Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 5, 2024

Administrator
Episcopal Church Home Of Minnesota
1879 Feronia Avenue
Saint Paul, MN 55104

RE: CCN: 245452
Cycle Start Date: May 29, 2024

Dear Administrator:

On June 13, 2024, we notified you a remedy was imposed. On June 25, 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 June 24, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 28, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 13, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 28, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on June 24, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS 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

July 5, 2024

Administrator
Episcopal Church Home Of Minnesota
1879 Feronia Avenue
Saint Paul, MN 55104

Re: Reinspection Results
Event ID: CRT512

Dear Administrator:

On June 25, 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 May 29, 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

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June 13, 2024

Administrator
Episcopal Church Home Of Minnesota
1879 Feronia Avenue
Saint Paul, MN 55104

RE: CCN: 245452
Cycle Start Date: May 29, 2024

Dear Administrator:

On May 29, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 28, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 28, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 28, 2024.

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

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 28, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Episcopal Church Home Of Minnesota will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 28, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Annette Winters, Regional Operations Supervisor
Federal Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 29, 2024 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

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.

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 13, 2024

Administrator
Episcopal Church Home Of Minnesota
1879 Feronia Avenue
Saint Paul, MN 55104

Re: State Nursing Home Licensing Orders
Event ID: CRT511

Dear Administrator:

The above facility was surveyed on May 28, 2024 through May 29, 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:

Annette Winters, Regional Operations Supervisor
Federal Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPISCOPAL CHURCH HOME OF MINNESOTA	1879 FERONIA AVENUE SAINT PAUL, MN 55104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/28/24 - 5/29/24, 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. The following complaints were reviewed. H54524041C (MN103530/103533) & H54523951C (MN103509) deficiencies issued at F580, F609, F657, F684 & F686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		6/24/24

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

Electronically Signed | 06/18/2024

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.

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F 580	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility	F 580	R1 resident representative is notified with	

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F 580	Continued From page 2 failed to notify the resident's representative with a change to a resident's health when a new medication and treatment were ordered for 1 of 3 resident reviewed. R1 was identified as having a wound on his right leg and the facility notified the provider, obtained an order for an antibiotic, and a dressing change. The change and treatment were initiated without informing the resident representative. Findings include: R1's quarterly Minimum Data Set (MDS) dated 4/30/24 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 10 indicating R1 was cognitively impaired. R1 required moderate assistance with toileting and transfer activities. He required maximum assistance with dressing and grooming. R1 was ambulatory with the use of a walker. R1's diagnoses were chronic atrial fibrillation (cardiac arrhythmia), anemia, hypertension (high blood pressure), renal (kidney) failure, diabetes type II, Non-Alzheimer's Dementia, long term use of anticoagulants (blood thinners) and edema. The MDS indicated R1 was at risk for pressure ulcers but did not have any pressure ulcers or wounds. R1 had a pressure reducing device on his bed. R1's progress note dated 5/6/24 11:38 a.m. indicated a call was placed to R1's Primary Care Physician (PCP) regarding his right leg having a "lots of drainage from two big patches on the right outer aspect." In addition, a urine culture >100,000 colonies were called and faxed to the Primary Care Provider (PCP). R1's progress note dated 5/6/24 indicated R1 was ordered Macrobid (antibiotic) 100 milligram (mg)	F 580	changes and treatment per the facility policy titled, Change in Condition Policy. The facility policy, titled Change in Condition Policy was reviewed and is current. Current residents□ changes and treatment are initiated with informing the resident representative per the facility policy titled, Change in Condition Policy. Education to nursing staff to ensure resident representative is notified with changes and treatment per the facility policy titled, Change in Condition Policy. Included in the education is notifying the resident representative to changes in medical condition and treatment plan. DON/Designee will complete random audits for current like dependent residents each week x 4 weeks to ensure resident representative is notified with changes and treatment per the facility policy titled, Change in Condition Policy. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance.	

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F 580	Continued From page 3 by mouth twice daily for weeping blisters on R1's right leg until 5/14/24. R1's physician order sheet dated 5/7/24 indicated treatment for R1's blisters to his right leg, was to wash area daily with mild soap and pat dry. Okay to cover with Mepilex (a dressing which covers and secures wounds) if draining, allow the fluid to drain, if significant drainage then cover with an ABD pad (a pad used for heavy drainage) and wrap with Kerlix and secure until resolution, update if area around blister/blisters itself starts to look inflamed, surrounding tissue becomes hot to the touch, and/or drainage becomes purulent (pus), bloody or otherwise appears infected. Hospital Emergency Department note dated 5/16/24 at 5:54 p.m. indicated R1 had a large ulceration that was necrotic appearing on his right posterior calf and a small ulceration over his right posterior heel. He also had a necrotic wound appearing on his left posterior calf. General Surgery Post-Operative Progress note dated 5/21/24 at 10:29 a.m. indicated R1 had excisional debridement of bilateral lower extremity wounds. Tissue culture was growing gram positive-cocci and gram-negative bacilli. Post-surgical plan for wound care was to re-consult regarding ongoing wound recommendations, continue wound cares per their recommendations and for Plastic Surgery was to be involved regarding future inventions with the wound depending on the POA's decisions. Upon interview on 5/28/24 at 8:06 a.m. family member (FM)-A stated she became aware that R1 had a wound at his care conference on	F 580		

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F 580	Continued From page 4 5/14/24. The reason she was told at that point about the wound was to consent to R1 seeing the wound care team for treatment. She stated that as a nurse she was aware that the facility had noticed a wound and did not report that to her. She stated she spoke with the R1's nurse practitioner (NP) who saw R1 and was told that the NP was notified of a wound on 5/6/24 and provided orders of Macrobid 100 mg twice daily and a dressing change. FM-A stated R1 was found to have wounds on both legs, both his heels and his buttock when he arrived at the hospital. FM-A stated if she had been informed when the wound had first identified her, and her sister would have monitored the wound when they visited R1 and that maybe could have prevented the hospitalization if they had eyes on him as well. FM-A stated she is the Power of Attorney (POA) for R1, and the facility is aware that she makes the decision for R1. Upon interview on 5/29/24 at 1:47 p.m. the assistant director of nursing (ADON) stated he could not produce any documentation that R1's representative was notified prior the care conference on 5/14/24 when she was asked to give consent for the wound nurse to treat R1. He stated FM-A was the POA and the decision maker for R1. A facility policy titled Change in Condition with a revised date of 5/4/22 indicated the facility shall promptly notify their attending Medical Doctor, and the elder's power of attorney, substitute decision maker or other person as indicated by the resident of changes in the resident's condition.	F 580		
F 609 SS=D	Reporting of Alleged Violations	F 609		6/24/24

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F 609	Continued From page 5 CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to report an allegation of neglect immediately, but not later than two hours, to the State Agency (SA) for 1 of 1 resident (R1) reviewed for skin integrity when the hospital contacted the facility when R1 was admitted for wound care that required surgical intervention	F 609	Alleged Violations to R1 will be reported immediately, but not later than two hours, to the State Agency. The facility policies, VA-Right to Be Free From Maltreatment and VA-Reporting and Investigation Procedure were reviewed	

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	245452	A. BUILDING _____ B. WING _____	C 05/29/2024

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F 609	Continued From page 6 and three pressure ulcers were found. Findings include: R1's quarterly Minimum Data Set (MDS) dated 4/30/24 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 10 indicating R1 was cognitively impaired. R1 required moderate assistance with toileting and transfer activities. He required maximum assistance with dressing and grooming. R1 was ambulatory with the use of a walker. R1's diagnoses were chronic atrial fibrillation (cardiac arrhythmia), anemia, hypertension (high blood pressure), renal (kidney) failure, diabetes type II, Non-Alzheimer's Dementia, long term use of anticoagulants (blood thinners) and edema. The MDS indicated R1 was at risk for pressure ulcers but did not have any pressure ulcers or wounds. R1 had a pressure reducing device on his bed. R1's physician order sheet dated 5/7/24 indicated treatment for R1's blisters to right leg, was to wash area daily with mild soap and pat dry. Ok to cover with Mepilex if draining, allow the fluid to drain, if significant drainage then cover with an ABD pad (a pad used for heavy drainage) and wrap with Kerlix and secure until resolution, update if area around blister/blisters itself starts to look inflamed, surrounding tissue becomes hot to the touch, and/or drainage becomes purulent (pus), bloody or otherwise appears infected. R1's progress note dated 5/13/24 at 11:28 a.m. indicated R1's nurse practitioner (NP) looked at R1's wounds and recommended the wound care team to evaluate and treat the bilateral lower extremity wounds, due to likely needing debridement due to slough and eschar (dead	F 609	and are current. Alleged Violations to current residents will be reported immediately, but not later than two hours, to the State Agency. Education to facility staff to follow the facility policies, VA-Right to Be Free From Maltreatment and VA-Reporting and Investigation Procedure. Included in the education will be training specifically covering immediate reporting suspected neglect, but not later than two hours, to the State Agency. for all staff on recognizing and reporting alleged violations. Training will also cover the types of abuse, neglect, exploitation, and mistreatment, and the importance of immediate reporting. Administrator/Designee will complete random audits for review of types of abuse, neglect, exploitation, and mistreatment and the importance of immediate reporting. Audit in the form of asking questions in regards to something being reportable and what they would do. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance.	

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F 609	Continued From page 7 tissue). The NP placed an order to send R1 to the hospital on 5/17/24 following a visit from the wound care team. Emergency Department note dated 5/16/24 at 5:54 p.m. indicated R1 had a large ulceration that was necrotic appearing on his right posterior calf and a small ulceration over his right posterior heel. He also had a necrotic wound appearing on his left posterior calf. Hospital history and physical dated 5/17/24 indicated R1 presented from his nursing home for evaluation of lower extremity wounds. Per report, he has had wounds on his legs for about a month. Unclear how these occurred. He had local wound at the facility, but the patient's physician requested evaluation at the hospital. R1 had an extensive necrotic wound on the posterolateral right lower extremity and smaller necrotic wound on posterior left lower extremity. Hospital assessment and plan dated 5/17/24 indicated the principal problem was a necrotic right leg wound. He would be inpatient for extensive right lower leg wound and smaller necrotic left lower leg wound. R1 was started on intravenous Vancomycin (broad spectrum antibiotic). R1 had blood cultures in process and a consultation was ordered for General Surgery and Plastic Surgery. R1 arrived from the emergency department with an ABD pat wrapped in kerlix on his right lower extremity saturated, which was changed. Mepilexes were applied to several wounds on his bilateral lower extremities including his heels. Aflex (protective) boots applied to both feet. General Surgery Consultation Plan dated 5/17/24	F 609		

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F 609	Continued From page 8 indicated R1 would likely need debridement of the wounds in the operating room. Hospital Wound Initial Assessment Note dated 5/19/24 at 12:49 p.m. indicated wounds: -Wound #1 was on the right lateral posterior lower leg. The wound was full thickness, the base was 90% dry adherent, brown eschar, 10% white moist slough. The peri wound: denuded (loss of epidermis) and erythema (redness) measurements were length (L) 17 centimeters (cm) x width (W) 12 cm x depth (D) 0.5 cm. The drainage amount was small. -Wound #2 left posterior lower leg with an unknown etiology, full thickness. The wound base was 100% necrotic tissue-black, adherent eschar, demarcation at the wound edge with purulent drainage. The peri wound area had erythema with a small amount of drainage, the drainage was purulent, malodorous the wound had moderate odor. -Wound #3 location was the right buttocks, a pressure injury - community acquired. The base was 100% non-blanchable tissue. The peri wound was intact. There was no drainage. General Surgery Post-Operative Progress note dated 5/21/24 at 10:29 a.m. indicated R1 had excisional debridement of bilateral lower extremity wounds. Tissue culture was growing gram positive-cocci and gram-negative bacilli. Post-surgical plan for wound care was to re-consult regarding ongoing wound recommendations, continue wound cares per their recommendations and for Plastic Surgery to be involved regarding future inventions with the wound depending on the POA's decisions. Upon interview on 5/28/24 at 2:39 p.m. the social	F 609		

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F 609	Continued From page 9 worker (SW)-A stated the facility did not report the incident. She stated through her contact with the hospital and the family she was aware that the incident had been reported to the state agency for neglect on the facility. SW-A stated the facility became aware of the severity of the leg wounds and the addition of the pressure ulcer on 5/20/24 when the hospital was called about an updated status. Upon interview on 5/29/24 at 1:47 p.m. the assistant director of nursing deferred any questions about reporting the wounds stating the director of nursing (DON) was on vacation during the survey and he does report for the facility. He stated he was part of the facility investigation. Upon interview on 5/29/24 at 1:55 p.m. the Administrator stated he became aware that the facility received an update that a resident was in the hospital with wounds on 5/20/24. He stated he sat down with the DON and the SW to discuss the seriousness. It was decided the wounds were not in a location where it was caused by laying bed or kept wet. The Medical Director did not offer any concerns when the facility reached out to him. The facility had started to write-up an education plan for the staff following the investigation. A facility policy on reporting was not obtained.	F 609		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		6/24/24

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F 657	Continued From page 10 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a care plan to address a significant change to skin integrity with wound treatment interventions for 1 of 3 residents (R1) reviewed. In addition, R1 was using a mechanical lift for transfers and a wheelchair for ambulation and the care plan indicated R1 transferred with the assistance of one staff member. Findings include: R1's care plan dated 10/28/23 - 5/28/24 did not indicate any focus, goals or interventions for	F 657	R1 care plan has been reviewed and updated to address wound treatment interventions and transfers. R1 care plan is up to date. The facility policy, Care Plan Policy Baseline and timeframe was reviewed and is current. Current residents care plans have been reviewed and updated to address wound treatment interventions and transfers as necessary. Current residents care plans are up to date. Current like dependent residents wound	

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F 657	Continued From page 11 potential skin integrity concerns or actual focus, goals, or interventions when a wound was discovered on 5/1/24. R1's care plan dated 8/15/23 indicated R1 required one staff member to move between surfaces. R1's quarterly Minimum Data Set (MDS) dated 4/30/24 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 10 indicating R1 was cognitively impaired. R1 required moderate assistance with toileting and transfer activities. He required maximum assistance with dressing and grooming. R1 was ambulatory with the use of a walker. R1's diagnoses were chronic atrial fibrillation (cardiac arrhythmia), anemia, hypertension (high blood pressure), renal (kidney) failure, diabetes type II, Non-Alzheimer's Dementia, long term use of anticoagulants (blood thinners) and edema. The MDS indicated R1 was at risk for pressure ulcers but did not have any pressure ulcers or wounds. R1 had a pressure reducing device on his bed. R1's physician order sheet dated 5/7/24 indicated treatment for R1's blisters to right leg, was to wash area daily with mild soap and pat dry. Ok to cover with Mepilex if draining, allow the fluid to drain, if significant drainage then cover with ABD pad (pad for heavy drainage) and wrap with Kerlix and secure until resolution, update if area around blister/blisters itself starts to look inflamed, surrounding tissue becomes hot to the touch, and/or drainage becomes purulent (pus), bloody or otherwise appears infected. R1's progress note dated 5/12/24 at 2:07 p.m. indicated R1's dressing was changed to bilateral	F 657	treatment interventions and transfer status are up to date. Current like dependent residents care plans reviewed for accuracy and revised as needed. Care Sheets have been updated for dependent residents needing wound treatment interventions and transfers. Care needs will be reviewed with each MDS/Care Conference. Direct care staff, MDS, and Unit Manager will work together to update Wound treatment interventions and transfers needs on the care plan/Kardex. Nursing staff have been re-educated on care plans and updating the care plan. DON/Designee will complete random audits for 4 current like dependent residents each week x 4 weeks to ensure wound treatment interventions and transfer status is up to date. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance.	

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F 657	Continued From page 12 (both legs) low extremities as ordered, dressing was soaked with fluids and had a foul smell to it. The blisters were open, and the wounds had some black and dark yellowish coverings all over. R1's progress note dated 5/13/24 at 11:28 a.m. indicated R1's nurse practitioner (NP) looked at R1's wounds and recommended the wound care team to evaluate and treat the bilateral lower extremity wounds, due to likely needing debridement due to slough and eschar (dead tissue). R1's weekly skin body audit dated 5/15/24 indicated R1 had bruising of the right and left antecubital and his buttocks. Upon interview on 5/28/24 at 8:06 a.m. R1's family member (FM)-A stated she became aware that R1 had a wound at his care conference on 5/14/24. She asked for a copy of R1' care plan following the conference because she wanted to see when the wound care was initiated and what the treatment. She stated there was wound treatment plan or wound preventative measures on the R1's care plan. The care plan did not have directions for staff regarding the use of a mechanical lift with R1. Upon interview on 5/28/24 at 11:32 a.m. nursing assistant (NA)-A stated he was aware that R1 required nursing to do a dressing change daily on his right leg. He stated "around the week of 5/6/24" R1 was in his bed more than usual and the staff used an EZ-stand mechanical lift to get him up and a wheelchair for ambulation around the unit and prior R1 self-transferred and wandered most of the day by walking. NA-A felt the reason for his decline was either the wound	F 657		

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F 657	Continued From page 13 on his heels or that he was having pain from a few recent falls of time. Upon interview on 5/29/24 at 9:51 a.m. registered nurse (RN)-A stated she completed the skin audit on R1 on 5/1/24. He had "so many bruises," but then she noticed a wound on his right lower extremity, describing the wound as very pink, no drainage and larger than a quarter. RN-A worked with R1 again on 5/15/24 and completed a skin audit. She stated on 5/15/24 R1 was too weak for a shower so the nursing assistant completed a bed bath, and the staff were using a mechanical lift to transfer R1 to his wheelchair and staff were required to assist R1 with mobility in the wheelchair. Upon interview on 5/29/24 at 1:47 the ADON stated any skin integrity concerns should be on the resident's care plan. The ADON was not aware that R1 declined from ambulating to requiring assistance with transfers and using a wheelchair. He stated the nurses can make that decision, but he is the one who updated the care plans. He confirmed that the skin integrity concerns, and the EZ-stand use were not on the care plan. A facility Policy titled Skin Care dated 1/2015 indicated each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care related to skin care. No other care plan related policies were obtained.	F 657		
F 684 SS=G	Quality of Care CFR(s): 483.25	F 684		6/24/24

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F 684	Continued From page 14 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure treatment, monitoring, and care in accordance with professional standards of practice were provided for 1 of 3 residents (R1) reviewed when skin ulcerations developed. R1's primary physician was not immediately notified when the first wound was discovered or when the wound had a significant change. R1 was admitted to the hospital with wounds on both legs requiring surgical interventions. The facility was only aware of the wound on R1's right leg. Findings include: R1's care plan dated 10/28/23 - 5/28/24 did not indicate any focus, goals or interventions for potential skin integrity concerns or actual focus, goals, or interventions when a wound was discovered on 5/1/24. R1's nursing assistant skin monitoring documentation dated 4/29/24-5/28/24 indicated on 4/30/24, 5/1/24, 5/2/24, 5/5/24, 5/8/24, and 5/10/24 R1 had a skin tear. The audit did not provide any other information regarding a skin tear documented. In addition, the form indicated on 5/10/24, 5/14/24 and 5/15/24 R1 had an open area. The audit did not provide any other	F 684	R1 has returned to the facility and treatment, monitoring, and care is in accordance with professional standards of practice in regards to skin ulcerations. MD will be notified immediately with any changes in condition. Facility policies, Skin Care Policies and Wound protocols were reviewed and are current. Current residents□ treatment, monitoring, and care is in accordance with professional standards of practice are provided for when skin ulcerations develop. MD will be notified immediately with any changes in condition Nursing staff have been re-educated on providing wound treatment interventions and notifying MD per facility policy Change in Condition Policy. DON/Designee will complete random audits for 4 ADL current like residents each week x 4 weeks to ensure wound treatment interventions are completed and MD has been updated as necessary. The results of the audits will be reviewed in the facility QAPI committee for continued	

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F 684	Continued From page 15 information regarding the open area. R1's quarterly Minimum Data Set (MDS) dated 4/30/24 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 10 indicating R1 was cognitively impaired. R1 required moderate assistance with toileting and transfer activities. He required maximum assistance with dressing and grooming. R1 was ambulatory with the use of a walker. R1's diagnoses were chronic atrial fibrillation (cardiac arrhythmia), anemia, hypertension (high blood pressure), renal (kidney) failure, diabetes type II, Non-Alzheimer's Dementia, long term use of anticoagulants (blood thinners) and edema. The MDS indicated R1 was at risk for pressure ulcers but did not have any pressure ulcers or wounds. R1 had a pressure reducing device on his bed. R1's weekly skin body audit dated 5/1/24 at 1:45 p.m. indicated a skin deficit was noted. The form indicated for the nurse to describe the deficiency and to call the wound nurse if the finding was the first occurrence. The audit indicated R1 had bruising to the right and left antecubital (area around the elbows), lower back, buttock, right and left lower leg bruising and a wound on the right lower leg. The columns for length, width and depth measurements were left blank. A note indicated bruises were noted "all over" R1's body and dry wound on his right low leg, cleaned and covered with Mepilex. R1's progress note dated 5/6/24 11:38 a.m. indicated a call was placed to R1's triage regarding right leg having a "lots of drainage from two big patches on the right outer aspect." In addition, a urine culture >100,000 colonies were called and faxed to the Primary Care Provider	F 684	quality improvement and compliance. The DON or designee will be responsible for compliance.	

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F 684	Continued From page 16 (PCP). R1's progress note dated 5/6/24 indicated R1 was ordered Macrobid (antibiotic) 100 milligram (mg) by mouth twice daily for weeping blisters on R1's right leg until 5/14/24. R1's physician order sheet dated 5/7/24 indicated treatment for R1's blisters to right leg, was to wash area daily with mild soap and pat dry. Ok to cover with Mepilex (a dressing to cover wounds to secure an prevent movement of the primary dressing) if draining, allow the fluid to drain, if significant drainage then cover with ABD pad (a pad for heavy drainage) and wrap with Kerlix and secure until resolution, update if area around blister/blisters itself starts to look inflamed, surrounding tissue becomes hot to the touch, and/or drainage becomes purulent (pus), bloody or otherwise appears infected. R1's list of weekly skin body audits did not show any documentation of a body audit completed on 5/8/14. R1's progress note dated 5/12/24 at 2:07 p.m. indicated R1's dressing was changed to bilateral (both legs) low extremities as ordered, dressing was soaked with fluids and had a foul smell to it. The blisters were open, and the wounds had some black and dark yellowish coverings all over. R1's progress note dated 5/12/24 at 2:17 p.m. indicated a voicemail was for the nurse manager, also the assistant director of nursing (ADON) to follow-up with the wound doctor. R1's progress note dated 5/13/24 at 11:28 a.m. indicated R1's nurse practitioner (NP) looked at	F 684		

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EPISCOPAL CHURCH HOME OF MINNESOTA	1879 FERONIA AVENUE SAINT PAUL, MN 55104

(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 17 R1's wounds and recommended the wound care team to evaluate and treat the bilateral lower extremity wounds, due to likely needing debridement due to slough and eschar (dead tissue). R1's weekly skin body audit dated 5/15/24 indicated R1 had bruising of the right and left antecubital and his buttocks. R1 had a wound to the rear of his right lower leg and a wound to the right ankle on the outer side. The length, width and depth measurements were left blank. A note indicated the dressing was changed on the right lower leg and ankle. The old dressing was soaked with drainage. Emergency Department note dated 5/16/24 at 5:54 p.m. indicated R1 had a large ulceration that was necrotic (dead tissue) appearing on his right posterior calf and a small ulceration over his right posterior heel. He also had a necrotic wound appearing on his left posterior calf. Hospital history and physical dated 5/17/24 indicated R1 presented from his nursing home for evaluation of lower extremity wounds. Per report, he has had wounds on his legs for about a month. Unclear how these occurred. Apparently, he had local wound at the facility, but the patient's physician requested evaluation at the hospital. R1 had an extensive necrotic wound on the posterolateral right lower extremity and smaller necrotic wound on posterior left lower extremity. Hospital assessment and plan dated 5/17/24 indicated the principal problem was a necrotic right leg wound. He would be inpatient for extensive right lower leg wound and smaller necrotic left lower leg wound. R1 was started on	F 684		

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F 684	Continued From page 18 intravenous Vancomycin (broad spectrum antibiotic). R1 had blood cultures in process and a consultation was ordered for General Surgery and Plastic Surgery. R1 arrived from the emergency department with an ABD pat wrapped in kerlix on his right lower extremity saturated, which was changed. Mepilexes were applied to several wounds on his bilateral lower extremities including his heels. Aflex (protective) boots were applied to both of his feet. General Surgery Consultation Plan dated 5/17/24 indicated R1 would likely need debridement of the wounds in the operating room. R1's Power of Attorney (POA) was called and decided to hold surgery in an attempt for wounds to heal on their own. Hospital Wound Initial Assessment Note dated 5/19/24 at 12:49 p.m. indicated wound #1 was on the right lateral posterior lower leg. The wound was full thickness, the base was 90% dry adherent, brown eschar, 10% white moist slough. The peri wound: denuded (loss of epidermis) and erythema (redness) measurements were length (L) 17 centimeters (cm) x width (W) 12 cm x depth (D) 0.5 cm. the drainage amount was small. Wound #2 left posterior lower leg with an unknown etiology, full thickness. The wound base was 100% necrotic tissue-black, adherent eschar, demarcation at the wound edge with purulent drainage. The periwound area had erythema with a small amount of drainage, the drainage was purulent, malodorous the wound had moderate odor. Plastic surgery consultation note dated 5/16/24	F 684		

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F 684	Continued From page 19 indicated dressing changes were going to be ordered for both lower extremities and in the next 24-48 hours discuss appropriately of wound vacuum assistance therapy (VAC) therapy. R1 would benefit from skin grafting given the size of the wounds. Surgical note dated 5/20/24 family gave verbal consent for debridement of the bilateral lower extremity wounds via surgical procedure. General Surgery Post-Operative Progress note dated 5/21/24 at 10:29 a.m. indicated R1 had excisional debridement of bilateral lower extremity wounds. Tissue culture was growing gram positive-cocci and gram-negative bacilli. Post-surgical plan for wound care was to re-consult regarding ongoing wound recommendations, continue wound cares per their recommendations and for Plastic Surgery to be involved regarding future inventions with the wound depending on the POA's decisions. Upon interview on 5/28/24 at 8:06 a.m. family member (FM)-A stated she became aware that R1 had a wound at his care conference on 5/14/24. The reason she was told at that point about the wound was to consent to R1 seeing the wound care team. She stated that as a nurse she was aware that the facility had noticed a wound and did not report that to her. She stated she spoke with the care team who saw R1 and was told that they were notified of a wound on 5/6/24 and provided orders of Macrobid 100 mg twice daily and a dressing change. FM-A stated R1 was found to have wounds on both legs, both his heels and his buttock when he arrived at the hospital. "I wish I wouldn't have looked at the	F 684		

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F 684	Continued From page 20 photos, they disgust and sadden me at the same time. This was a sentinel event." She stated making decisions for R1 were difficult due to his age, mental status, kidney function and diabetes, but decided on a surgical intervention. Upon interview on 5/28/24 at 11:32 a.m. nursing assistant (NA)-A stated he was aware that R1 required nursing to do a daily dressing change on R1's right leg. He stated the wound would weep through the dressing at least once during his shift so he would ask the nurses rechange the dressing and he would have to change R1's clothing and sometimes his bed. Upon interview on 5/28/24 at 1:29 p.m. R1's Nurse Practitioner (NP) stated the first she knew of a wound the was on 5/6/24 at 11:07 a.m. when she received a page about urinalysis results and that R1 had skin integrity issues. The skin issues were described as a new blister on his right lower leg with no edema, clear drainage, no redness or swelling. She stated she ordered Macrobid 100 mg twice a day and a daily dressing change. She stated she did round the facility every Monday and on 5/13/24 with the same nurse who sent her a message on 5/6/24 who asked her to see R1 as he had concerns about the wound. The NP stated she saw both legs were wrapped in Kerlix. She was unaware of any concerns with R1's left leg. The nurse unwrapped both legs and on the right anterior leg below the knee to the ankle was fully sloughed. She could not see any depth to the wound. She stated the left leg appeared the same, but not as large. She asked the nurse "When did this start?" licensed practical nurse (LPN)-A responded, "last week when I paged you," The NP stated he needs debridement on his legs due a wound, this was not a blister. She	F 684		

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F 684	Continued From page 21 lifted his legs to look at his heels and ordered wound care for his heels bilaterally for the pressure ulcers. The NP messaged the ADON to order wound care as soon as possible. She stated it was not until 5/16/24 that the wound nurse visited R1 and reached out to the NP because R1's right leg was necrotic, and he required hospitalization. The NP wrote an order to send R1 to the hospital immediately. The NP stated from 5/6/24 until 5/13/24 R1 had an acute change of the right leg and the addition of a wound to the left leg, and they were not reported to her. She stated if she were notified earlier instead of waiting until she rounded, she could have ordered wound care earlier. The NP stated she was also not aware that R1 had declined. Upon interview on 5/28/24 at 2:15 p.m. LPN-A stated he worked on the dementia unit once a week. On 5/6/24 he noticed R1 had his right leg wrapped with saturated Kerlix. He removed the dressing and noticed a blistered he described as about the size of a quarter. He looked for an order to see if he were to administer a treatment and was unable to find one. He notified the NP to get orders. He stated he did not work on the dementia unit again until the following Monday 5/13/24 and R1 was using his wheelchair. He had staff use the EZ-stand to lay R1 down in bed so he could complete his dressing change treatment. He stated he pulled off saturated dressing from both of R1's lower extremities and the wound on the right leg was from R1's knee to his foot and now there was a black wound on his left lower extremity. He knew the NP was onsite so he got her, so she could visualize the wounds. He stated she ordered the wound care team immediately, stating R1 needed debridement.	F 684		

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F 684	Continued From page 22 Upon interview on 5/29/24 at 9:51 a.m. registered nurse (RN)-A stated she completed the skin audit on R1 5/1/24. He had "so many bruises," but then she noticed a wound on his right lower extremity, describing the wound as very pink, no drainage and larger than a quarter. She cleaned the wound and covered it with Kerlix. She denied obtaining wound measurements or notifying the provider of the change to his skin integrity. RN-A worked with R1 again on 5/15/24 and completed a skin audit. She stated on 5/15/24 R1 was too weak for a shower so the nursing assistant completed a bed bath. When RN-A observed the skin, she stated the wound was now "totally different," it was on the back of his right leg and from his knee to his foot and half of the wound was red and the other half of the wound was white. RN-A immediately called the ADON and asked if he was aware of R1's wound as it was large and "new" to her. The ADON told her that the wound nurse would see R1 "soon". Upon interview on 5/29/24 at 10:09 a.m. a hospital registered wound nurse (RN)-B stated she completed R1's initial wound assessment at the hospital on 5/19. She stated he had significant infected wounds on both legs that required surgical intervention to remove necrotic tissue. She stated she was uncertain of the etiology of the leg wounds. She stated to prevent the wounds from getting to the level that they did she believed routine skin assessments were not performed because "the state the wounds were in didn't happen overnight." The facility should have contacted the wound nurse or PCP for the infection sooner than they did. Upon interview on 5/29/24 at 11:20 a.m. NA-B stated she recalled R1 having a wound on his	F 684		

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F 684	Continued From page 23 right leg. She stated she noticed a "small circular red area" before the nurses started wrapping R1's legs because she put compression hose on R1 in the mornings. She stated then his leg became swollen and drainage the staff stopped putting the compression hose on him, which she believed was around the end of 4/2024. Upon interview on 5/29/24 the Medical Director stated after he reviewed R1's records and interviewed the family and a few staff members he felt that R1's situation was a communication issue. He stated he believed that at times nursing staff does not want to tell a provider "You need to come in and evaluate." He stated he also believed the facility was not aware of how long it would take the wound team to start the cares. The order was placed on 5/13/24 and the wound care nurse did not evaluate until 5/16/24. He stated on his record review he believed the wound started on 5/1/24, and orders were started on 5/6/24, but then a skin audit was missed on 5/8/24 and then not again until 5/15/24. The director stated he had not spoken with the NP or the PCP, however he would want to discuss the choice of antibiotic treatment and that they did not visualize the wound. He stated the NP or the PCP only see's patient's every 60 days and rely on the facility staff for all concerns in between and that is where the communication needs improvement. If the residents need to be seen more often the staff needs to complete their assessments and be reaching out to the providers. "We should have stepped on the gas sooner with his wounds." R1 had a lot of acute issues, and he was a DNR/DNI with comfort cares and since R1 was not complaining of pain, the facility could have felt like they were meeting his needs. "I still am doing a root cause	F 684		

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F 684	Continued From page 24 analysis." The facility needs consistent staff on that unit, however that is a concern in all facilities of not having consistent staff. This will be worked on at QAPI. Upon interview on 5/29/24 at 1:47 the ADON stated any skin integrity concerns should be reported when it first arises. He believed 5/1/24 was the date the wound could have started with a fall that R1 had, he denied ability to find any documentation on R1's fall incident reports that indicated any injury to the lower extremities. He stated when staff finds a weeping wound, they are to clean it and cover it until they receive treatment orders from the provider. The ADON stated he was aware that there was a wound with drainage on R1's right leg on "5/4/24 or 5/5/24" the weekend before the nurse reported the wound to the NP. The ADON stated he expects staff to obtain the required information on the skin audits so the wound status can be tracked. The ADON received a call on 5/12/24 which was a Sunday about the wound worsening, so the facility waited until 5/13/24 a Monday when the NP was onsite to show her the wound. The ADON denied assessing the wound at any time since 5/1/24 and did not visualize the wound until the wound nurse saw R1 on 5/16/24 requesting he be sent to the hospital. The ADON stated he did not notice the wound on R1's left leg. The ADON was not aware that R1 declined from ambulating to requiring assistance with transfers and using a wheelchair. He stated the nurses can make those decisions about using a lift or not, but he is the one who updated the care plans and denied that the skin integrity concerns, and the EZ-stand use were on the care plan. The ADON stated there are a lot of nurses who work on the dementia unit and as he was investigating	F 684		

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F 684	Continued From page 25 R1's concerns he noticed seven different nurses working in the past seven days. A facility Policy titled Skin Care dated 1/2015 indicated each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care related to skin care.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to prevent three pressure ulcers for 1 of 3 residents (R1) reviewed for skin integrity. R1 was harmed when he developed three pressure ulcers that went without treatment, staff were aware but did not implement a treatment plan. The hospital identified the pressure ulcers when R1 was admitted for wound care and subsequent surgical debridement.	F 686	R1 has returned to the facility and treatment, monitoring, and care is in accordance with professional standards of practice in regards to skin ulcerations. Facility policies, Skin Care Policies and Wound protocols were reviewed and are current. Current residents□ treatment, monitoring, and care is in accordance with professional standards of practice are	6/24/24

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F 686	Continued From page 26 Findings include: R1's care plan dated 10/28/23 - 5/28/24 did not indicate any focus, goals, or interventions for potential or actual skin integrity concerns when three pressure ulcers were discovered on 5/16/24 during a hospital admission. R1's quarterly Minimum Data Set (MDS) dated 4/30/24 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 10 indicating R1 was cognitively impaired. R1 required moderate assistance with toileting and transfer activities. He required maximum assistance with dressing and grooming. R1 was ambulatory with the use of a walker. R1's diagnoses were chronic atrial fibrillation (cardiac arrhythmia), anemia, hypertension (high blood pressure), renal (kidney) failure, diabetes type II, Non-Alzheimer's Dementia, long term use of anticoagulants (blood thinners) and edema. The MDS indicated R1 was at risk for pressure ulcers but did not have any pressure ulcers or wounds. R1 had a pressure reducing device on his bed. R1's weekly skin body audit dated 5/1/24 at 1:45 p.m. indicated a skin deficit was noted. The audit indicated R1 had bruising to the right and left antecubital (area around the elbows), lower back, buttock, right and left lower leg bruising and a wound on the right lower leg. The audit does not note any pressure ulcers. R1's list of weekly skin body audits did not show any documentation of a body audit completed on 5/8/14. R1's weekly skin body audit dated 5/15/24 indicated R1 had bruising of the right and left	F 686	provided for when skin ulcerations develop and to prevent. Nursing staff have been re-educated on providing wound treatment/prevention interventions DON/Designee will complete random audits for 4 current like dependent residents each week x 4 weeks to ensure wound treatment interventions are completed. The results of the audits will be reviewed in the facility QAPI committee for continued quality improvement and compliance. The DON or designee will be responsible for compliance.	

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F 686	Continued From page 27 antecubital and his buttocks. R1 had a wound to the rear of his right lower leg and a wound to the right ankle on the outer side. The audit does not note any pressure ulcers. Hospital Emergency department review of systems note dated 5/16/24 indicated R1 had a large ulceration that was necrotic appearing on his right posterior calf and a small ulceration over his right posterior heel. Hospital assessment and plan dated 5/17/24 indicated the principal problem was a necrotic right leg wound. He would be inpatient for extensive right lower leg wound and smaller necrotic left lower leg wound. Mepilexes were applied to several wounds on his bilateral lower extremities including his heels. Aflex (protective) boots applied to both feet. Hospital Wound Initial Assessment Note dated 5/19/24 at 12:49 p.m. indicated R1 had three a pressure injury that were acquired in the nursing facility. -Pressure ulcer to right buttock. The base was 100% non-blanchable tissue. The peri-wound (skin surround the wound) was intact. There was no drainage. -Pressure ulcer to left heel. The wound base was 100% red moist tissue. The peri-wound had loss of epidermis. The measurements were length (L) 3 centimeters (cm) x width (W) 3 cm x depth (D) 0.2 cm. The heel pressure ulcer had a small amount of blood drainage with no odor. -Pressure ulcer to the right heel. The wound was full thickness (damage extends below all layers or skin in the subcutaneous tissue or beyond into the muscle, bone, tendons, etc.) The wound base was 100% grey, with slough. The	F 686		

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F 686	Continued From page 28 peri-wound had loss of epidermis. The wound measured L 4 cm. x W 3.5 cm and D 0.3 cm with a small amount of drainage, a mild odor and mild pain. The wound was unstageable (the wound was covered by a layer of dead tissue and the doctor cannot see the base of the wound). Upon interview on 5/28/24 at 11:11 a.m. registered nurse (RN)-E a hospital wound nurse described R1's pressure ulcer as: The right buttock pressure ulcer was a shallow Stage II (broken through the top layer or skin). The right heel pressure ulcer was unstageable due to the dead tissue covering the wound. The left heel pressure ulcer was a Stage III (exposed muscle and subcutaneous fat). Upon interview on 5/28/24 at 11:32 a.m. nursing assistant (NA)-A stated he did not notice a pressure ulcer to R1's buttock, but the area was red, and he would apply barrier cream when he worked. He stated R1 "around the week of 5/6/24" was in his bed more than usual and the staff used an EZ-stand mechanical lift to get him up and a wheelchair for ambulation around the unit. Prior to this R1 self-transferred and wandered most of the day by walking. NA-A felt the reason for his decline was either the wound on his heels or that he was having pain from a few recent falls. NA-A stated he did not report to a nurse about the heel sores that he just knew to float the heels while R1 was in bed and turn and reposition him if he was to remain in bed for long periods of time. NA-A described the heel wounds as redness and the top layer of skin missing. Upon interview on 5/29/24 at 9:51 a.m. registered nurse (RN)-A stated the skin audit on 5/15/24 R1's right heel had a "white covered area over the	F 686		

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F 686	Continued From page 29 heel." She denied documenting a wound description or measurements. Upon interview on 5/29/24 at 11:20 a.m. nursing assistant (NA)-B stated a few days before R1 was sent to the hospital she noticed the skin on R1's right heel was gone, and she did notify the nurse but could not recall which nurse. She stated R1 stopped ambulating about a week before he was sent to the hospital. It was when he was "bedridden" she noticed the right heel pressure injury. Upon interview on 5/29/24 at 1:47 p.m. the assistant director of nursing (ADON) sated he was of the pressure ulcers to R1's buttock or bilateral heels. Upon interview on 5/29/25 at 1:55 p.m. the Administrator stated he was not aware R1 had wounds until 5/20/24 when he received an update from the hospital. He stated the facility made a plan to educate staff on wounds. The director of nursing (DON) was on the vacation during the survey and the education would be completed upon her return. A facility protocol titled Wound care protocol indicated to prevent wounds the staff was do daily skin inspection. If a Stage I, II, or III wound was identified to notify the physician and obtain orders and a diagnosis.	F 686		

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	00486	A. BUILDING: _____ B. WING _____	C 05/29/2024

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/28/24 - 5/29/24, 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 order(s) were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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

Electronically Signed | 06/18/24

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed. H54524041C (MN103530/103533) & H54523951C (MN103509) with licensing orders issued at 0265 and 0900. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265		6/24/24

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2 265	Continued From page 3 D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to notify the resident's representative with a change to a resident's health when a new medication and treatment were ordered for 1 of 3 resident reviewed. R1 was identified as having a wound on his right leg and the facility notified the provider, obtained an order for an antibiotic, and a dressing change. The change and treatment were initiated without informing the resident representative. Findings include: R1's quarterly Minimum Data Set (MDS) dated 4/30/24 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 10 indicating R1 was cognitively impaired. R1 required moderate assistance with toileting and transfer activities. He required maximum assistance with dressing and grooming. R1 was ambulatory with the use of a walker. R1's diagnoses were chronic atrial fibrillation (cardiac arrhythmia), anemia, hypertension (high blood pressure), renal (kidney) failure, diabetes type II, Non-Alzheimer's Dementia, long term use of anticoagulants (blood thinners) and edema. The MDS indicated R1 was at risk for pressure ulcers but did not have any pressure ulcers or wounds. R1 had a pressure reducing device on his bed. R1's progress note dated 5/6/24 11:38 a.m.	2 265	corrected	

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2 265	Continued From page 4 indicated a call was placed to R1's Primary Care Physician (PCP) regarding his right leg having a "lots of drainage from two big patches on the right outer aspect." In addition, a urine culture >100,000 colonies were called and faxed to the Primary Care Provider (PCP). R1's progress note dated 5/6/24 indicated R1 was ordered Macrobid (antibiotic) 100 milligram (mg) by mouth twice daily for weeping blisters on R1's right leg until 5/14/24. R1's physician order sheet dated 5/7/24 indicated treatment for R1's blisters to his right leg, was to wash area daily with mild soap and pat dry. Okay to cover with Mepilex (a dressing which covers and secures wounds) if draining, allow the fluid to drain, if significant drainage then cover with an ABD pad (a pad used for heavy drainage) and wrap with Kerlix and secure until resolution, update if area around blister/blisters itself starts to look inflamed, surrounding tissue becomes hot to the touch, and/or drainage becomes purulent (pus), bloody or otherwise appears infected. Hospital Emergency Department note dated 5/16/24 at 5:54 p.m. indicated R1 had a large ulceration that was necrotic appearing on his right posterior calf and a small ulceration over his right posterior heel. He also had a necrotic wound appearing on his left posterior calf. General Surgery Post-Operative Progress note dated 5/21/24 at 10:29 a.m. indicated R1 had excisional debridement of bilateral lower extremity wounds. Tissue culture was growing gram positive-cocci and gram-negative bacilli. Post-surgical plan for wound care was to re-consult regarding ongoing wound recommendations, continue wound cares per	2 265		

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2 265	Continued From page 5 their recommendations and for Plastic Surgery was to be involved regarding future inventions with the wound depending on the POA's decisions. Upon interview on 5/28/24 at 8:06 a.m. family member (FM)-A stated she became aware that R1 had a wound at his care conference on 5/14/24. The reason she was told at that point about the wound was to consent to R1 seeing the wound care team for treatment. She stated that as a nurse she was aware that the facility had noticed a wound and did not report that to her. She stated she spoke with the R1's nurse practitioner (NP) who saw R1 and was told that the NP was notified of a wound on 5/6/24 and provided orders of Macrobid 100 mg twice daily and a dressing change. FM-A stated R1 was found to have wounds on both legs, both his heels and his buttock when he arrived at the hospital. FM-A stated if she had been informed when the wound had first identified her, and her sister would have monitored the wound when they visited R1 and that maybe could have prevented the hospitalization if they had eyes on him as well. FM-A stated she is the Power of Attorney (POA) for R1, and the facility is aware that she makes the decision for R1. Upon interview on 5/29/24 at 1:47 p.m. the assistant director of nursing (ADON) stated he could not produce any documentation that R1's representative was notified prior the care conference on 5/14/24 when she was asked to give consent for the wound nurse to treat R1. He stated FM-A was the POA and the decision maker for R1. A facility policy titled Change in Condition with a revised date of 5/4/22 indicated the facility shall	2 265		

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2 265	Continued From page 6 promptly notify their attending Medical Doctor, and the elder's power of attorney, substitute decision maker or other person as indicated by the resident of changes in the resident's condition. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 265		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by:	2 900		6/24/24

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2 900	Continued From page 7 Based on interview and record review the facility failed to prevent three pressure ulcers for 1 of 3 residents (R1) reviewed for skin integrity. R1 was harmed when he developed three pressure ulcers that went without treatment, staff were aware but did not implement a treatment plan. The hospital identified the pressure ulcers when R1 was admitted for wound care and subsequent surgical debridement. Findings include: R1's care plan dated 10/28/23 - 5/28/24 did not indicate any focus, goals, or interventions for potential or actual skin integrity concerns when three pressure ulcers were discovered on 5/16/24 during a hospital admission. R1's quarterly Minimum Data Set (MDS) dated 4/30/24 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 10 indicating R1 was cognitively impaired. R1 required moderate assistance with toileting and transfer activities. He required maximum assistance with dressing and grooming. R1 was ambulatory with the use of a walker. R1's diagnoses were chronic atrial fibrillation (cardiac arrhythmia), anemia, hypertension (high blood pressure), renal (kidney) failure, diabetes type II, Non-Alzheimer's Dementia, long term use of anticoagulants (blood thinners) and edema. The MDS indicated R1 was at risk for pressure ulcers but did not have any pressure ulcers or wounds. R1 had a pressure reducing device on his bed. R1's weekly skin body audit dated 5/1/24 at 1:45 p.m. indicated a skin deficit was noted. The audit indicated R1 had bruising to the right and left antecubital (area around the elbows), lower back, buttock, right and left lower leg bruising and a	2 900	corrected	

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2 900	Continued From page 8 wound on the right lower leg. The audit does not note any pressure ulcers. R1's list of weekly skin body audits did not show any documentation of a body audit completed on 5/8/14. R1's weekly skin body audit dated 5/15/24 indicated R1 had bruising of the right and left antecubital and his buttocks. R1 had a wound to the rear of his right lower leg and a wound to the right ankle on the outer side. The audit does not note any pressure ulcers. Hospital Emergency department review of systems note dated 5/16/24 indicated R1 had a large ulceration that was necrotic appearing on his right posterior calf and a small ulceration over his right posterior heel. Hospital assessment and plan dated 5/17/24 indicated the principal problem was a necrotic right leg wound. He would be inpatient for extensive right lower leg wound and smaller necrotic left lower leg wound. Mepilexes were applied to several wounds on his bilateral lower extremities including his heels. Aflex (protective) boots applied to both feet. Hospital Wound Initial Assessment Note dated 5/19/24 at 12:49 p.m. indicated R1 had three a pressure injury that were acquired in the nursing facility. -Pressure ulcer to right buttock. The base was 100% non-blanchable tissue. The peri-wound (skin surround the wound) was intact. There was no drainage. -Pressure ulcer to left heel. The wound base was 100% red moist tissue. The peri-wound had loss of epidermis. The measurements were length (L)	2 900		

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2 900	Continued From page 9 3 centimeters (cm) x width (W) 3 cm x depth (D) 0.2 cm. The heel pressure ulcer had a small amount of blood drainage with no odor. -Pressure ulcer to the right heel. The wound was full thickness (damage extends below all layers or skin in the subcutaneous tissue or beyond into the muscle, bone, tendons, etc.) The wound base was 100% grey, with slough. The peri-wound had loss of epidermis. The wound measured L 4 cm. x W 3.5 cm and D 0.3 cm with a small amount of drainage, a mild odor and mild pain. The wound was unstageable (the wound was covered by a layer of dead tissue and the doctor cannot see the base of the wound). Upon interview on 5/28/24 at 11:11 a.m. registered nurse (RN)-E a hospital wound nurse described R1's pressure ulcer as: The right buttock pressure ulcer was a shallow Stage II (broken through the top layer or skin). The right heel pressure ulcer was unstageable due to the dead tissue covering the wound. The left heel pressure ulcer was a Stage III (exposed muscle and subcutaneous fat). Upon interview on 5/28/24 at 11:32 a.m. nursing assistant (NA)-A stated he did not notice a pressure ulcer to R1's buttock, but the area was red, and he would apply barrier cream when he worked. He stated R1 "around the week of 5/6/24" was in his bed more than usual and the staff used an EZ-stand mechanical lift to get him up and a wheelchair for ambulation around the unit. Prior to this R1 self-transferred and wandered most of the day by walking. NA-A felt the reason for his decline was either the wound on his heels or that he was having pain from a few recent falls. NA-A stated he did not report to a nurse about the heel sores that he just knew to float the heels while R1 was in bed and turn and	2 900		

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2 900	Continued From page 10 reposition him if he was to remain in bed for long periods of time. NA-A described the heel wounds as redness and the top layer of skin missing. Upon interview on 5/29/24 at 9:51 a.m. registered nurse (RN)-A stated the skin audit on 5/15/24 R1's right heel had a "white covered area over the heel." She denied documenting a wound description or measurements. Upon interview on 5/29/24 at 11:20 a.m. nursing assistant (NA)-B stated a few days before R1 was sent to the hospital she noticed the skin on R1's right heel was gone, and she did notify the nurse but could not recall which nurse. She stated R1 stopped ambulating about a week before he was sent to the hospital. It was when he was "bedridden" she noticed the right heel pressure injury. Upon interview on 5/29/24 at 1:47 p.m. the assistant director of nursing (ADON) sated he was of the pressure ulcers to R1's buttock or bilateral heels. Upon interview on 5/29/25 at 1:55 p.m. the Administrator stated he was not aware R1 had wounds until 5/20/24 when he received an update from the hospital. He stated the facility made a plan to educate staff on wounds. The director of nursing (DON) was on the vacation during the survey and the education would be completed upon her return. A facility protocol titled Wound care protocol indicated to prevent wounds the staff was do daily skin inspection. If a Stage I, II, or III wound was identified to notify the physician and obtain orders and a diagnosis.	2 900		

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2 900	Continued From page 11 SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 900		