DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
September 10, 2024

Administrator
St Crispin Living Community
213 Pioneer Road
Red Wing, MN  55066

RE: CCN: 245449
Cycle Start Date: August 7, 2024

Dear Administrator:

On August 14, 2024, we notified you a remedy was imposed. On September 3, 2024 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 30, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 29, 2024 be discontinued as of August 30, 2024. (42 CFR 488.417 (b))

In our letter of August 14, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 7, 2024. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

September 10, 2024

Administrator
St Crispin Living Community
213 Pioneer Road
Red Wing, MN  55066

Re: Reinspection Results
Event ID:  5B7812

Dear Administrator:

On September 3, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 7, 2024.  At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Submitted
August 14, 2024

Administrator
St. Crispin Living Community
213 Pioneer Road
Red Wing, MN 55066

RE: CCN: 245449
Cycle Start Date: August 7, 2024

Dear Administrator:

On August 7, 2024, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

## REMOVAL OF IMMEDIATE JEOPARDY

On August 6, 2024, the situation of immediate jeopardy to potential health and safety cited at F684 was removed. However, continued non-compliance remains at the lower scope and severity of D.

## REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 29, 2024.

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

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of

payment for new admissions is effective August 29, 2024, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 29, 2024, (42 CFR 488.417 (b)).

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

## NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 7, 2024. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

## SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of

alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, St Crispin Living Community is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 7, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

## ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

## DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115

Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program 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 February 7, 2025 (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 Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's

Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

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

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

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

## APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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://forms.web.health.state.mn.us/form/NHDisputeResolution

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 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,

Kamala Fiske-Downing

Kamala Fiske-Downing

Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
August 14, 2024

Administrator
St. Crispin Living Community
213 Pioneer Road
Red Wing, MN  55066

Re: State Nursing Home Licensing Orders
Event ID: 5B7811

Dear Administrator:

The above facility was surveyed on August 1, 2024 through August 7, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245449 | A. BUILDING _____ B. WING _____ | C 08/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST CRISPIN LIVING COMMUNITY | 213 PIONEER ROAD RED WING, MN 55066 |

| (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<br><br>On 8/1/24, 8/5/24, 8/6/24, and 8/7/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The survey resulted in an Immediate Jeopardy (IJ) at F684 when the facility failed to identify a surgical wound that was not assessed, monitored, and treated according to physician's orders that dehisced and became infected resulting in a five-day hospital admission with surgical intervention, antibiotic therapy, and wound vacuum assisted closure (VAC) therapy for 1 of 1 resident (R1). The IJ began on 7/12/24, and the immediacy was removed on 8/6/24.<br><br>The following complaint was reviewed: H54496292C (MN00105240) with a deficiency issued at F684<br><br>The above findings constituted substandard quality of care, and an extended survey was conducted on 8/7/24.<br><br>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.<br><br>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 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 08/15/2024 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245449 | A. BUILDING _____ B. WING _____ | C 08/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST CRISPIN LIVING COMMUNITY | 213 PIONEER ROAD RED WING, MN 55066 |

| (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 684 SS=J | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to assess, monitor and treat a surgical wound according to physician orders for 1 of 1 resident (R1). This resulted in immediate jeopardy (IJ) when the wound dehisced and became infected resulting in a five-day hospital admission with surgical intervention, antibiotic therapy, and wound vacuum assisted closure (VAC).<br><br>The immediate jeopardy began on 7/12/24 when R1 admitted to the facility and the facility failed to comprehensively assess the surgical wound and transcribe physician's orders for its monitoring and treatment, and was identified on 8/5/24. The administrator and director of nursing were notified of the immediate jeopardy on 8/5/24 at 4:53 p.m. The immediate jeopardy was removed on 8/6/24 at 5:17 p.m., but noncompliance remained at the lower scope and severity level 2 (D), which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.<br><br>Findings include: | F 684 | This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies.<br>The plan of correction is prepared and/or executed in accordance with federal and state law requirements.<br><br>Current facility licensed nursing staff, including agency/contract associates and HUC, received education pertaining to their scope, on the facility wound and skin care protocol, reviewing hospital discharges, completing admission skin assessments, routine monitoring of skin/wounds, assessing skin/wounds, following physician orders, and communicating the presence of all wounds and incisions to facility provider and IDT team. Education includes both CNA and licensed nurse competencies for inspecting skin daily with cares and conducting skin assessments/body audits. | 8/30/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ST CRISPIN LIVING COMMUNITY | 213 PIONEER ROAD RED WING, MN 55066 |

| (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 684 | Continued From page 2<br>R1's admission Minimum Data Set (MDS) dated 7/18/24, indicated R1 admitted to the facility on 7/12/24 from a hospital with diagnoses including multiple fractures of pelvis with stable disruption of pelvic ring (multiple pelvic fractures where the broken bones remain in a stable position), other fracture of right femur, hip fracture, contusion (bruise) of right thigh, and complication of unspecified artery following a procedure. The MDS indicated R1 was cognitively intact, had an indwelling catheter and was occasionally incontinent of bowel, had a recent fall with fracture and recent major surgery, had surgical wound(s) and surgical wound care, and was 73 inches tall and weighed 252 pounds.<br><br>R1's hospital After Visit Summary (Facility) document dated 7/12/24, indicated R1 was discharged from the hospital and the "Lines/Drains/Airways/Wounds" list included "Wound 07/05/24 Incision Groin Left." "Discharge Wound/Incision Care Instructions" were included for a hematoma/contusion (collection of blood trapped outside of a blood vessel), but the document did not include instructions regarding the left groin incision.<br><br>R1's hospital Discharge Summary document dated 7/12/24, indicated R1 discharged from the hospital on 7/12/24 and included a section titled "VASCULAR SURGERY RECOMMENDATIONS" with subheading "Mepilex Ag Dressing" [an antimicrobial foam adherent dressing]. The provider recommendations were "1. You had a special dressing placed over your left groin incision on 7/10/24. This is to aid in wound healing and prevent wound breakdown where the skin surface causes friction. 2. You may shower with this dressing in place. 3. If three of the | F 684 | Education began on 08/01/2024 and will continue until completed by all facility associates and agency/contract associates. Staff will be educated before working their next scheduled shift. Staff have been notified of need to complete education prior to their shift via group text message as well as a sign posted at the schedules.<br><br>On 08/02/2024 IDT reviewed hospital discharge orders for all new admissions still residing in the facility from 6/23/2024 to the present to ensure wound care, wound monitoring, and order transcription were accurate and complete. Residents without wound care orders were reviewed with the provider for additional direction.<br><br>On 08/06/2024, IDT reviewed hospital discharge orders for all new admissions still residing in the facility from 6/23/2024 to the present to ensure that any identified or noted skin impairments and treatments were identified in the resident record.<br><br>On 08/06/2024, all interviewable facility residents who were admitted from 6/23/24 to present were interviewed regarding their skin care and treatment regimen.<br><br>On 08/06/2024, all facility residents who were admitted from 6/23/24 to the present had their skincare plans reviewed and updated as necessary with findings from comprehensive skin assessments.<br><br>On 08/06/2024, all facility residents who were admitted from 6/23/24 to the present | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ST CRISPIN LIVING COMMUNITY | 213 PIONEER ROAD RED WING, MN 55066 |

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| F 684 | Continued From page 3<br>dressing edges are saturated with drainage, please immediately remove the dressing. 4. This dressing will stay in place for seven days. Remove your dressing on 7/17/24. 5. If you note that there is redness or drainage around the incision, please call [doctor's] advanced practice provider through the [hospital's] operator [phone number]. 6. After removing the dressing, keep the groin area clean and dry." The following section was titled "VASCULAR RECOMMENDATIONS" and included "In 5-7 days, our team would like to see him either in [clinic] or here in hospital to assess the groin incision and drain (appointment created)." The outpatient follow-up appointments list included an appointment with vascular scheduled for 7/18/24. The details of hospital stay narrative section indicated a diagnosis of femoral pseudoaneurysm (outpouching of the wall of the femoral artery due to injury with leaking blood that collects in surrounding tissue) post procedural complication and identified R1 had a hematoma associated with his left femoral artery that was removed, a drain (Jackson-Pratt surgical drain, JP drain) was placed into the site of the hematoma, the femoral artery was repaired with sutures, and a wound VAC was placed over the wound that was later removed though the drain and sutured site remained with a plan for later removal of the drain.<br><br>In review of R1's electronic health record (EHR), the treatment orders for R1's left groin incision from vascular surgery included on the Discharge Summary dated 7/12/24, were not present. The treatment orders were not transcribed into R1's physician orders, were not present on the Medication Administration Record (MAR) or Treatment Administration Record (TAR), and were not included in the baseline care plan. | F 684 | had comprehensive skin assessments completed to identify any areas or folds at risk for abrasions, surgical incisions, and/or wounds.<br><br>On 08/02/2024, The Prevention and Treatment of Skin Breakdown Policy was reviewed for accuracy and remains current.<br>On 08/02/2024, surgical incisions were added to the facility's weekly wound rounds to ensure weekly rounding and oversight of incision care and treatment by nurse managers.<br><br>On 08/02/2024, surgical incisions were added to the facility Daily IDT/Clinical Meeting to be discussed daily in the facility IDT meeting under the topic of wounds.<br><br>On 08/02/2024, a new process was implemented for IDT to review all new admission after visit summaries and discharge summaries and compare to orders placed in facility eMAR for discrepancies. All identified residents will have discrepant orders clarified and placed into Matrix correctly. Providers will be updated accordingly.<br><br>On 8/6/2024 risk group was expanded to include other long-term care residents within the facility at high risk for skin impairment utilizing their most recent Braden risk scores, as well as defining risk factors, dependence on staff for assistance with ADLs, obesity diagnosis, and residents who refuse cares. Following | |

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| F 684 | Continued From page 4<br>Review of R1's EHR did not identify any documentation noting the presence, absence, or removal of the Mepilex Ag dressing ordered to be in place over the left groin incision through 7/17/24.<br><br>R1's physician order dated 7/12/24, instructed staff to-complete full admission skin assessment utilizing skin check sheet, with 2 nurses signing; remove all NON-SURGICAL dressing to observe skin; turn into care manager (CM) when complete" scheduled for completion one time between 2:30 p.m. and 10:00 p.m. on 7/12/24. R1's TAR included the order charted as not administered: other on 7/12/24 at 11:39 p.m.<br><br>R1's physician order dated 7/12/24, instructed staff to complete "Weekly Bath/Skin Note (similar to admission note), VS [vital signs], weight, observe for new skin issues, include grooming performed, shaving, nail care, transferring assist to/from shower/bath, amount of assistance needed. Document refusals and approaches used" schedule for completion once daily on Mondays with start date of 7/12/24.<br><br>R1's baseline care plan for skin with creation date of 7/12/24, noted "I am at risk for alteration of skin status d/t [due to] assist with adls [activities of daily living] and mobility. Goals included "I will not have further skin alteration related to _____ (describe current skin breakdown or wound)." Interventions included "I require a wound treatment plan as follows: _____ (describe steps)." The skin care plan contained blanks and was not completed or individualized for R1, it did not identify his current alterations in skin integrity.<br><br>A Skin Risk Observation with Braden Scale | F 684 | review, new skin checks were completed for all residents determined to be a high risk for skin impairments. Skincare plans were reviewed and updated as necessary with findings from comprehensive skin assessments.<br><br>Audits of residents with treatment orders in place will be conducted three times a week for two weeks, then two times a week for two weeks, then once a week for two weeks. Audits will be reviewed by IDT. The results of the audits will be reported through the facility QA committee with ongoing frequency and duration to be determined through analysis and review of results.<br><br>Audits of new admission orders will be conducted by the IDT three times a week for two weeks, then two times a week for two weeks, then once a week for two weeks. Audits will be reviewed by IDT. The results of the audits will be reported through the facility QA committee with ongoing frequency and duration to be determined through analysis and review of results. | |

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| F 684 | Continued From page 5<br>assessment dated 7/12/24, identified R1 had a surgical wound however the location and description was not included.<br><br>A Clinical Documentation (Admission) assessment dated 7/12/24, included "Skin Assessment with Braden Score: ... indwelling catheter that is draining dark yellow clear urine at time of assessment. Ketoconazole [anti-fungal] cream applied to groin and folds and Polysporin applied to scrotum and penis daily for redness and has swelling to scrotum with scrotum sling in use ... Skin is observed by CNA with cares and assessed weekly by licensed nurse. Goal is to remain free from pressure related skin impairments through next review date. No referrals or change of action needed at this time. Will continue with POC and update Provider with any changes as needed." It did not identify R1's left groin incision.<br><br>R1's progress notes dated 7/13/24 at 5:50 a.m., identified presence of the JP drain, progress note at 1:56 p.m. identified R1 had skin care and treatments, which were not defined, and progress note at 9:58 p.m. indicated skin care and treatments were completed to R1's scrotum. None of the three progress notes identified the presence of the left groin incision.<br><br>R1's progress notes dated 7/14/24 at 6:19 a.m. identified R1's catheter and JP drain and progress note at 2:54 p.m. indicated R1 had skin care and treatments, however neither progress notes identified the left groin incision.<br><br>A progress note dated 7/14/24 at 9:39 p.m., identified antibiotic ointment was applied to the scrotum and penis, noted the presence of the | F 684 | | |

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| F 684 | Continued From page 6<br>catheter, and indicated abdominal and groin folds had been cleansed and patted dry with no redness or foul odor noted. Progress notes dated 7/14/24 did not identify the presence of R1's left groin incision.<br><br>R1's progress notes dated 7/15/24 at 6:15 a.m. and 4:28 p.m. identified R1's JP drain however, did not mention R1's left groin incision.<br><br>A progress note dated 7/15/24 at 9:11 p.m., indicated R1 received a bed bath and included "observe for new skin issues: no new issues observed. Continues to have multiple old bruises on right forearm, right hip and leg, swollen scrotum which is treated with polysporin [antibiotic ointment] this eve[ening] per md [doctor] orders. Abdominal folds and groin have slight redness no foul odor or tenderness. Cleansed patted dry and anti-fungal applied per md[doctor] order." It did not identify R1's left groin incision.<br><br>A paper skin observation charting form dated 7/15/24, indicated it was completed with R1's bed bath on the p.m. shift. It included an outline of a person with a circle around the left hip and "L[left] side large bruise." It contained no further assessment of the bruise such as size, color, or pain and did not note R1's left groin incision.<br><br>A second paper skin observation charting form dated 7/15/24, included a depiction of the front of a body with a circle around the outer edge of the right forearm and note "scattered bruises," a circle around the outer right hip with note "bruise," circles around the lower abdomen and left groin with note "faint redness." The depiction of the back of the body included a circle around the | F 684 | | |

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| F 684 | Continued From page 7<br>outer right forearm with note "scattered bruises," circle around the peri-area with note "swollen scrotum," and circle around the outer right hip with note "bruising." No further assessment of the noted bruises, redness, or swelling was included and it did not note R1's left groin incision.<br><br>R1's baseline care plan for infection with creation date of 7/16/24, noted "I require Enhanced Barrier Precautions r/t [related to] presence of indwelling catheter, JP drain, and surgical incision." Goals included "I will not develop signs or symptoms of infection." Interventions included monitor for signs and symptoms of infection, and notify physician/nurse practitioner if signs and symptoms occur.<br><br>R1's record that included progress notes dated 7/16/24, 7/17/24, and 7/18/24 mentioned R1's JP drain however did not identify the presence of R1's left groin incision.<br><br>A progress note dated 7/18/24 at 3:20 p.m., identified R1 was seen by the primary care provider Physician Assistant, had a clinic appointment the next day, and noted the presence of the JP drain. It did not identify R1's left groin incision.<br><br>A Physician Assistant visit note dated 7/18/24, indicated R1 had an appointment with vascular surgery the next day but did not include identification or assessment of R1's left groin incision.<br><br>A progress note by the director of nursing (DON) dated 7/19/24 at 12:38 p.m., included "Resident went out to his follow-up ortho[pedics] appointment today where it was found that his left | F 684 | | |

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| F 684 | Continued From page 8 | F 684 | | |

groin incision had dehisced. He was admitted for surgical management, left groin irrigation, and debridement. He will remain in the hospital throughout the weekend."

A vascular surgery office visit note by nurse practitioner (NP)-A dated 7/19/24, indicated R1 was seen in the clinic for wound assessment. It included "[R1] presents today with no information from his nursing facility ... He believes the facility removed the Mepilex from his left groin incision a few days ago. They have not been utilizing any gauze to his groin incision ... Left groin incision: wound dehiscence to the very center aspect of the incision, approximately 1.5 cm ... [R1] unfortunately has experience [sic] dehiscence of his left groin incision. Admit to [physician's] surgical service and proceed to operating room for left groin irrigation and debridement."

A hospital Surgeon Documentation note dated 7/19/24, indicated R1 was known by the surgical service from his previous surgery "for evacuation of a large left-sided groin hematoma and primary repair of his actively bleeding femoral artery." It noted "He was seen in clinic today for evaluation of his wound and was found to have some dehiscence with opening of the skin around his nylon sutures. For this reason he was brought to the operating room for irrigation and debridement [removal of infected or diseased tissue in a wound and washing out the open wound] ... Upon initial inspection of the wound it was clear that he had had dehiscence in the medical portion of the suture line but has [sic] other sutures remained intact ... we sharply debrided [cut away] a 3 x 3 x 3 cm [centimeter] area of necrotic fat .... The decision was made to place a wound VAC for ongoing drainage ... we will plan to bring him back

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| F 684 | Continued From page 9<br>to the operating room on Monday for another irrigation and debridement."<br><br>A hospital Infectious Disease physician consult note dated 7/23/24, identified bacterial culture swabs from R1's left groin site returned positive for two types of bacteria, enterococcus faecalis and citrobacter koseri. The recommendations included continuing the intravenous antibiotics R1 was already receiving and, upon discharge, to complete a further course of oral antibiotics for two weeks after the date of his last debridement.<br><br>A hospital Discharge Summary dated 7/24/24, noted R1 was admitted on 7/19/24 and discharged on 7/24/24. Follow-up noted "wound vac is to continue until you are re-evaluated by a member of [doctor's] surgical team, and will most likely continue for many weeks, possibly up to a few months." The Details of Hospital Stay, noted R1 "was directly admitted from [clinic] on 7/19/2024 for management of left groin wound dehiscence. He proceeded to the operating room on 07/19/2024 and underwent left groin irrigation and debridement with wound VAC placement ... He proceeded to the operating room again on 7/22/2024 and underwent left groin irrigation and debridement. Left groin incision with wound vac in place."<br><br>In an interview on 8/1/24 at 12:30 p.m., hospital vascular nurse practitioner (NP)-A stated she had previously cared for R1 when his left femoral artery required nylon sutures and indicated he discharged from the hospital on 7/12/24 with nylon sutures that were "very nicely closed and no issues whatsoever with any openings" and a Mepilex Ag dressing that was to stay on for seven days. NP-A stated she saw R1 at a vascular | F 684 | | |

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| F 684 | Continued From page 10<br>surgery clinic appointment on 7/19/24 and the Mepilex was off and his groin incision was "very obviously dehisced." She states "we should have been called or talked to about it and that required him to be readmitted and needing a couple of wash-outs of that groin and now wound VAC placement. The cultures from that came back positive for enterococcus requiring him to be on antibiotics." NP-A stated R1 reported no one even looked at his groin while he was at the facility and NP-A noted R1 was a larger guy and it would require lifting up his pannus to visualize the groin area where the incision was located. She stated that, upon inspection at the appointment, the groin incision was approximately six inches and had dehisced in the center of the incision "probably two centimeters wide and at minimum a centimeter and a half deep." She stated R1 also had a JP drain on the left side, but it was approximately four to six inches away from the incision. NP-A stated possible outcomes of the dehiscence were "repeat surgical intervention, overall infection risk, he could have gone septic from this, I think that would be the worst outcome from this if it were to have gotten any worse, or if it got down to the artery and if the artery was exposed he could have bled to death." NP-A stated "I would say that it [the dehiscence] was probably happening over a minimum of three days." Regarding treatment, NP-A noted the expectation from the vascular surgery group was that if the Mepilex Ag dressing had stayed intact it would be removed at the seven day mark (7/17/24) and gauze would be placed in the area to avoid any moisture or skin-on-skin contact to prevent breakdown, and even though the discharge instructions did not say specifically to use gauze they instructed staff to keep the area clean and dry. | F 684 | | |

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| F 684 | Continued From page 11<br><br>In an interview on 8/5/24 at 9:33 a.m., R1 stated facility staff "didn't pay attention to that groin area incision that I had when I went there. I just had a couple of stitches in the groin ... I went with the stitches and a little drainage bag [JP drain], they drained the bag but they never checked the groin where the incision was, it was on the left side." R1 stated staff never checked on the incision or cleaned around the incision. He did not recall having a dressing on it and stated "there was no dressing, one of them looked at it and said I don't know why there isn't gauze there but they didn't pay attention to that." R1 stated he wasn't able to visualize the incision because of its location and he thought everything was going well with it until his appointment with vascular surgery and noted bacteria was found in the incision "so I imagine it must have been open for more than one day." He stated he was admitted right away after his appointment and "then I had surgery again, I think I was put under two or three times and now I have a wound VAC on that area where the incision is which is another thing I have to deal with, another machine on me ... It has delayed everything and not only do I still not have my weight bearing on that leg now I also have the wound VAC to deal with and physical therapy is limited as to what they can do with me."<br><br>In an interview on 8/5/24 at 8:08 a.m., licensed practical nurse (LPN)-A stated she remembered R1 wasn't there long, but he was a big guy with a drain and a catheter. LPN-A stated "he had an incision, a surgical incision, I don't remember where it was" LPN-A stated "I don't remember documenting his incision site and I didn't remember an order in there to do anything with it" and noted this was an oversight because they | F 684 | | |

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| F 684 | Continued From page 12<br>should have had an order.<br>LPN-A stated R1 arrived at the facility during her shift, but second shift usually completed skin check and confirmed she would include surgical incisions and bruises on a skin assessment. LPN-A stated with a surgical incision with no orders she would contact the clinical manager and assumed they were to leave it alone, but if it was "wet and nasty" she would call the provider to get an order to do something.<br><br>In an interview on 8/5/24 at 1:26 p.m., LPN-B stated she remembered R1 and had taken care of him for a few days. She noted R1's groin area had been bruised and she thought he had an angiogram in the hospital where they nicked an artery and he had a bleed in the groin area, but did not recall an incision or dressing in his groin.<br><br>In an interview on 8/5/24 at 1:54 p.m., registered nurse (RN)-C stated R1 had a femoral dressing in his groin from something post-operative and thought it was on the left, but "honestly I can't recall if I ever saw it." RN-C did not identify a dressing present on the left grin incision.<br><br>In an interview on 8/5/24 at 8:55 a.m., RN-B stated she was covering for clinical manage (CM)-A when R1 admitted and completed his admission assessments though she did not provide direct care for him. RN-B stated "he has an incision, can't remember which side, it was in his hip and he had a JP drain out of a separate spot on his left side" and stated she had never seen the incision. RN-B stated she was aware R1 had orders for wound care but did not recall the details of the wound care orders. She stated if someone had a surgical incision and a dressing and no orders she would call to get orders and | F 684 | | |

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| F 684 | Continued From page 13<br>check with her manager. RN-B noted she would look at orders to see how to manage a specific wound because hospital discharge orders usually specify what you have to do.<br><br>In an interview on 8/5/24 at 11:06 a.m., CM-A stated she was not familiar with R1 as did not work during the time of his admission. CM-A confirmed R1's admission skin assessment, Skin Observation Form dated 7/15/24, should have been completed on 7/12/24, noted a need for surgical wound care but did not identify the wound, did not identify the left groin surgical incision, did not note the JP drain site, did not meet her expectations for assessment of bruises, and did not constitute a comprehensive skin assessment. CM-A confirmed R1's EHR did not include orders for monitoring or treatment of the left groin surgical incision, progress notes did not include documentation of monitoring, there was no documentation of a dressing over the left groin surgical incision, no documentation that wound care for the surgical incision was provided per provider orders, and stated "I don't see the assessment or monitoring of the surgical incision in the groin anywhere." She further confirmed R1's baseline care plan was not completed and did not identify his left groin surgical incision or the treatment plan, stated it should have been included in the care plan, and noted the baseline care plan should have been completed per protocol within 48 hours of admission. CM-A noted wound care orders for the left groin surgical incision were included in the hospital's Discharge Summary but not the After Visit Summary and the facility utilized the After Visit Summary for admission orders, not the Discharge Summary, but she was aware the hospital sometimes has other orders in the Discharge Summary that are | F 684 | | |

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| F 684 | Continued From page 14<br>not included in the After Visit Summary. She confirmed that if R1 had a surgical incision but did not have wound care orders she would expect nursing staff to notice something was missing and obtain orders by reaching out to her or the on-call provider. CM-A stated "I have no idea what happened, I was gone and it fell through the cracks. It appears a couple checks didn't happen." She identified potential outcomes of the lack of assessment, monitoring, and treatment as infection, sepsis, and "he could have died if we're going for worst case scenario."<br><br>In an interview on 8/5/24 at 12:41 p.m., the DON stated R1 had had admitted to the facility with the left groin surgical incision and at a follow-up provider appointment on 7/19/24 they noted the incision had dehisced and he was admitted for further care of his incision. The DON confirmed she was aware there were discrepancies between the orders in R1's hospital Discharge Summary and After Visit Summary. She confirmed R1's EHR lacked documentation of assessments of the incision and stated there was no comprehensive assessment. The DON noted she would expect the incision to have been assessed within eight hours of admission, to be monitored every shift, findings to be documented, and the provider to be updated with any concerns or abnormalities noted. The DON stated she would expect the incision's dressing to be put in as an order and to have been documented. She noted the assessment and monitoring of R1's bruises were not in line with her expectations for monitoring every shift and weekly comprehensive skin assessments. The DON stated she could not demonstrate that R1's left groin surgical incision was treated in accordance with physician orders or assessed and monitored in accordance with | F 684 | | |

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| F 684 | Continued From page 15<br>physician orders and facility policy. She identified potential outcomes as "adverse events, infection, many terrible things."<br><br>In an interview on 8/5/24 at 1:59 p.m., the facility's medical director (MD) stated he had spoken to the DON about R1 and knew a bit about the situation. The MD stated he would expect staff to identify the presence of a dressing, wound, incision, or skin or soft tissue abnormality through orders from the hospital to monitor and care for it, in the discharge summary if it wasn't in the orders, or from the initial body audit (comprehensive skin assessment on admission) completed same day or by the morning after admission. He would expect treatment and monitoring per physician orders and if there were no orders, would expect staff to talk to the attending provider or hospital provider to "make sure they didn't omit orders and, if they did, find out what needs to be done in terms of monitoring and dressing changes." The MD identified possible outcomes of the femoral groin incision not being monitored, assessed, and treated as a potential delay in observing a change in condition of the groin, superficial or deeper infection, wound dehiscence, aneurysm or pseudoaneurysm, or other potential vascular complications. The MD stated, "it is more of a delay in identification if it [the incision] dehisced before the person [R1] was at the office visit," and noted "we know there was a delay in identifying anything that might have been doing on but when it exactly was going on was unclear." The MD stated, "treatment should be provided in accordance with orders so you can identify changes in condition when they occur more promptly and to carry out what a specialist wants in terms of particular wounds." The MD confirmed | F 684 | | |

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| F 684 | Continued From page 16<br>the incision was "seemingly not tended to" and noted the facility lacked a plan of care for the incision.<br><br>Facility policy titled Prevention and Treatment of Skin Breakdown dated 9/1/18, included "Resident skin integrity is assessed upon admission and weekly thereafter ... Those residents' who experience a break in skin integrity or wounds are provided care and service to heal the skin according to professional standards of care ... A licensed nurse completes Braden Skin Risk Assessment: Upon admission or readmission; Weekly for the first 4 weeks post admission or readmission ... A resident centered care plan is implemented/updated for skin risk with interventions based upon; Areas of risk; Resident Assessment; Braden evaluation score of 15 or less; Clinicians assessment/evaluation; Resident preferences. Members of the care team are notified and consulted as necessary. Skin integrity is monitored and abnormal findings are documented: Skin is observed daily with cares. If any skin concerns are noted, they are reported to the licensed nurse; Weekly skin audits are performed by a licensed nurse."<br><br>Facility policy titled Comprehensive Assessments and Care Planning dated 7/2/18, included "A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals, and sign and certify that the assessment is completed. The assessment process begins with the development of the baseline care plan within the first 48 hours of admission. The baseline care plant includes the minimum healthcare information necessary to care for each resident immediately upon their admission, which would address resident-specific | F 684 | | |

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| F 684 | Continued From page 17<br>health and safety concerns to prevent decline or injury. Baseline care plans address, at a minimum, the following: Initial goals based on admission orders; Physician orders ... The baseline care plan reflects the resident's stated goals and objectives, and includes interventions that address his or her current needs ... The assessment must accurately reflect the resident's status, and each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment ... The following assessments and time frames are calculated from the day of admission unless otherwise noted ... Baseline Care Plan developed with 48 hours of admission ... skin assessment within 8 hours."<br><br>Facility policy titled Order Review dated 9/2018 included "Purpose: To assure appropriate medications and treatments are in place for each resident. Procedure: EHR System: Orders are transcribed into the electronic health record."<br><br>The immediate jeopardy that began on 8/5/24, was removed on 8/6/24, when it was verified the facility implemented the following corrective actions:<br>-Educated licensed nursing staff about skin and wound care protocols, reviewing hospital discharges, admission skin assessments, skin and wound assessment and monitoring, following physician orders, and provider notification with competency testing;<br>-Reviewed hospital discharge orders for current residents admitted since 6/23/24 for transcription accuracy and completeness and identification of skin impairments and treatments; interviewed said residents regarding skin care and | F 684 | | |

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| F 684 | Continued From page 18<br>treatments;<br>-Completed comprehensive skin assessments on said residents; reviewed and updated skin care plans as needed for said residents;<br>-Reviewed facility Prevention and Treatment of Skin Breakdown policy for accuracy; added surgical incisions to weekly wound rounds; and added surgical incisions to daily inter-disciplinary team meetings, | F 684 | | |

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 8/1/24, 8/5/24, 8/6/24, and 8/7/24 a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you | 2 000 | | |

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| 2 000 | Continued From page 1<br><br>have reviewed these orders and identify the date when they will be completed.<br><br>The following complaint was reviewed: H54496292C (MN00105240). Licensing order was issued at 0830.<br><br>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.<br><br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is | 2 000 | | |

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| 2 000 | Continued From page 2<br>not required at the bottom of the first page of state form.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. | 2 000 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to assess, monitor and treat a surgical wound according to physician orders for 1 of 1 resident (R1). This resulted in immediate jeopardy (IJ) when the wound dehisced and became infected resulting in a five-day hospital admission with surgical intervention, antibiotic therapy, and wound vacuum assisted closure (VAC). | 2 830 | Corrected | 8/30/24 |

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| 2 830 | Continued From page 3<br><br>The immediate jeopardy began on 7/12/24 when R1 admitted to the facility and the facility failed to comprehensively assess the surgical wound and transcribe physician's orders for its monitoring and treatment, and was identified on 8/5/24. The administrator and director of nursing were notified of the immediate jeopardy on 8/5/24 at 4:53 p.m. The immediate jeopardy was removed on 8/6/24 at 5:17 p.m., but noncompliance remained at the lower scope and severity level 2 (D), which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.<br><br>Findings include:<br><br>R1's admission Minimum Data Set (MDS) dated 7/18/24, indicated R1 admitted to the facility on 7/12/24 from a hospital with diagnoses including multiple fractures of pelvis with stable disruption of pelvic ring (multiple pelvic fractures where the broken bones remain in a stable position), other fracture of right femur, hip fracture, contusion (bruise) of right thigh, and complication of unspecified artery following a procedure. The MDS indicated R1 was cognitively intact, had an indwelling catheter and was occasionally incontinent of bowel, had a recent fall with fracture and recent major surgery, had surgical wound(s) and surgical wound care, and was 73 inches tall and weighed 252 pounds.<br><br>R1's hospital After Visit Summary (Facility) document dated 7/12/24, indicated R1 was discharged from the hospital and the "Lines/Drains/Airways/Wounds" list included "Wound 07/05/24 Incision Groin Left." "Discharge Wound/Incision Care Instructions" were included for a hematoma/contusion (collection of blood trapped outside of a blood vessel), but the | 2 830 | | |

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| 2 830 | Continued From page 4<br><br>document did not include instructions regarding the left groin incision.<br><br>R1's hospital Discharge Summary document dated 7/12/24, indicated R1 discharged from the hospital on 7/12/24 and included a section titled "VASCULAR SURGERY RECOMMENDATIONS" with subheading "Mepilex Ag Dressing" [an antimicrobial foam adherent dressing]. The provider recommendations were "1. You had a special dressing placed over your left groin incision on 7/10/24. This is to aid in wound healing and prevent wound breakdown where the skin surface causes friction. 2. You may shower with this dressing in place. 3. If three of the dressing edges are saturated with drainage, please immediately remove the dressing. 4. This dressing will stay in place for seven days. Remove your dressing on 7/17/24. 5. If you note that there is redness or drainage around the incision, please call [doctor's] advanced practice provider through the [hospital's] operator [phone number]. 6. After removing the dressing, keep the groin area clean and dry." The following section was titled "VASCULAR RECOMMENDATIONS" and included "In 5-7 days, our team would like to see him either in [clinic] or here in hospital to assess the groin incision and drain (appointment created)." The outpatient follow-up appointments list included an appointment with vascular scheduled for 7/18/24. The details of hospital stay narrative section indicated a diagnosis of femoral pseudoaneurysm (outpouching of the wall of the femoral artery due to injury with leaking blood that collects in surrounding tissue) post procedural complication and identified R1 had a hematoma associated with his left femoral artery that was removed, a drain (Jackson-Pratt surgical drain, JP drain) was placed into the site of the hematoma, the femoral artery was repaired with | 2 830 | | |

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| 2 830 | Continued From page 5<br><br>sutures, and a wound VAC was placed over the wound that was later removed though the drain and sutured site remained with a plan for later removal of the drain.<br><br>In review of R1's electronic health record (EHR), the treatment orders for R1's left groin incision from vascular surgery included on the Discharge Summary dated 7/12/24, were not present. The treatment orders were not transcribed into R1's physician orders, were not present on the Medication Administration Record (MAR) or Treatment Administration Record (TAR), and were not included in the baseline care plan. Review of R1's EHR did not identify any documentation noting the presence, absence, or removal of the Mepilex Ag dressing ordered to be in place over the left groin incision through 7/17/24.<br><br>R1's physician order dated 7/12/24, instructed staff to-complete full admission skin assessment utilizing skin check sheet, with 2 nurses signing; remove all NON-SURGICAL dressing to observe skin; turn into care manager (CM) when complete" scheduled for completion one time between 2:30 p.m. and 10:00 p.m. on 7/12/24. R1's TAR included the order charted as not administered: other on 7/12/24 at 11:39 p.m.<br><br>R1's physician order dated 7/12/24, instructed staff to complete "Weekly Bath/Skin Note (similar to admission note), VS [vital signs], weight, observe for new skin issues, include grooming performed, shaving, nail care, transferring assist to/from shower/bath, amount of assistance needed. Document refusals and approaches used" schedule for completion once daily on Mondays with start date of 7/12/24. | 2 830 | | |

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| 2 830 | Continued From page 6<br><br>R1's baseline care plan for skin with creation date of 7/12/24, noted "I am at risk for alteration of skin status d/t [due to] assist with adls [activities of daily living] and mobility. Goals included "I will not have further skin alteration related to _____ (describe current skin breakdown or wound)." Interventions included "I require a wound treatment plan as follows: _____ (describe steps)." The skin care plan contained blanks and was not completed or individualized for R1, it did not identify his current alterations in skin integrity.<br><br>A Skin Risk Observation with Braden Scale assessment dated 7/12/24, identified R1 had a surgical wound however the location and description was not included.<br><br>A Clinical Documentation (Admission) assessment dated 7/12/24, included "Skin Assessment with Braden Score: ... indwelling catheter that is draining dark yellow clear urine at time of assessment. Ketoconazole [anti-fungal] cream applied to groin and folds and Polysporin applied to scrotum and penis daily for redness and has swelling to scrotum with scrotum sling in use ... Skin is observed by CNA with cares and assessed weekly by licensed nurse. Goal is to remain free from pressure related skin impairments through next review date. No referrals or change of action needed at this time. Will continue with POC and update Provider with any changes as needed." It did not identify R1's left groin incision.<br><br>R1's progress notes dated 7/13/24 at 5:50 a.m., identified presence of the JP drain, progress note at 1:56 p.m. identified R1 had skin care and treatments, which were not defined, and progress note at 9:58 p.m. indicated skin care and treatments were completed to R1's scrotum. | 2 830 | | |

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| 2 830 | Continued From page 7<br><br>None of the three progress notes identified the presence of the left groin incision.<br><br>R1's progress notes dated 7/14/24 at 6:19 a.m. identified R1's catheter and JP drain and progress note at 2:54 p.m. indicated R1 had skin care and treatments, however neither progress notes identified the left groin incision.<br><br>A progress note dated 7/14/24 at 9:39 p.m., identified antibiotic ointment was applied to the scrotum and penis, noted the presence of the catheter, and indicated abdominal and groin folds had been cleansed and patted dry with no redness or foul odor noted. Progress notes dated 7/14/24 did not identify the presence of R1's left groin incision.<br><br>R1's progress notes dated 7/15/24 at 6:15 a.m. and 4:28 p.m. identified R1's JP drain however, did not mention R1's left groin incision.<br><br>A progress note dated 7/15/24 at 9:11 p.m., indicated R1 received a bed bath and included "observe for new skin issues: no new issues observed. Continues to have multiple old bruises on right forearm, right hip and leg, swollen scrotum which is treated with polysporin [antibiotic ointment] this eve[ening] per md [doctor] orders. Abdominal folds and groin have slight redness no foul odor or tenderness. Cleansed patted dry and anti-fungal applied per md[doctor] order." It did not identify R1's left groin incision.<br><br>A paper skin observation charting form dated 7/15/24, indicated it was completed with R1's bed bath on the p.m. shift. It included an outline of a person with a circle around the left hip and "L[left] side large bruise." It contained no further | 2 830 | | |

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| 2 830 | Continued From page 8<br><br>assessment of the bruise such as size, color, or pain and did not note R1's left groin incision.<br><br>A second paper skin observation charting form dated 7/15/24, included a depiction of the front of a body with a circle around the outer edge of the right forearm and note "scattered bruises," a circle around the outer right hip with note "bruise," circles around the lower abdomen and left groin with note "faint redness." The depiction of the back of the body included a circle around the outer right forearm with note "scattered bruises," circle around the peri-area with note "swollen scrotum," and circle around the outer right hip with note "bruising." No further assessment of the noted bruises, redness, or swelling was included and it did not note R1's left groin incision.<br><br>R1's baseline care plan for infection with creation date of 7/16/24, noted "I require Enhanced Barrier Precautions r/t [related to] presence of indwelling catheter, JP drain, and surgical incision." Goals included "I will not develop signs or symptoms of infection." Interventions included monitor for signs and symptoms of infection, and notify physician/nurse practitioner if signs and symptoms occur.<br><br>R1's record that included progress notes dated 7/16/24, 7/17/24, and 7/18/24 mentioned R1's JP drain however did not identify the presence of R1's left groin incision.<br><br>A progress note dated 7/18/24 at 3:20 p.m., identified R1 was seen by the primary care provider Physician Assistant, had a clinic appointment the next day, and noted the presence of the JP drain. It did not identify R1's left groin incision. | 2 830 | | |

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| 2 830 | Continued From page 9<br><br>A Physician Assistant visit note dated 7/18/24, indicated R1 had an appointment with vascular surgery the next day but did not include identification or assessment of R1's left groin incision.<br><br>A progress note by the director of nursing (DON) dated 7/19/24 at 12:38 p.m., included "Resident went out to his follow-up ortho[pedics] appointment today where it was found that his left groin incision had dehisced. He was admitted for surgical management, left groin irrigation, and debridement. He will remain in the hospital throughout the weekend."<br><br>A vascular surgery office visit note by nurse practitioner (NP)-A dated 7/19/24, indicated R1 was seen in the clinic for wound assessment. It included "[R1] presents today with no information from his nursing facility ... He believes the facility removed the Mepilex from his left groin incision a few days ago. They have not been utilizing any gauze to his groin incision ... Left groin incision: wound dehiscence to the very center aspect of the incision, approximately 1.5 cm ... [R1] unfortunately has experience [sic] dehiscence of his left groin incision. Admit to [physician's] surgical service and proceed to operating room for left groin irrigation and debridement."<br><br>A hospital Surgeon Documentation note dated 7/19/24, indicated R1 was known by the surgical service from his previous surgery "for evacuation of a large left-sided groin hematoma and primary repair of his actively bleeding femoral artery." It noted "He was seen in clinic today for evaluation of his wound and was found to have some dehiscence with opening of the skin around his nylon sutures. For this reason he was brought to the operating room for irrigation and debridement | 2 830 | | |

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| 2 830 | Continued From page 10<br><br>[removal of infected or diseased tissue in a wound and washing out the open wound] ... Upon initial inspection of the wound it was clear that he had had dehiscence in the medical portion of the suture line but has [sic] other sutures remained intact ... we sharply debrided [cut away] a 3 x 3 x 3 cm [centimeter] area of necrotic fat .... The decision was made to place a wound VAC for ongoing drainage ... we will plan to bring him back to the operating room on Monday for another irrigation and debridement."<br><br>A hospital Infectious Disease physician consult note dated 7/23/24, identified bacterial culture swabs from R1's left groin site returned positive for two types of bacteria, enterococcus faecalis and citrobacter koseri. The recommendations included continuing the intravenous antibiotics R1 was already receiving and, upon discharge, to complete a further course of oral antibiotics for two weeks after the date of his last debridement.<br><br>A hospital Discharge Summary dated 7/24/24, noted R1 was admitted on 7/19/24 and discharged on 7/24/24. Follow-up noted "wound vac is to continue until you are re-evaluated by a member of [doctor's] surgical team, and will most likely continue for many weeks, possibly up to a few months." The Details of Hospital Stay, noted R1 "was directly admitted from [clinic] on 7/19/2024 for management of left groin wound dehiscence. He proceeded to the operating room on 07/19/2024 and underwent left groin irrigation and debridement with wound VAC placement ... He proceeded to the operating room again on 7/22/2024 and underwent left groin irrigation and debridement. Left groin incision with wound vac in place."<br><br>In an interview on 8/1/24 at 12:30 p.m., hospital | 2 830 | | |

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| 2 830 | Continued From page 11<br><br>vascular nurse practitioner (NP)-A stated she had previously cared for R1 when his left femoral artery required nylon sutures and indicated he discharged from the hospital on 7/12/24 with nylon sutures that were "very nicely closed and no issues whatsoever with any openings" and a Mepilex Ag dressing that was to stay on for seven days. NP-A stated she saw R1 at a vascular surgery clinic appointment on 7/19/24 and the Mepilex was off and his groin incision was "very obviously dehisced." She states "we should have been called or talked to about it and that required him to be readmitted and needing a couple of wash-outs of that groin and now wound VAC placement. The cultures from that came back positive for enterococcus requiring him to be on antibiotics." NP-A stated R1 reported no one even looked at his groin while he was at the facility and NP-A noted R1 was a larger guy and it would require lifting up his pannus to visualize the groin area where the incision was located. She stated that, upon inspection at the appointment, the groin incision was approximately six inches and had dehisced in the center of the incision "probably two centimeters wide and at minimum a centimeter and a half deep." She stated R1 also had a JP drain on the left side, but it was approximately four to six inches away from the incision. NP-A stated possible outcomes of the dehiscence were "repeat surgical intervention, overall infection risk, he could have gone septic from this, I think that would be the worst outcome from this if it were to have gotten any worse, or if it got down to the artery and if the artery was exposed he could have bled to death." NP-A stated "I would say that it [the dehiscence] was probably happening over a minimum of three days." Regarding treatment, NP-A noted the expectation from the vascular surgery group was that if the Mepilex Ag dressing had stayed intact it | 2 830 | | |

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| 2 830 | Continued From page 12<br><br>would be removed at the seven day mark (7/17/24) and gauze would be placed in the area to avoid any moisture or skin-on-skin contact to prevent breakdown, and even though the discharge instructions did not say specifically to use gauze they instructed staff to keep the area clean and dry.<br><br>In an interview on 8/5/24 at 9:33 a.m., R1 stated facility staff "didn't pay attention to that groin area incision that I had when I went there. I just had a couple of stitches in the groin ... I went with the stitches and a little drainage bag [JP drain], they drained the bag but they never checked the groin where the incision was, it was on the left side." R1 stated staff never checked on the incision or cleaned around the incision. He did not recall having a dressing on it and stated "there was no dressing, one of them looked at it and said I don't know why there isn't gauze there but they didn't pay attention to that." R1 stated he wasn't able to visualize the incision because of its location and he thought everything was going well with it until his appointment with vascular surgery and noted bacteria was found in the incision "so I imagine it must have been open for more than one day." He stated he was admitted right away after his appointment and "then I had surgery again, I think I was put under two or three times and now I have a wound VAC on that area where the incision is which is another thing I have to deal with, another machine on me ... It has delayed everything and not only do I still not have my weight bearing on that leg now I also have the wound VAC to deal with and physical therapy is limited as to what they can do with me."<br><br>In an interview on 8/5/24 at 8:08 a.m., licensed practical nurse (LPN)-A stated she remembered R1 wasn't there long, but he was a big guy with a | 2 830 | | |

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| 2 830 | Continued From page 13<br><br>drain and a catheter. LPN-A stated "he had an incision, a surgical incision, I don't remember where it was" LPN-A stated "I don't remember documenting his incision site and I didn't remember an order in there to do anything with it" and noted this was an oversight because they should have had an order.<br>LPN-A stated R1 arrived at the facility during her shift, but second shift usually completed skin check and confirmed she would include surgical incisions and bruises on a skin assessment. LPN-A stated with a surgical incision with no orders she would contact the clinical manager and assumed they were to leave it alone, but if it was "wet and nasty" she would call the provider to get an order to do something.<br><br>In an interview on 8/5/24 at 1:26 p.m., LPN-B stated she remembered R1 and had taken care of him for a few days. She noted R1's groin area had been bruised and she thought he had an angiogram in the hospital where they nicked an artery and he had a bleed in the groin area, but did not recall an incision or dressing in his groin.<br><br>In an interview on 8/5/24 at 1:54 p.m., registered nurse (RN)-C stated R1 had a femoral dressing in his groin from something post-operative and thought it was on the left, but "honestly I can't recall if I ever saw it." RN-C did not identify a dressing present on the left grin incision.<br><br>In an interview on 8/5/24 at 8:55 a.m., RN-B stated she was covering for clinical manage (CM)-A when R1 admitted and completed his admission assessments though she did not provide direct care for him. RN-B stated "he has an incision, can't remember which side, it was in his hip and he had a JP drain out of a separate spot on his left side" and stated she had never | 2 830 | | |

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| 2 830 | Continued From page 14<br><br>seen the incision. RN-B stated she was aware R1 had orders for wound care but did not recall the details of the wound care orders. She stated if someone had a surgical incision and a dressing and no orders she would call to get orders and check with her manager. RN-B noted she would look at orders to see how to manage a specific wound because hospital discharge orders usually specify what you have to do.<br><br>In an interview on 8/5/24 at 11:06 a.m., CM-A stated she was not familiar with R1 as did not work during the time of his admission. CM-A confirmed R1's admission skin assessment, Skin Observation Form dated 7/15/24, should have been completed on 7/12/24, noted a need for surgical wound care but did not identify the wound, did not identify the left groin surgical incision, did not note the JP drain site, did not meet her expectations for assessment of bruises, and did not constitute a comprehensive skin assessment. CM-A confirmed R1's EHR did not include orders for monitoring or treatment of the left groin surgical incision, progress notes did not include documentation of monitoring, there was no documentation of a dressing over the left groin surgical incision, no documentation that wound care for the surgical incision was provided per provider orders, and stated "I don't see the assessment or monitoring of the surgical incision in the groin anywhere." She further confirmed R1's baseline care plan was not completed and did not identify his left groin surgical incision or the treatment plan, stated it should have been included in the care plan, and noted the baseline care plan should have been completed per protocol within 48 hours of admission. CM-A noted wound care orders for the left groin surgical incision were included in the hospital's Discharge Summary but not the After Visit Summary and the | 2 830 | | |

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| 2 830 | Continued From page 15<br><br>facility utilized the After Visit Summary for admission orders, not the Discharge Summary, but she was aware the hospital sometimes has other orders in the Discharge Summary that are not included in the After Visit Summary. She confirmed that if R1 had a surgical incision but did not have wound care orders she would expect nursing staff to notice something was missing and obtain orders by reaching out to her or the on-call provider. CM-A stated "I have no idea what happened, I was gone and it fell through the cracks. It appears a couple checks didn't happen." She identified potential outcomes of the lack of assessment, monitoring, and treatment as infection, sepsis, and "he could have died if we're going for worst case scenario."<br><br>In an interview on 8/5/24 at 12:41 p.m., the DON stated R1 had had admitted to the facility with the left groin surgical incision and at a follow-up provider appointment on 7/19/24 they noted the incision had dehisced and he was admitted for further care of his incision. The DON confirmed she was aware there were discrepancies between the orders in R1's hospital Discharge Summary and After Visit Summary. She confirmed R1's EHR lacked documentation of assessments of the incision and stated there was no comprehensive assessment. The DON noted she would expect the incision to have been assessed within eight hours of admission, to be monitored every shift, findings to be documented, and the provider to be updated with any concerns or abnormalities noted. The DON stated she would expect the incision's dressing to be put in as an order and to have been documented. She noted the assessment and monitoring of R1's bruises were not in line with her expectations for monitoring every shift and weekly comprehensive skin assessments. The DON stated she could not | 2 830 | | |

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| 2 830 | Continued From page 16<br><br>demonstrate that R1's left groin surgical incision was treated in accordance with physician orders or assessed and monitored in accordance with physician orders and facility policy. She identified potential outcomes as "adverse events, infection, many terrible things."<br><br>In an interview on 8/5/24 at 1:59 p.m., the facility's medical director (MD) stated he had spoken to the DON about R1 and knew a bit about the situation. The MD stated he would expect staff to identify the presence of a dressing, wound, incision, or skin or soft tissue abnormality through orders from the hospital to monitor and care for it, in the discharge summary if it wasn't in the orders, or from the initial body audit (comprehensive skin assessment on admission) completed same day or by the morning after admission. He would expect treatment and monitoring per physician orders and if there were no orders, would expect staff to talk to the attending provider or hospital provider to "make sure they didn't omit orders and, if they did, find out what needs to be done in terms of monitoring and dressing changes." The MD identified possible outcomes of the femoral groin incision not being monitored, assessed, and treated as a potential delay in observing a change in condition of the groin, superficial or deeper infection, wound dehiscence, aneurysm or pseudoaneurysm, or other potential vascular complications. The MD stated, "it is more of a delay in identification if it [the incision] dehisced before the person [R1] was at the office visit," and noted "we know there was a delay in identifying anything that might have been doing on but when it exactly was going on was unclear." The MD stated, "treatment should be provided in accordance with orders so you can identify changes in condition when they occur more | 2 830 | | |

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| 2 830 | Continued From page 17<br><br>promptly and to carry out what a specialist wants in terms of particular wounds." The MD confirmed the incision was "seemingly not tended to" and noted the facility lacked a plan of care for the incision.<br><br>Facility policy titled Prevention and Treatment of Skin Breakdown dated 9/1/18, included "Resident skin integrity is assessed upon admission and weekly thereafter ... Those residents' who experience a break in skin integrity or wounds are provided care and service to heal the skin according to professional standards of care ... A licensed nurse completes Braden Skin Risk Assessment: Upon admission or readmission; Weekly for the first 4 weeks post admission or readmission ... A resident centered care plan is implemented/updated for skin risk with interventions based upon; Areas of risk; Resident Assessment; Braden evaluation score of 15 or less; Clinicians assessment/evaluation; Resident preferences. Members of the care team are notified and consulted as necessary. Skin integrity is monitored and abnormal findings are documented: Skin is observed daily with cares. If any skin concerns are noted, they are reported to the licensed nurse; Weekly skin audits are performed by a licensed nurse."<br><br>Facility policy titled Comprehensive Assessments and Care Planning dated 7/2/18, included "A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals, and sign and certify that the assessment is completed. The assessment process begins with the development of the baseline care plan within the first 48 hours of admission. The baseline care plant includes the minimum healthcare information necessary to care for each resident immediately upon their | 2 830 | | |

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| 2 830 | Continued From page 18<br><br>admission, which would address resident-specific health and safety concerns to prevent decline or injury. Baseline care plans address, at a minimum, the following: Initial goals based on admission orders; Physician orders ... The baseline care plan reflects the resident's stated goals and objectives, and includes interventions that address his or her current needs ... The assessment must accurately reflect the resident's status, and each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment ... The following assessments and time frames are calculated from the day of admission unless otherwise noted ... Baseline Care Plan developed with 48 hours of admission ... skin assessment within 8 hours."<br><br>Facility policy titled Order Review dated 9/2018 included "Purpose: To assure appropriate medications and treatments are in place for each resident. Procedure: EHR System: Orders are transcribed into the electronic health record."<br><br>The immediate jeopardy that began on 8/5/24, was removed on 8/6/24, when it was verified the facility implemented the following corrective actions:<br>-Educated licensed nursing staff about skin and wound care protocols, reviewing hospital discharges, admission skin assessments, skin and wound assessment and monitoring, following physician orders, and provider notification with competency testing;<br>-Reviewed hospital discharge orders for current residents admitted since 6/23/24 for transcription accuracy and completeness and identification of skin impairments and treatments; interviewed said residents regarding skin care and | 2 830 | | |

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| ST CRISPIN LIVING COMMUNITY | 213 PIONEER ROAD RED WING, MN 55066 |

| (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 |
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| 2 830 | Continued From page 19<br><br>treatments;<br>-Completed comprehensive skin assessments on said residents; reviewed and updated skin care plans as needed for said residents;<br>-Reviewed facility Prevention and Treatment of Skin Breakdown policy for accuracy; added surgical incisions to weekly wound rounds; and added surgical incisions to daily inter-disciplinary team meetings,<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents with impaired skin integrity, to assure they are receiving ongoing monitoring and assessment of the skin along with the necessary treatment/services to promote improvement. The director of nursing or designee, could conduct random audits of the delivery of care; review nursing assessments; to ensure appropriate care and services are implemented and reduce the risk of edema not being cared for properly.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 830 | | |