DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 17, 2021

Administrator
Talahi Nursing And Rehab Center
1717 University Drive Southeast
Saint Cloud, MN 56304

RE: CCN: 245438
Cycle Start Date: June 17, 2021

Dear Administrator:

On July 23, 2021, we notified you a remedy was imposed. On August 6, 2021 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 August 3, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 17, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 1, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 17, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 3, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered

July 23, 2021

Administrator
Talahi Nursing And Rehab Center
1717 University Drive Southeast
Saint Cloud, MN 56304

RE: CCN: 245438
Cycle Start Date: June 17, 2021

Dear Administrator:

On July 1, 2021, we informed you that we may impose enforcement remedies.

On July 1, 2021, the Minnesota Department(s) of Health and Public Safety completed a revisit/survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 17, 2021

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 17, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 17, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions. This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; 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 September 17, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Talahi Nursing And Rehab Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 17, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 17, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING _____ B. WING _____	C 07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAHI NURSING AND REHAB CENTER	**1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304**

(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 6/30/21 - 7/1/21, an abbreviated survey was conducted at your facility. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5438118C (MN00074219), with deficiencies cited at F686 and F636 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		8/3/21

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

Electronically Signed | 07/28/2021

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F 686	Continued From page 1 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and develop care plan interventions for a resident assessed to be at risk for pressure ulcers, who subsequently development of a stage 2 pressure ulcer (partial-thickness skin loss with exposed dermis), for 1 of 3 residents (R1) reviewed for pressure ulcers. In addition, the facility failed to update the medical provider after a pressure ulcer was initially observed and failed to ensure appropriate interventions were communicated to all necessary caregivers following the development of the stage 2 pressure ulcer to prevent potential for worsening of the ulcer. Findings include: R1's admission Minimum Data Set (MDS), dated 5/21/21, identified R1 had been admitted on 5/14/21 related to cellulitis (a serious bacterial infection of the skin). R1 had moderately impaired cognition with diagnosis of intellectual disability, medication noncompliance, diabetes (DM), obesity, renal impairments and multiple cardiac conditions. The MDS identified R1 required extensive physical assist with activities of daily living (ADL) and experienced frequent incontinence of both bowel and bladder. Further, R1 was at risk for pressure ulcer development. No alterations to R1's skin were reported at that time; however, he had treatments as follows: pressure reducing device in chair, application of dressing to feet, and ointment/medications to areas other than his feet. In addition, R1 received	F 686	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: R1 discharged from our facility How the facility will identify other residents having the potential to be affected by the same deficient practice: Residents in our building who are at risk via the Braden Assessment have the potential to be affected by the same deficiency. Residents who have a Braden identifying at risk have had their care plans reviewed for further intervention. Weekly Skin Checks have been reviewed for new skin alterations. What measures will be put into place, or systemic changes made, to ensure the deficient practice will not recur: The baseline care plan will be completed to its entirety and will be reviewed by IDT. Braden scores will be reviewed upon completion by the IDT team and intervention will be implemented as needed. Education is provided to licensed nurses surround identification of residents at increased risk for developing pressure injuries, prompt documentation of new wounds, provider notification and updating care plan/Kardex with preventative interventions.	

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F 686	Continued From page 2 antibiotic and diuretic medication, along with the use of oxygen. R1's admission MDS Care Area Assessments (CAAs) identified the following information: - Nutritional Status, dated 5/24/21: R1 had "Potential for alteration in nutritional status related to elevated BMI [body mass index] and orders to receive a therapeutic diet." The section labeled "Other diseases and condition that can affect ... nutritional needs" had an available option for "Pressure ulcers/injuries;" however, this remained unchecked with directions to "See active diagnosis list. See nursing pain assessment." The overall objective for care planning was to "Maintain current level of functioning" and R1 would continue to be monitored and care planned on. - Pressure Ulcer/Injury, dated 5/26/21: R1 had an "Actual" problem related to an existing pressure ulcer/injury. Risk factors were identified; "Pressure" in which R1 needed a "special mattress or seat cushion to reduce or relieve pressure," along with, immobility, incontinence, altered mental status, cognitive loss, diabetes, renal and heart disease, pain, having been newly admitted, and using devices that could cause pressure, such as oxygen. The CAA's impact of this problem/need on R1 and the rationale for care planning to "minimize risks" recorded the "CAA triggered related to resident [R1] being at risk for skin break down related to urinary incontinence, decreased mobility, DM, open areas to lower extremities and buttocks present on admission. Treatment in place and areas on lower extremities are healing. Skin is observed with AM/HS [morning and evening] cares and with bath. Staff assist him with repositioning in bed he is able to make small adjustments independently	F 686	How that facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The facility will audit weekly wound rounds and at-risk residents with a Braden score at risk and to validate that new wound(s) are identified timeline, providers updated, and care plan/Kardex are updated. These audits will be completed weekly x 2 months. Completed audits will be brought to QAPI for review to determine if any changes are needed, to extend the time of the audits, or to discontinue. The date that each deficiency was corrected:8/3/2021 An electronic acknowledgement signature and date by an official facility representative Responsible Party: Director of Nursing or Designee	

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F 686	Continued From page 3	F 686		

from side to side. See assessments, MAR/TAR [medication and treatment administration records] and progress notes. Will care plan." The CAA's Referral to Other Disciplines remained blank of any referral information.
- Urinary Incontinence and Indwelling Catheter, dated 5/26/21: R1 had this "CAA triggered related to needing assistance with toileting and incontinence. He has been using his urinal with improved urinary continence, he needs assist with transfers for toileting not able to complete cleansing tasks independently. Open area noted to buttocks area on admission, barrier creams applied. Staff are to offer toileting with rounds and prn [as needed]. See POC [point of care] charting and progress notes. Will care plan."

R1's MARs, May and June 2021, identified the following orders:
- 5/14/21: "Diet orders, including supplements, hydration program and enteral nutrition may be delegated to Registered (Certified) Dietitian." The order lacked any specific changes per the dietitian.
- 5/26/21: "Ensure resident is turned/repositioned/off-loaded every 2 hours. Document refusals every shift." The MARs lacked evidence of a turning/repositioning/off-loading order prior to 5/26/21.

R1's TARs, May and June 2021, identified the following order:
- 5/26/21: "TO COCCYX: Change boarder [sic] foam dressing daily and PRN. Cleanse with wound cleanser every day shift." The May TAR indicated staff started to perform the treatment on 5/27/21.

R1's Hospital Summary, dated 5/14/21, identified

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F 686	Continued From page 4	F 686		

R1's discharge diagnosis included right lower extremity cellulitis. The summary lacked details related to pressure ulcer(s). R1's Discharge Pre-Placement Report was reviewed which compiled information from his hospital stay and identified a wound nurse progress note dated 5/10/21 that reported R1 had bilateral lower extremity vascular ulcerations within the gaiter (area extending from just above the ankle region to below the knee) area of both legs; however, the report lacked evidence R1 had any additional skin alteration(s), i.e. pressure ulcer(s), noted during his stay and/or upon discharge.

R1's Admission Screener - V3, effective date 5/14/21, identified a Skin Observation section had been completed on 5/17/21 by the assistant director of nursing (ADON) that indicated R1 had two skin alterations; one on his right lower front leg and one on his left lower front leg. The admission screener lacked evidence R1 had been admitted with any other skin alterations i.e. pressure ulcer(s) and lacked evidence of a comprehensive skin assessment section.

R1's Skin & Wound Evaluation V5.0s identified the following information:
- Effective date 5/14/21: R1 had been admitted with an abrasion to his left foot, a diabetic ulcer (associated with impaired circulation of the lower legs in a person with diabetes) to his left calf, a diabetic ulcer to his left shin, and another diabetic ulcer to his right shin. Each evaluation had a section labeled "Additional Care" which identified the following interventions: "Moisture barrier," "Moisture Control," "Nutrition/dietary supplementation." The Additional Care sections presented additional option choices for interventions such as preventative cushions/bed

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F 686	Continued From page 5	F 686		

mattresses, foot cradle, customized shoe wear, heel suspension/protection device, mobility aid(s), turning/repositioning program, and "other" which all remained unchecked. In addition, the evaluations identified a "Notifications" section that provided options for the practitioner, resident/responsible party, dietician, and therapy disciplines; all remained unchecked.
- Effective date 5/26/21 (12 days later): R1 continued to have previously identified skin alterations; however, R1 had documentation this date to have a "Stage 2 (partial thickness skin loss with exposed dermis (second layer of skin)" coccyx (area at the base of the spinal column) pressure ulcer. The evaluation identified the pressure ulcer had been present on admission and had an "Exact Date" of 5/14/21. The pressure ulcer measured 5.4 centimeters (cm) long by 4.8 cm wide. The wound bed had 20 percent (%) epithelial (outer layer of skin) coverage, along with 80% filled with slough (dead tissue). The "Additional Care" section indicated the following interventions: "Moisture barrier," "Moisture Control," and "Cushion." No other additional care items were checked and the "Notification" section remained unchecked.
- Effective date 6/2/21: R1's "Stage 2" coccyx pressure ulcer measured 4.9 cm long by 4.1 cm wide. The wound bed had 100% slough with a "moderate" amount of "serous (thin, watery and clear)" drainage with no odor. The pressure ulcer had been "stable." The "Additional Care" section indicated continued moisture barrier and control, along with nutrition/dietary supplementation, in which the "Turning/repositioning program" intervention had been checked. The "Notification" section remained unchecked.
- Effective date 6/9/21: R1's "Stage 2" coccyx pressure ulcer measured 3.5 cm long by 2.6 cm

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F 686	Continued From page 6	F 686		

wide. The wound bed had 10% granulation (new connective tissue) with 90% slough and had indicated a "light" amount of serous drainage with no odor. The pressure ulcer had been "stable." The "Additional Care" section indicated continued moisture barrier and control and a cushion. The evaluation no longer indicated the intervention of a turning and repositioning program or nutrition/dietary supplementation. The "Notification" section remained unchecked.
- Effective date 6/17/21: R1's "Stage 2" coccyx pressure ulcer measured 3.1 cm long by 2.5 cm wide. The wound bed continued to have 10% granulation and 90% slough with no odor; however, a "moderate" amount of serous drainage was noted. The pressure ulcer had been "stable." The "Additional Care" section indicated continued moisture barrier and control and a cushion only and the "Notification" section remained unchecked.
- On 6/23/21, R1 had Skin & Wound Evaluations V5.0 completed for his lower leg skin alterations; however, R1's medical record lacked evidence the "Stage 2" coccyx pressure ulcer had been evaluated that day.

R1's Braden Scale for Predicting Pressure Sore Risk (Braden), effective date 5/14/21, identified R1 was slightly limited in his ability to respond meaningfully to pressure-related discomfort, had an occasionally moist degree to which his skin was exposed to moisture, walked occasionally for physical activity, was slightly limited in his ability to change and control his body position, had an adequate pattern of food intake, and had a potential problem in relation to friction and shearing. The Braden indicated a score of 17 which categorized R1 at a "Mild Risk" for pressure ulcer development.

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Subsequent Braden assessments were completed for R1 on 5/21/21, 5/28/21, 6/4/21, and 6/11/21. These Braden assessment indicated scores of 13 and 14 which categorized R1 at a "Moderate Risk" for pressure ulcer development. The medical record lacked evidence of any initiated and/or adjusted care planned interventions in response to R1's increased pressure ulcer risk based on these completed Braden assessment.

R1's Baseline Care Plan/Evaluation - V8, undated, had checkmarks that identified he had occasional urinary incontinence, was diabetic, and had "Current skin integrity issues." The section labeled "Specify skin integrity issues" remained blank. The section labeled "Skin alteration plan of care" identified a checked "Focus: I have an alteration in skin integrity related to" with additional checkmarks for "Goal: I will be free of complications and minimized pain related to my skin alteration through the review date" with "Intervention: Administer my medications as ordered...Keep my skin well moisturized with lotion...Minimize edema of my extremities. Elevate my legs." A section labeled "Risk for skin breakdown" remained without checkmarks. The section labeled "Dietary/Nutritional Status" indicated R1 had a diet order for "consistent carbs, regular textures, regular liquids" and a dietary goal to maintain his current weight. The dietary section indicated he was at risk for potentially altered nutritional status related to his diagnosis of diabetes. The dietary section did not identify concerns related to skin alteration(s) or nutrition/dietary supplementation. Further, the baseline care plan lacked evidence of specific skin integrity issues or specific

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interventions to address them, approaches for managing urinary incontinence, or interventions that addressed turning and repositioning due to his impaired mobility.

R1's Weekly Skin Check - V3's identified the following information:
- Effective date 5/20/21: lacked evidence R1 had skin alteration(s).
- Effective date 5/27/21: lacked evidence R1 had skin alterations(s).
- Effective date 6/1/21: R1 had a pressure ulcer on his coccyx and three vascular ulcers; right front lower leg, left front lower leg, right rear lower leg. The skin check lacked the pressure ulcer measurements or observations. In addition, the skin check identified R1 had "No" new skin alterations identified.
- Effective date 6/3/21: lacked evidence R1 had skin alteration(s); however, indicated R1 had +3 pitting edema to bilateral lower legs.
- Effective date 6/10/21: R1 had a pressure ulcer on his coccyx and three vascular ulcers. The skin check lacked evidence of the pressure ulcer measurements or observations. In addition, the skin check identified R1 had "No" new skin alterations identified.
- Effective date 6/17/21: R1 had a pressure ulcer on his coccyx and three vascular ulcers. The skin check lacked the pressure ulcer measurements or observations. In addition, the skin check identified R1 had "No" new skin alterations identified.

R1's comprehensive care plan identified the following information and revisions:
- Initiated on 6/8/21: "The resident has Diabetes Mellitus" with interventions to check body for skin alterations and treat promptly as ordered by

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doctor and to monitor/document/report as needed any signs and symptoms of infection to any open areas.
- Revised on 6/9/21: "I have an alteration in skin integrity r/t [related to] sacral ulcer, R [right] calf ulcer, and bilateral heel (R+L) diabetic ulcers" with a goal "I will be free of complications and minimized pain related to my skin alteration through the review date." Interventions were identified which were initiated on 5/14/21 by the completion of the baseline care plan with adjustments made on 6/4/21 to elevate his legs due to venous insufficiency, administer his treatments as ordered, and directed staff to apply "Blue Pressure relieving boots on outside of transferring."
- Revised on 6/24/21: "The resident has potential for altered nutritional status r/t DM, Obesity and wounds," which lacked evidence of nutrition/dietary supplementation or specific dietary interventions to address R1's wounds.
- The care plan lacked further evidence R1 had a risk for pressure ulcer/skin alteration development and interventions to help decrease his risk for pressure ulcer development, other than the placement of blue pressure relieving boots. In addition, the care plan lacked evidence R1 had a risk for bowel and bladder incontinence and interventions to help decrease associated risk factors.

R1's Kardex [nursing assistant plan of care], printed 6/30/21, directed staff to apply the blue pressure relieving boots outside of transferring R1. R1's Kardex lacked evidence that identified he had skin alterations and further lacked interventions for skin alteration management i.e. nutrition supplementation, pressure relieving bed and/or wheelchair cushion, toileting plan,

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incontinence care, or a turning/repositioning program.

R1's progress notes, dated 5/14/21 - 6/26/21 identified the following entries:
- 5/18/21, at 8:17 a.m. a dietitian entry identified R1 had vascular wounds to bilateral lower extremities in which his "current intake is adequate to support healing" and that no new dietary recommendations were given at that time.
- 5/30/21, at 9:24 a.m. identified an Orders-Administration Note entered by the director of nursing (DON); "Bed of coccyx wound is 100% slough, no pain during dressing change, small amount of serous drainage with no odor, edges are red."
- 6/10/21, at 2:38 p.m. identified an Orders-Administration Note entered by a licensed practical nurse (LPN); "missed wound [coccyx] care, passed onto PM's."
- 6/23/21, at 10:00 p.m. R1 was sent to the emergency room at the St. Cloud Hospital and admitted for seizure like activity and unresponsiveness.

Review of R1's progress notes lacked any other additional entries related to his coccyx pressure ulcer.

Review of R1's medical record lacked evidence to support a "stage 2" coccyx pressure ulcer had been present upon admission, prior to the first pressure ulcer indication on 5/26/21. In addition, the medical record lacked evidence that the medical provider(s) were updated concerning the pressure ulcer after development. Further, it lacked that R1 had a comprehensive skin assessment performed which identified all factors related to R1's pressure ulcer risk on admission and after the "stage 2" pressure ulcer had been

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initially documented . Furthermore, the medical record lacked evidence R1 had care planned intervention(s) to support a decreased risk for pressure ulcer development or to help decrease the risk of concerns related to the documented "stage 2" coccyx pressure ulcer.

When interviewed on 6/30/21, at 12:03 p.m. nursing assistant (NA)-A acknowledged having been aware that R1 had sores on his legs and coccyx. NA-A acknowledged she reviewed the Kardex for resident information and interventions on how to care for them. NA-A had not been aware of any sort of repositioning or toileting plan for R1; however, stated she would use pillows to help support him when she encouraged "him to get off of his bottom." Further, NA-A stated R1 directed his toileting programming and she needed to assist him physically at those times. NA-A had been unsure if R1 used a cushion in his wheelchair and/or required a specialized mattress. After NA-A reviewed R1's Kardex, she verbalized "It does not say," when questioned concerning R1's pressure ulcer interventions.

During a telephone interview on 6/30/21, at 12:42 p.m. licensed practical nurse (LPN) - B stated she recollected having been updated when R1 admitted that he had cellulitis; however, she could not recollect if he had been admitted with a pressure ulcer on his coccyx. LPN-B stated she had thought the coccyx ulcer had gotten "worse since he got here;" before it started to "get slightly better; however, later in the interview, LPN-B mentioned, "...not sure thinking back if it [pressure ulcer] really got better." LPN-B explained R1 initially did not desire to get up out of bed and he had a preference for lying on his right side due to his wish to face the television.

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LPN-B confirmed tissue tolerance testing was not completed on residents to help determine turning and repositioning programs and further stated, "We do rounds every two hours." LPN-B explained if a resident had a change in condition their medical provider would be updated by whoever found the change.

When interviewed by telephone on 6/30/21, at 1:39 p.m. the interim wound care nurse LPN-A denied knowledge that R1 had been admitted with a pressure ulcer as she had not been in her interim role at the time of his admission; however, she explained she had been "under the impression" staff had been aware that R1 had a pressure ulcer on admission when staff questioned the lack of a pressure ulcer picture in R1's medical record. LPN-A had been unsure of the date staff brought this to her attention. LPN-A voiced when a resident was admitted they would receive a head to toe skin assessment by a registered nurse (RN). If a pressure ulcer was identified then they were expected to ensure the ulcer had an ordered treatment, was documented on the "admission screener assessment" and in the medical record, an accompanying picture was taken, and then the pressure ulcer would have "wound documentation every week" following it's identification. She explained the comprehensive skin assessment was located in the admission screener assessment and the facility did not have a separate comprehensive skin assessment form. When questioned on the facility's tissue tolerance identification process, LPN-A denied nursing performed this type of determination. When questioned on how a resident had a turning and repositioning program identified, LPN-A stated that if a resident were at risk "in my practice it is every two hours" and if "any [skin]

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abnormalities" were observed then they "would initiate or adjust off loading or repositioning" based on the resident's risk factors. LPN-A stated she expected residents would have a weekly skin check by the cart nurses in which the skin check form would identify "any skin abnormalities" and replied "I would imagine" R1's pressure ulcer should have been identified on his weekly skin checks if it had been present during the evaluations. She explained the cart nurses were not expected to add the skin abnormality measurements as "we measure [the abnormalities] weekly." LPN-A denied knowledge R1's medical provider had been updated regarding his coccyx pressure ulcer since his admission and explained again she had not been in her interim role at the time of his admission.

During interview on 6/30/21, at 2:33 p.m. MDS nurse RN-B stated R1's pressure ulcer had not been noted in R1's medical record [on or before 5/21/21] when she had completed R1's admission MDS on 5/27/21 and she explained when she had wrote R1's pressure ulcer CAA the case manager had stated to her the pressure ulcer had been present on admission and thus the pressure ulcer information was added to the CAA. RN-B stated the purpose of the CAA process was to "drive their [the residents] care plan in order to "take care of the person [resident] the best you can." RN-B confirmed she assisted with the care planning process; however, she explained she did not determine repositioning interventions as that was a case manager care plan item and that she had been unsure as to how they determined resident repositioning as the facility no longer performed tissue tolerance testing.

When interviewed by telephone on 7/1/21, at 9:07

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a.m. the ADON confirmed upon a resident's admission an RN completed a head to toe skin assessment in which they documented any abnormalities "right away," along with photo identification, to support the abnormality was not facility acquired, and then followed up weekly with weekly wound rounds. The ADON explained upon admission a resident had a Braden completed to help determine pressure ulcer risk in which interventions would be based off of the Braden's calculated score, along with individual resident risk factors and needs. In addition, she explained the skin section in the admission screener assessment went "a little more in-depth with risk factors." She denied the facility performed resident tissue tolerance testing to help determine a resident's individualized turning/repositioning/off-loading programmed intervention and she explained if a resident was at risk they would be care planned to be repositioned "every two hours;" if a resident had a sacral coccyx ulcer staff "would turn them as much as you can." The ADON acknowledged skin alteration(s) observed during the weekly skin checks should be measured by the cart nurse and that the skin checks "should jive" with the weekly wound rounds for skin alteration locations. She stated it was "not acceptable" that some of R1's weekly skin checks "missed the information on [R1's] skin." The ADON confirmed R1's coccyx pressure ulcer had not been present on admission; "That developed after he got here." The ADON stated R1 had "blanchable [coccyx] redness upon admission" which had not been observed again during the proceeding week's weekly wound rounds; however, the ADON explained the pressure ulcer "got worse from just [the admission redness on] admission in which the ulcer "was pretty sloughy" and became harder

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to determine treatment despite it having been "...pretty stable.". The ADON verbalized R1's medical provider had been updated on his pressure ulcer in which there should have been documentation in his medical record to support a conversation with the "triage nurse" and she further verbalized R1 was given a cushion in his wheelchair upon admission and he was provided with an air mattress and an every two hour repositioning plan when the ulcer "opened up." She also was "pretty sure" R1 had been started on nutrition/dietary supplementation "right away" [upon admission] for his venous leg ulcers and to prevent any new ulcers. The ADON confirmed these interventions should have been in R1's care plan, along with a care plan section which identified his skin alteration risk factors. The ADON stated the interventions related to R1's skin alteration risk factors and his current pressure ulcer should be in his care plan so that it pulled to the Kardex as once in the Kardex the nursing assistants would then know the interventions. The ADON explained if staff did not know R1's risk factors and/or current skin alterations and interventions they would not know how to care for him and he then would have the potential for a deterioration of his current skin alterations and/or new skin alteration development.

During interview on 7/1/21, at 11:26 a.m. NA-B (a contracted pool staff) stated she was expected to use the Kardex for resident information. She explained the Kardex had "everything I need to know" in order to care for the residents. R1 confirmed she had not worked with R1 prior to his hospitalization on 6/23/21. After NA-B reviewed R1's Kardex, she confirmed the Kardex lacked information R1 had any skin alterations and that

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the Kardex did not indicate if R1 had a repositioning plan, used interventions such as a cushion in his wheelchair or air mattress, that he had a toileting plan or if he had indication of bowel/bladder incontinence, or any other interventions for toileting. NA-B stated, "If I had to work with him, it [Kardex] does not say I would have to reposition him." Further, NA-B stated if R1 required a repositioning plan, or other interventions, the Kardex should have that information "otherwise he is not getting the care he deserves."

When interviewed on 7/1/21, at 11:39 a.m. LPN-C stated staff would refer to the Kardex to know how to care for a resident and that she expected staff [NAs] to follow what was indicated on it "...so they [residents] are getting the proper care." Thus, LPN-C explained resident care interventions needed to be present on the Kardex for this to happen. Further, she stated she expected interventions to be on the comprehensive care plan so that the Kardex would be accurate as care planned interventions "flow over" to the Kardex. After LPN-C reviewed R1's Kardex, she confirmed the Kardex lacked information which indicated R1 had skin issues "other than the blue boots." She further confirmed R1's Kardex lacked interventions to help decrease skin alteration risk other than a walking program. LPN-C voiced, "Our general guideline for repositioning if every two hours," and further voiced there was "always a potential that it would not be followed." LPN-C stated R1's turning and repositioning program "probably should be on there [the Kardex]" and, "It should be on the care plan itself at least."

During interview on 7/1/21, at 11:52 a.m. the

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director of nursing (DON) stated the Kardex was part of the care plan and is what the NAs used to "execute their duties" for resident care and thus she expected the Kardex to contain interventions such as repositioning and toileting plans if applicable to the resident and any skin alteration interventions. The DON explained if such specific resident interventions were not identified on the Kardex there was a "risk for pressure injury" and any current skin alterations may decline. After review of R1's Kardex, the DON confirmed R1's Kardex lacked evidence which instructed staff on skin integrity and/or coccyx pressure ulcer interventions, other than the blue boots. The DON stated she expected the admission screener assessment to indicate all skin alterations noted on admission, along with the base line and comprehensive care plans should address risk factors for skin alterations; not just the skin alterations that were present. In addition, the DON explained she also expected a new comprehensive assessment to be completed after a new pressure ulcer was acquired, along with the medical provider to be updated, in order to "prevent further injury or concern" and to ensure appropriate wound treatment.

A policy Change in Condition, revised 12/19/18, directed that the residents physician would be notified promptly when there had been an onset of a pressure ulcer, in which the notification would be documented in the medical record and the care plan would be updated as necessary.

A policy Care Plan/Conference, revised 1/25/21, indicated its purpose was to ensure that each resident received care individualized to him or herself and that the goals and approaches for care were communicated to caregivers. The

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F 686	Continued From page 18 policy identified the comprehensive care plan was based on the resident's medical condition, medical history and assessments, and that the care plan would be revised as information about the resident's condition changed.	F 686		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 23, 2021

Administrator
Talahi Nursing And Rehab Center
1717 University Drive Southeast
Saint Cloud, MN 56304

Re: State Nursing Home Licensing Orders
Event ID: 2RH711

Dear Administrator:

The above facility was surveyed on June 30, 2021 through July 1, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00614	A. BUILDING: _____ B. WING _____	C 07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAHI NURSING AND REHAB CENTER	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/30/21 - 7/1/21, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5438118C (MN00074219) with licensing orders issued at 0545 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 state form.	2 000		

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2 545	MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident assessments must be conducted: A. within 14 days after the date of admission; B. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure a comprehensive Minimum Data Set (MDS) and associated Care Area Assessment (CAA) processes were completed timely for 1 of 3 residents (R1) reviewed for assessment accuracy. Findings include: The Centers for Medicare and Medicare Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2019, identified the RAI MDS and CAA's primary purpose was to identify resident care problems which would be addressed in an individualized care plan. Further, data collected from MDS assessments was also used for the Skilled Nursing Facility Prospective Payment System (SNF PPS) Medicare reimbursement system, many State Medicaid reimbursement	2 545	The director of nursing or designee to develop a system to educate staff and develop a monitoring system to ensure MDS processes are completed timely. Education will be provided to the SS representative on timely completion of MDS/CAA on newly admitted residents. Audits will be conducted twice monthly by Director of nursing or designee and information will be brought to QAPI.	8/3/21

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2 545	Continued From page 3	2 545		

systems, and for monitoring the quality of care provided to nursing home residents. The manual identified comprehensive "assessment completion is defined as completion of the CAA process in addition to the MDS items, meaning that the RN [registered nurse] assessment coordinator has signed and dated both the MDS (item Z0500) and CAA(s) (item V0200B) completion attestations." In addition, the manual instructed the MDS and CAA(s) admission (comprehensive) completion date(s) (items Z0500 and V0200B2) were to be no later than the "14th calendar day of the resident's admission (admission date + [plus] 13 calendar days)." The manual provided additional details to ensure accurate coding for each MDS section of the assessment as follows:

"Section C: Cognitive Patterns," with intent "to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions."

"Section D: Mood," with intent to "address mood distress, a serious condition that is under-diagnosed and under-treated in the nursing home..."

"Section E: Behavior," with intent to identify behavioral symptoms that may cause distress to the resident and/or other facility residents, staff members or the care environment. "These behaviors may place the resident at risk for injury, isolation, and inactivity and may also indicate unrecognized needs, preferences, or illness."

R1's admission MDS dated 5/21/21, identified R1 had an admission date of 5/14/21, and had been utilizing SNF PPS reimbursement for his stay.

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2 545	Continued From page 4 The MDS indicated R1 had moderately impaired cognition with diagnosis of intellectual disability and medication noncompliance. Further diagnosis included cellulitis, diabetes, and obesity in which R1 required extensive physical assist with his activities of daily living (ADL's). The MDS indicated R1 had minimal depression; however, identified he reported "feeling down, depressed, or hopeless," "feeling tired or having little energy," and "feeling bad about yourself - or that you are a failure or have let yourself or your family down" several days during the MDS assessment period. The MDS "Section Z - Assessment Administration" indicated sections "C ,D, E" and item Z0500, had been completed on 6/1/21 (five days late per RAI admission completion instructions). The MDS "Section V - Care Area Assessment (CAA) Summary" indicated item V0200B had been completed on 6/1/21 (five days late). When interviewed on 6/30/21, at 2:33 p.m. MDS nurse (RN)-B acknowledged R1's admission MDS and CAA process had not been completed timely per the RAI requirements. RN-B voiced R1's admission MDS and CAA processes should have been completed on or before the 14th day of his stay [5/27/21]. RN-B explained the MDS and CAA processes needed to be done timely as they drove care planning processes in order to "take care of a person [resident] the best you can." Lateness of this process also had "the potential for delayed treatment." RN-B identified a resident's admission assessment reference date (ARD) would be setup for day eight of a resident's stay. During interview on 6/30/21, at 2:57 p.m. the social services director (SSD) acknowledged she completed the MDS sections C, D, and E, along	2 545		

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2 545	Continued From page 5	2 545		

with any triggered CAAs. She stated she attempted to complete the MDS process as soon as she could which typically was "five or seven days after the ARD." The SSD voiced she had not been aware of the RAI manual instructions for MDS and CAA completion timeframe's; however, she explained she "tends to look at the computer [Point Click Care MDS software] system to see when things are due." She denied knowledge she had completed R1's MDS process past the required date. She explained the purpose of completing the MDS process was to capture what the residents needs were for care planning purposes and funding, and that late MDS processes had the potential for "payment issues" and "not having certain pieces of the care plan" in order to "care for the residents properly. The SSD voiced she "does the best" she can being she was the only social worker in the building.

When interviewed on 7/1/21, at 11:52 a.m. the director of nursing (DON) stated she expected the MDS and CAA processes to be completed "per the regulations." The DON explained MDS and CAA lateness had the potential to miss "something that is going on in that window of time" and voiced the example that if a resident were a high fall risk "we could have falls."

A policy MDS 3.0 Process, revised 3/15/21, indicated the interdisciplinary team (IDT) was expected to use the MDS 3.0 RAI manual and directed the "Admission assessments (MDS and CAA's) will be completed within fourteen (14) days of admission."

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review and revise policies and procedures related to Minimum Data Set (MDS) process completion

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2 545	Continued From page 6 date regulations. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure MDS processes are completed timely. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 545		
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 interview and document review, the facility failed to comprehensively assess and develop care plan interventions for a resident assessed to be at risk for pressure ulcers, who subsequently development of a stage 2 pressure ulcer (partial-thickness skin loss with exposed dermis), for 1 of 3 residents (R1) reviewed for pressure ulcers. In addition, the facility failed to	2 900	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: R1 discharged from our facility How the facility will identify other residents having the potential to be affected by the	8/3/21

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2 900	Continued From page 7 update the medical provider after a pressure ulcer was initially observed and failed to ensure appropriate interventions were communicated to all necessary caregivers following the development of the stage 2 pressure ulcer to prevent potential for worsening of the ulcer. Findings include: R1's admission Minimum Data Set (MDS), dated 5/21/21, identified R1 had been admitted on 5/14/21 related to cellulitis (a serious bacterial infection of the skin). R1 had moderately impaired cognition with diagnosis of intellectual disability, medication noncompliance, diabetes (DM), obesity, renal impairments and multiple cardiac conditions. The MDS identified R1 required extensive physical assist with activities of daily living (ADL) and experienced frequent incontinence of both bowel and bladder. Further, R1 was at risk for pressure ulcer development. No alterations to R1's skin were reported at that time; however, he had treatments as follows: pressure reducing device in chair, application of dressing to feet, and ointment/medications to areas other than his feet. In addition, R1 received antibiotic and diuretic medication, along with the use of oxygen. R1's admission MDS Care Area Assessments (CAAs) identified the following information: - Nutritional Status, dated 5/24/21: R1 had "Potential for alteration in nutritional status related to elevated BMI [body mass index] and orders to receive a therapeutic diet." The section labeled "Other diseases and condition that can affect ... nutritional needs" had an available option for "Pressure ulcers/injuries;" however, this remained unchecked with directions to "See active diagnosis list. See nursing pain assessment." The	2 900	same deficient practice: Residents in our building who are at risk via the Braden Assessment have the potential to be affected by the same deficiency. Residents who have a Braden identifying at risk have had their care plans reviewed for further intervention. Weekly Skin Checks have been reviewed for new skin alterations. What measures will be put into place, or systemic changes made, to ensure the deficient practice will not recur: The baseline care plan will be completed to its entirety and will be reviewed by IDT. Braden scores will be reviewed upon completion by the IDT team and intervention will be implemented as needed. Education is provided to licensed nurses surround identification of residents at increased risk for developing pressure injuries, prompt documentation of new wounds, provider notification and updating care plan/ Kardex with preventative interventions. How that facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The facility will audit weekly wound rounds and at-risk residents with a Braden score at risk and to validate that new wound(s) are identified timeline, providers updated, and care plan/Kardex are updated. These audits will be completed weekly x 2 months. Completed audits will be brought to QAPI for review to determine if any changes are needed, to extend the time of the audits, or to discontinue.	

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2 900	Continued From page 8 overall objective for care planning was to "Maintain current level of functioning" and R1 would continue to be monitored and care planned on. - Pressure Ulcer/Injury, dated 5/26/21: R1 had an "Actual" problem related to an existing pressure ulcer/injury. Risk factors were identified; "Pressure" in which R1 needed a "special mattress or seat cushion to reduce or relieve pressure," along with, immobility, incontinence, altered mental status, cognitive loss, diabetes, renal and heart disease, pain, having been newly admitted, and using devices that could cause pressure, such as oxygen. The CAA's impact of this problem/need on R1 and the rationale for care planning to "minimize risks" recorded the "CAA triggered related to resident [R1] being at risk for skin break down related to urinary incontinence, decreased mobility, DM, open areas to lower extremities and buttocks present on admission. Treatment in place and areas on lower extremities are healing. Skin is observed with AM/HS [morning and evening] cares and with bath. Staff assist him with repositioning in bed he is able to make small adjustments independently from side to side. See assessments, MAR/TAR [medication and treatment administration records] and progress notes. Will care plan." The CAA's Referral to Other Disciplines remained blank of any referral information. - Urinary Incontinence and Indwelling Catheter, dated 5/26/21: R1 had this "CAA triggered related to needing assistance with toileting and incontinence. He has been using his urinal with improved urinary continence, he needs assist with transfers for toileting not able to complete cleansing tasks independently. Open area noted to buttocks area on admission, barrier creams applied. Staff are to offer toileting with rounds and prn [as needed]. See POC [point of care] charting	2 900	The date that each deficiency was corrected: 8/3/2021 An electronic acknowledgement signature and date by an official facility representative Responsible Party: Director of Nursing or Designee	

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2 900	Continued From page 9 and progress notes. Will care plan." R1's MARs, May and June 2021, identified the following orders: - 5/14/21: "Diet orders, including supplements, hydration program and enteral nutrition may be delegated to Registered (Certified) Dietitian." The order lacked any specific changes per the dietitian. - 5/26/21: "Ensure resident is turned/repositioned/off-loaded every 2 hours. Document refusals every shift." The MARs lacked evidence of a turning/repositioning/off-loading order prior to 5/26/21. R1's TARs, May and June 2021, identified the following order: - 5/26/21: "TO COCCYX: Change boarder [sic] foam dressing daily and PRN. Cleanse with wound cleanser every day shift." The May TAR indicated staff started to perform the treatment on 5/27/21. R1's Hospital Summary, dated 5/14/21, identified R1's discharge diagnosis included right lower extremity cellulitis. The summary lacked details related to pressure ulcer(s). R1's Discharge Pre-Placement Report was reviewed which compiled information from his hospital stay and identified a wound nurse progress note dated 5/10/21 that reported R1 had bilateral lower extremity vascular ulcerations within the gaiter (area extending from just above the ankle region to below the knee) area of both legs; however, the report lacked evidence R1 had any additional skin alteration(s), i.e. pressure ulcer(s), noted during his stay and/or upon discharge. R1's Admission Screener - V3, effective date 5/14/21, identified a Skin Observation section had	2 900		

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2 900	Continued From page 10	2 900		

been completed on 5/17/21 by the assistant director of nursing (ADON) that indicated R1 had two skin alterations; one on his right lower front leg and one on his left lower front leg. The admission screener lacked evidence R1 had been admitted with any other skin alterations i.e. pressure ulcer(s) and lacked evidence of a comprehensive skin assessment section.

R1's Skin & Wound Evaluation V5.0s identified the following information:
- Effective date 5/14/21: R1 had been admitted with an abrasion to his left foot, a diabetic ulcer (associated with impaired circulation of the lower legs in a person with diabetes) to his left calf, a diabetic ulcer to his left shin, and another diabetic ulcer to his right shin. Each evaluation had a section labeled "Additional Care" which identified the following interventions: "Moisture barrier," "Moisture Control," "Nutrition/dietary supplementation." The Additional Care sections presented additional option choices for interventions such as preventative cushions/bed mattresses, foot cradle, customized shoe wear, heel suspension/protection device, mobility aid(s), turning/repositioning program, and "other" which all remained unchecked. In addition, the evaluations identified a "Notifications" section that provided options for the practitioner, resident/responsible party, dietician, and therapy disciplines; all remained unchecked.
- Effective date 5/26/21 (12 days later): R1 continued to have previously identified skin alterations; however, R1 had documentation this date to have a "Stage 2 (partial thickness skin loss with exposed dermis (second layer of skin)" coccyx (area at the base of the spinal column) pressure ulcer. The evaluation identified the pressure ulcer had been present on admission and had an "Exact Date" of 5/14/21. The pressure

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2 900	Continued From page 11 ulcer measured 5.4 centimeters (cm) long by 4.8 cm wide. The wound bed had 20 percent (%) epithelial (outer layer of skin) coverage, along with 80% filled with slough (dead tissue). The "Additional Care" section indicated the following interventions: "Moisture barrier," "Moisture Control," and "Cushion." No other additional care items were checked and the "Notification" section remained unchecked. - Effective date 6/2/21: R1's "Stage 2" coccyx pressure ulcer measured 4.9 cm long by 4.1 cm wide. The wound bed had 100% slough with a "moderate" amount of "serous (thin, watery and clear)" drainage with no odor. The pressure ulcer had been "stable." The "Additional Care" section indicated continued moisture barrier and control, along with nutrition/dietary supplementation, in which the "Turning/repositioning program" intervention had been checked. The "Notification" section remained unchecked. - Effective date 6/9/21: R1's "Stage 2" coccyx pressure ulcer measured 3.5 cm long by 2.6 cm wide. The wound bed had 10% granulation (new connective tissue) with 90% slough and had indicated a "light" amount of serous drainage with no odor. The pressure ulcer had been "stable." The "Additional Care" section indicated continued moisture barrier and control and a cushion. The evaluation no longer indicated the intervention of a turning and repositioning program or nutrition/dietary supplementation. The "Notification" section remained unchecked. - Effective date 6/17/21: R1's "Stage 2" coccyx pressure ulcer measured 3.1 cm long by 2.5 cm wide. The wound bed continued to have 10% granulation and 90% slough with no odor; however, a "moderate" amount of serous drainage was noted. The pressure ulcer had been "stable." The "Additional Care" section indicated continued moisture barrier and control and a	2 900		

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cushion only and the "Notification" section remained unchecked.
- On 6/23/21, R1 had Skin & Wound Evaluations V5.0 completed for his lower leg skin alterations; however, R1's medical record lacked evidence the "Stage 2" coccyx pressure ulcer had been evaluated that day.

R1's Braden Scale for Predicting Pressure Sore Risk (Braden), effective date 5/14/21, identified R1 was slightly limited in his ability to respond meaningfully to pressure-related discomfort, had an occasionally moist degree to which his skin was exposed to moisture, walked occasionally for physical activity, was slightly limited in his ability to change and control his body position, had an adequate pattern of food intake, and had a potential problem in relation to friction and shearing. The Braden indicated a score of 17 which categorized R1 at a "Mild Risk" for pressure ulcer development.

Subsequent Braden assessments were completed for R1 on 5/21/21, 5/28/21, 6/4/21, and 6/11/21. These Braden assessment indicated scores of 13 and 14 which categorized R1 at a "Moderate Risk" for pressure ulcer development. The medical record lacked evidence of any initiated and/or adjusted care planned interventions in response to R1's increased pressure ulcer risk based on these completed Braden assessment.

R1's Baseline Care Plan/Evaluation - V8, undated, had checkmarks that identified he had occasional urinary incontinence, was diabetic, and had "Current skin integrity issues." The section labeled "Specify skin integrity issues" remained blank. The section labeled "Skin alteration plan of care" identified a checked

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2 900	Continued From page 13 "Focus: I have an alteration in skin integrity related to" with additional checkmarks for "Goal: I will be free of complications and minimized pain related to my skin alteration through the review date" with "Intervention: Administer my medications as ordered...Keep my skin well moisturized with lotion...Minimize edema of my extremities. Elevate my legs." A section labeled "Risk for skin breakdown" remained without checkmarks. The section labeled "Dietary/Nutritional Status" indicated R1 had a diet order for "consistent carbs, regular textures, regular liquids" and a dietary goal to maintain his current weight. The dietary section indicated he was at risk for potentially altered nutritional status related to his diagnosis of diabetes. The dietary section did not identify concerns related to skin alteration(s) or nutrition/dietary supplementation. Further, the baseline care plan lacked evidence of specific skin integrity issues or specific interventions to address them, approaches for managing urinary incontinence, or interventions that addressed turning and repositioning due to his impaired mobility. R1's Weekly Skin Check - V3's identified the following information: - Effective date 5/20/21: lacked evidence R1 had skin alteration(s). - Effective date 5/27/21: lacked evidence R1 had skin alterations(s). - Effective date 6/1/21: R1 had a pressure ulcer on his coccyx and three vascular ulcers; right front lower leg, left front lower leg, right rear lower leg. The skin check lacked the pressure ulcer measurements or observations. In addition, the skin check identified R1 had "No" new skin alterations identified. - Effective date 6/3/21: lacked evidence R1 had skin alteration(s); however, indicated R1 had +3	2 900		

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2 900	Continued From page 14 pitting edema to bilateral lower legs. - Effective date 6/10/21: R1 had a pressure ulcer on his coccyx and three vascular ulcers. The skin check lacked evidence of the pressure ulcer measurements or observations. In addition, the skin check identified R1 had "No" new skin alterations identified. - Effective date 6/17/21: R1 had a pressure ulcer on his coccyx and three vascular ulcers. The skin check lacked the pressure ulcer measurements or observations. In addition, the skin check identified R1 had "No" new skin alterations identified. R1's comprehensive care plan identified the following information and revisions: - Initiated on 6/8/21: "The resident has Diabetes Mellitus" with interventions to check body for skin alterations and treat promptly as ordered by doctor and to monitor/document/report as needed any signs and symptoms of infection to any open areas. - Revised on 6/9/21: "I have an alteration in skin integrity r/t [related to] sacral ulcer, R [right] calf ulcer, and bilateral heel (R+L) diabetic ulcers" with a goal "I will be free of complications and minimized pain related to my skin alteration through the review date." Interventions were identified which were initiated on 5/14/21 by the completion of the baseline care plan with adjustments made on 6/4/21 to elevate his legs due to venous insufficiency, administer his treatments as ordered, and directed staff to apply "Blue Pressure relieving boots on outside of transferring." - Revised on 6/24/21: "The resident has potential for altered nutritional status r/t DM, Obesity and wounds," which lacked evidence of nutrition/dietary supplementation or specific dietary interventions to address R1's wounds.	2 900		

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2 900	Continued From page 15 - The care plan lacked further evidence R1 had a risk for pressure ulcer/skin alteration development and interventions to help decrease his risk for pressure ulcer development, other than the placement of blue pressure relieving boots. In addition, the care plan lacked evidence R1 had a risk for bowel and bladder incontinence and interventions to help decrease associated risk factors. R1's Kardex [nursing assistant plan of care], printed 6/30/21, directed staff to apply the blue pressure relieving boots outside of transferring R1. R1's Kardex lacked evidence that identified he had skin alterations and further lacked interventions for skin alteration management i.e. nutrition supplementation, pressure relieving bed and/or wheelchair cushion, toileting plan, incontinence care, or a turning/repositioning program. R1's progress notes, dated 5/14/21 - 6/26/21 identified the following entries: - 5/18/21, at 8:17 a.m. a dietitian entry identified R1 had vascular wounds to bilateral lower extremities in which his "current intake is adequate to support healing" and that no new dietary recommendations were given at that time. - 5/30/21, at 9:24 a.m. identified an Orders-Administration Note entered by the director of nursing (DON); "Bed of coccyx wound is 100% slough, no pain during dressing change, small amount of serous drainage with no odor, edges are red." - 6/10/21, at 2:38 p.m. identified an Orders-Administration Note entered by a licensed practical nurse (LPN); "missed wound [coccyx] care, passed onto PM's." - 6/23/21, at 10:00 p.m. R1 was sent to the emergency room at the St. Cloud Hospital and	2 900		

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admitted for seizure like activity and unresponsiveness.
Review of R1's progress notes lacked any other additional entries related to his coccyx pressure ulcer.

Review of R1's medical record lacked evidence to support a "stage 2" coccyx pressure ulcer had been present upon admission, prior to the first pressure ulcer indication on 5/26/21. In addition, the medical record lacked evidence that the medical provider(s) were updated concerning the pressure ulcer after development. Further, it lacked that R1 had a comprehensive skin assessment performed which identified all factors related to R1's pressure ulcer risk on admission and after the "stage 2" pressure ulcer had been initially documented . Furthermore, the medical record lacked evidence R1 had care planned intervention(s) to support a decreased risk for pressure ulcer development or to help decrease the risk of concerns related to the documented "stage 2" coccyx pressure ulcer.

When interviewed on 6/30/21, at 12:03 p.m. nursing assistant (NA)-A acknowledged having been aware that R1 had sores on his legs and coccyx. NA-A acknowledged she reviewed the Kardex for resident information and interventions on how to care for them. NA-A had not been aware of any sort of repositioning or toileting plan for R1; however, stated she would use pillows to help support him when she encouraged "him to get off of his bottom." Further, NA-A stated R1 directed his toileting programming and she needed to assist him physically at those times. NA-A had been unsure if R1 used a cushion in his wheelchair and/or required a specialized mattress. After NA-A reviewed R1's Kardex, she verbalized "It does not say," when questioned

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2 900	Continued From page 17 concerning R1's pressure ulcer interventions. During a telephone interview on 6/30/21, at 12:42 p.m. licensed practical nurse (LPN) - B stated she recollected having been updated when R1 admitted that he had cellulitis; however, she could not recollect if he had been admitted with a pressure ulcer on his coccyx. LPN-B stated she had thought the coccyx ulcer had gotten "worse since he got here;" before it started to "get slightly better; however, later in the interview, LPN-B mentioned, "...not sure thinking back if it [pressure ulcer] really got better." LPN-B explained R1 initially did not desire to get up out of bed and he had a preference for lying on his right side due to his wish to face the television. LPN-B confirmed tissue tolerance testing was not completed on residents to help determine turning and repositioning programs and further stated, "We do rounds every two hours." LPN-B explained if a resident had a change in condition their medical provider would be updated by whoever found the change. When interviewed by telephone on 6/30/21, at 1:39 p.m. the interim wound care nurse LPN-A denied knowledge that R1 had been admitted with a pressure ulcer as she had not been in her interim role at the time of his admission; however, she explained she had been "under the impression" staff had been aware that R1 had a pressure ulcer on admission when staff questioned the lack of a pressure ulcer picture in R1's medical record. LPN-A had been unsure of the date staff brought this to her attention. LPN-A voiced when a resident was admitted they would receive a head to toe skin assessment by a registered nurse (RN). If a pressure ulcer was identified then they were expected to ensure the ulcer had an ordered treatment, was documented	2 900		

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2 900	Continued From page 18 on the "admission screener assessment" and in the medical record, an accompanying picture was taken, and then the pressure ulcer would have "wound documentation every week" following it's identification. She explained the comprehensive skin assessment was located in the admission screener assessment and the facility did not have a separate comprehensive skin assessment form. When questioned on the facility's tissue tolerance identification process, LPN-A denied nursing performed this type of determination. When questioned on how a resident had a turning and repositioning program identified, LPN-A stated that if a resident were at risk "in my practice it is every two hours" and if "any [skin] abnormalities" were observed then they "would initiate or adjust off loading or repositioning" based on the resident's risk factors. LPN-A stated she expected residents would have a weekly skin check by the cart nurses in which the skin check form would identify "any skin abnormalities" and replied "I would imagine" R1's pressure ulcer should have been identified on his weekly skin checks if it had been present during the evaluations. She explained the cart nurses were not expected to add the skin abnormality measurements as "we measure [the abnormalities] weekly." LPN-A denied knowledge R1's medical provider had been updated regarding his coccyx pressure ulcer since his admission and explained again she had not been in her interim role at the time of his admission. During interview on 6/30/21, at 2:33 p.m. MDS nurse RN-B stated R1's pressure ulcer had not been noted in R1's medical record [on or before 5/21/21] when she had completed R1's admission MDS on 5/27/21 and she explained when she had wrote R1's pressure ulcer CAA the case manager had stated to her the pressure ulcer had been	2 900		

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present on admission and thus the pressure ulcer information was added to the CAA. RN-B stated the purpose of the CAA process was to "drive their [the residents] care plan in order to "take care of the person [resident] the best you can." RN-B confirmed she assisted with the care planning process; however, she explained she did not determine repositioning interventions as that was a case manager care plan item and that she had been unsure as to how they determined resident repositioning as the facility no longer performed tissue tolerance testing.

When interviewed by telephone on 7/1/21, at 9:07 a.m. the ADON confirmed upon a resident's admission an RN completed a head to toe skin assessment in which they documented any abnormalities "right away," along with photo identification, to support the abnormality was not facility acquired, and then followed up weekly with weekly wound rounds. The ADON explained upon admission a resident had a Braden completed to help determine pressure ulcer risk in which interventions would be based off of the Braden's calculated score, along with individual resident risk factors and needs. In addition, she explained the skin section in the admission screener assessment went "a little more in-depth with risk factors." She denied the facility performed resident tissue tolerance testing to help determine a resident's individualized turning/repositioning/off-loading programmed intervention and she explained if a resident was at risk they would be care planned to be repositioned "every two hours;" if a resident had a sacral coccyx ulcer staff "would turn them as much as you can." The ADON acknowledged skin alteration(s) observed during the weekly skin checks should be measured by the cart nurse and that the skin checks "should jive" with the

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2 900	Continued From page 20 weekly wound rounds for skin alteration locations. She stated it was "not acceptable" that some of R1's weekly skin checks "missed the information on [R1's] skin." The ADON confirmed R1's coccyx pressure ulcer had not been present on admission; "That developed after he got here." The ADON stated R1 had "blanchable [coccyx] redness upon admission" which had not been observed again during the proceeding week's weekly wound rounds; however, the ADON explained the pressure ulcer "got worse from just [the admission redness on] admission in which the ulcer "was pretty sloughy" and became harder to determine treatment despite it having been "...pretty stable.". The ADON verbalized R1's medical provider had been updated on his pressure ulcer in which there should have been documentation in his medical record to support a conversation with the "triage nurse" and she further verbalized R1 was given a cushion in his wheelchair upon admission and he was provided with an air mattress and an every two hour repositioning plan when the ulcer "opened up." She also was "pretty sure" R1 had been started on nutrition/dietary supplementation "right away" [upon admission] for his venous leg ulcers and to prevent any new ulcers. The ADON confirmed these interventions should have been in R1's care plan, along with a care plan section which identified his skin alteration risk factors. The ADON stated the interventions related to R1's skin alteration risk factors and his current pressure ulcer should be in his care plan so that it pulled to the Kardex as once in the Kardex the nursing assistants would then know the interventions. The ADON explained if staff did not know R1's risk factors and/or current skin alterations and interventions they would not know how to care for him and he then would have the potential for a deterioration of his current skin	2 900		

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2 900	Continued From page 21 alterations and/or new skin alteration development. During interview on 7/1/21, at 11:26 a.m. NA-B (a contracted pool staff) stated she was expected to use the Kardex for resident information. She explained the Kardex had "everything I need to know" in order to care for the residents. R1 confirmed she had not worked with R1 prior to his hospitalization on 6/23/21. After NA-B reviewed R1's Kardex, she confirmed the Kardex lacked information R1 had any skin alterations and that the Kardex did not indicate if R1 had a repositioning plan, used interventions such as a cushion in his wheelchair or air mattress, that he had a toileting plan or if he had indication of bowel/bladder incontinence, or any other interventions for toileting. NA-B stated, "If I had to work with him, it [Kardex] does not say I would have to reposition him." Further, NA-B stated if R1 required a repositioning plan, or other interventions, the Kardex should have that information "otherwise he is not getting the care he deserves." When interviewed on 7/1/21, at 11:39 a.m. LPN-C stated staff would refer to the Kardex to know how to care for a resident and that she expected staff [NAs] to follow what was indicated on it "...so they [residents] are getting the proper care." Thus, LPN-C explained resident care interventions needed to be present on the Kardex for this to happen. Further, she stated she expected interventions to be on the comprehensive care plan so that the Kardex would be accurate as care planned interventions "flow over" to the Kardex. After LPN-C reviewed R1's Kardex, she confirmed the Kardex lacked information which indicated R1 had skin issues "other than the blue boots." She further confirmed	2 900		

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2 900	Continued From page 22 R1's Kardex lacked interventions to help decrease skin alteration risk other than a walking program. LPN-C voiced, "Our general guideline for repositioning if every two hours," and further voiced there was "always a potential that it would not be followed." LPN-C stated R1's turning and repositioning program "probably should be on there [the Kardex]" and, "It should be on the care plan itself at least." During interview on 7/1/21, at 11:52 a.m. the director of nursing (DON) stated the Kardex was part of the care plan and is what the NAs used to "execute their duties" for resident care and thus she expected the Kardex to contain interventions such as repositioning and toileting plans if applicable to the resident and any skin alteration interventions. The DON explained if such specific resident interventions were not identified on the Kardex there was a "risk for pressure injury" and any current skin alterations may decline. After review of R1's Kardex, the DON confirmed R1's Kardex lacked evidence which instructed staff on skin integrity and/or coccyx pressure ulcer interventions, other than the blue boots. The DON stated she expected the admission screener assessment to indicate all skin alterations noted on admission, along with the base line and comprehensive care plans should address risk factors for skin alterations; not just the skin alterations that were present. In addition, the DON explained she also expected a new comprehensive assessment to be completed after a new pressure ulcer was acquired, along with the medical provider to be updated, in order to "prevent further injury or concern" and to ensure appropriate wound treatment. A policy Change in Condition, revised 12/19/18, directed that the residents physician would be	2 900		

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TALAHI NURSING AND REHAB CENTER	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

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2 900	Continued From page 23 notified promptly when there had been an onset of a pressure ulcer, in which the notification would be documented in the medical record and the care plan would be updated as necessary. A policy Care Plan/Conference, revised 1/25/21, indicated its purpose was to ensure that each resident received care individualized to him or herself and that the goals and approaches for care were communicated to caregivers. The policy identified the comprehensive care plan was based on the resident's medical condition, medical history and assessments, and that the care plan would be revised as information about the resident's condition changed. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are assessed utilizing all risk factors, have risk factors care planned, and that 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, could conduct random audits of the assessment and care planning processes, along with the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		