conditions will be managed and interventions implemented in accordance with professional standards of practice to prevent complications of medical conditions. The attending physician will be notified of the presence, progression towards healing, or lack of healing of any foot ulcers, or any changes in a residents medical condition. 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		