



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 31, 2024

Administrator
Hillcrest Care & Rehabilitation Center
714 Southbend Avenue
Mankato, MN 56001

RE: CCN: 245507
Cycle Start Date: March 29, 2024

Dear Administrator:

On May 7, 2024, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 31, 2024

Administrator
Hillcrest Care & Rehabilitation Center
714 Southbend Avenue
Mankato, MN 56001

Re: Reinspection Results
Event ID: 7KJG12

Dear Administrator:

On May 7, 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 March 29, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 16, 2024

Administrator
Hillcrest Care & Rehabilitation Center
714 Southbend Avenue
Mankato, MN 56001

Re: State Nursing Home Licensing Orders
Event ID: 7KJG11

Dear Administrator:

The above facility was surveyed on March 26, 2024 through March 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office: (507) 206-2728

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

Please feel free to call me with any questions.



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 16, 2024

Administrator
Hillcrest Care & Rehabilitation Center
714 Southbend Avenue
Mankato, MN 56001

RE: CCN: 245507
Cycle Start Date: March 29, 2024

Dear Administrator:

On March 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office: (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 29, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 29, 2024 (six months after the identification of noncompliance), your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Hillcrest Care & Rehabilitation Center

April 16, 2024

Page 4

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "H. Zahler". The signature is fluid and cursive, with the first letter of the last name being a large, stylized 'Z'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245507		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/29/2024	
NAME OF PROVIDER OR SUPPLIER HILLCREST CARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001			
(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 3/26/24, 3/27/24, 3/28/24, and 3/29/24, 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 complaint was reviewed: H55072346C (MN00096558) and H55073221C (MN00096558) with a deficiencies cited at F550 and F684 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or			F 550			5/1/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/25/2024

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 550	Continued From page 1 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal privacy was maintained for 1 of 5 residents (R6) reviewed who required staff assistance with personal care. R6's face sheet identified R6 admitted on 2/9/24 with diagnoses of type 2 diabetes, obesity, dementia, unspecified psychosis.	F 550	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be accomplished for those residents found to		

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F 550	Continued From page 2 R6's current care plan identified an alteration in behavior and interventions included to go into room with two staff when completing care. On 3/27/24 at 10:22 a.m., nursing assistant (NA)-D came into room to change roommate d/t a strong urine odor in room. Curtain was drawn between roommates. NA-D yelled from the R6's side of the room "[LPN-A] "he keeps throwing his fists up at me, his sheet is wet." NA-D came over to R3's side of the room angrily with a garbage bag and stated, "He just keeps laughing now, it isn't funny." NA-D then left the room. LPN-A stated when a resident was not cooperative staff should let the nurse know and reapproach in 10 minutes. LPN-A stated she would talk to NA-D about the incident. During an interview on 3/28/24 at 10:53 a.m., NA-D conceded to being upset with R3. NA-D explained LPN-A advised her to reapproach R6 after she was upset. NA-D stated awareness R3 had been care planned for assistance of two staff with cares due to his behaviors. NA-D reported she walks away when residents become behavioral. During an interview on 3/28/24 at 11:50 A.M., director of nursing (DON) stated administration had educated NA-D and a staff meeting on 3/27/24 that encompassed customer service and dignity. A document titled Staff Meeting 3/27/24 identified attendance for the meeting. NA-D did not attend the meeting. During an interview on 3/29/24 at 12:25 P.M.,			F 550	have been affected by the deficient practice: - R6's alteration of mood and behavior care plan was reviewed to ensure personal privacy is maintained. How the facility will identify other residents having the potential to be affected by the same deficient practice: -All residents have the potential to be affected by the same alleged deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -The root cause of the issue was determined to be a staff member's reaction to R6's behaviors. Staff have been educated on customer service, including privacy during personal cares. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -Administrator or designee will conduct random audits of staff interactions with residents to ensure they are protecting their privacy. Audits will be completed 5x/week x 4 weeks and will report to the QA committee for further review and recommendations.		

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F 550	Continued From page 3	F 550			
F 684 SS=D	DON and Administrator verified NA-D had not attended the staff meeting. DON stated LPN-A educated NA-D on 3/27/24. No paperwork that verified education provided. Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to initiate, comprehensively assess, monitor, and treat skin conditions for 4 of 4 residents (R2, R3, R4, and R5) reviewed for impaired skin integrity. R2's face sheet undated identified an admission date of 7/2021. Diagnoses morbid obesity (obesity categorized by a body mass index greater than 40), type 2 diabetes, urinary incontinence, and erythema intertrigo (inflammatory skin condition caused by skin-to-skin friction (rubbing) that is intensified by heat and moisture). R2's Minimum Data Set (MDS) dated 3/7/24, identified R2 needed maximum assistance with movement and complete dependence with toileting. R2 used a motorized wheelchair.	F 684			5/2/24

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F 684	Continued From page 4 R2's current care plan identified an alteration in skin integrity with a goal to remain free of skin breakdown. Interventions included: followed by wound care, monitor skin integrity daily during cares, weekly skin inspection by nurse, treatment to open areas per order, turn and reposition or reminders to offload every 2-3 hours and as needed, pressure redistribution cushion to wheelchair and chair, weekly measurements and assessment of wound, monitor for skin breakdown for signs/symptoms of infection and report to doctor, document on skin condition and keep doctor informed of changes. R2's December orders identified skin care of buttocks and posterior thighs to gently cleanse skin with warm washcloth and soap if resident will allow and pat dry. Apply a thin layer of triad hydrophilic wound paste twice daily and as needed alternating with calmoseptine twice daily and as needed two times daily for skin care from 11/30/23-12/13/23 and from 12/14/23-12/20/23. Additionally, and as needed (PRN) order to apply a Mepilex (soft, silicone foam dressing for wounds) to right inner thigh for multiple raw skin irritations every three days, replace PRN. Discontinue when healed began 10/30/23 and discontinued 12/22/23. R2's treatment administration record (TAR) identified the aforementioned treatments were not completed on 12/6/23, and 12/20/23. R2's Occupational Therapy (OT) notes from 12/4/23-1/2/24 identified wheelchair dependence and EZ stand for transfers (mechanical lift that assists caregivers to move a resident from sitting to standing and from one place to another with the resident not using 100% of their body			F 684	affected by the same alleged deficient practice. Residents will have a skin inspection completed as a part of the Admission/Initial Data Collection to determine if they have any current skin concerns. Current residents will be monitored by their weekly skin inspection. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: -Nurses will be educated to complete the Admission/Initial Data Collection and weekly skin inspection for each resident. Nurses will also be educated to date packages when opened and reseal or discard dressings. -Nursing department staff will be educated on body pillow placement as they should not be tucked under fitted sheets (unless indicated in residents care plan) and care plans need to be followed, including intervention implementation. -Nursing assistants to perform routine skin inspections with daily care. Nurses will monitor and document any changes to wounds. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: -DON or designee will conduct random audits to ensure Admission/Initial Data Collection is being completed. Audits will be completed 5x/week x 2 months and will report to the QA committee for further review and recommendations. DON or designee will conduct random		

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F 684	Continued From page 5 strength). Baseline objectives on 12/4/24 identified that between the scooter and recliner R2 can only sit one hour, extremely uncomfortable, putting pressure on wound without noticing it. Relies on pain level to get out of scooter. R2 does not understand why sitting in scooter hurts so much, does not want to recline self when in recliner, and a poor overall awareness of positioning needs and pressure relief for healing of wounds. R2's reason for referral identified that R2 had a new blister/wound in right (r) crease of buttock, sliding in the scooter and inability to reposition self without shearing due to (d/t) decrease in upper body strength, and a recommendation for a pressure reduction device for the recliner as R2 only sleeps in a recliner. Current recliner 28" wide, 28" depth; current scooter 18" depth, can be 21" if reclined seat, 24" wide. Current scooter does not fit R2's body size, especially depth. OT goal is R2 can sit in scooter without pain. Discharge short term goals on 1/2/24 identified R2 is now able to sit several hours a day in scooter, changes position while sitting from hip to the other, denied pain, and is aware of pressure put on wounds and with new padding and pressure relief, met this goal. Long term goal met 1/2/24 identified that R2 can request to be transferred into recliner, staff is able to position R2 more in back of the seat for better positioning, R2 is aware of wounds and able to request staff to reposition and not put pressure directly on wound. R2's current orders included Triad hydrophilic wound dress external paste to apply to right posterior thigh topically one time a day every Monday, Wednesday, and Friday for wound care beginning 12/29/23. Additionally, for skin care of posterior right thigh: gently cleanse skin with	F 684	audits to ensure weekly skin inspections are being completed. Audits will be completed 3x/week x 2 months and will report to the QA committee for further review and recommendations. DON or designee will conduct random audits to ensure interventions are implemented on residents. Audits will be completed 4x/week x 2 months and will report to the QA committee for further review and recommendations.		

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F 684	Continued From page 6 warm wash cloth and soap if resident will allow, pat dry; apply a THIN layer of Triad hydrophilic wound paste over affected skin followed by a large border foam dressing; change every three days and PRN one time a day. R2's TAR identified the aforementioned treatment was not completed on 12/21/23, 12/30/23, 1/2/24, 2/7/24, 2/10,24, 2/16/24, 2/25/24, and 3/5/24. R2's weekly skin inspection by licensed nurses on the summary of current skin conditions identified: -12/12/23 right (R) thigh red and open, small amount of bleeding noted. -12/19/23 open area on R) inner thigh improving, R2 reports decreased pain. -12/26/23 R) thigh dressing intact. -1/2/24 no changes. -1/9/24 wound on R) thigh unchanged. -1/16/24 no documentation of R) thigh wound. -1/23/24-refused shower, no skin assessment completed. -1/30/24 no new skin condition. -2/6/24 wound on R) thigh, posteriors. Unchanged. -2/20/24 no changes to skin. -3/5/24 red on R) posterior thigh. 3/12/24 thighs just below buttocks are tender and Mepilex applied. Put on the list for wound nurse. 3/19/24 no documentation of R) posterior thigh. No weekly skin assessments completed by licensed nursing staff on 2/13/24, 2/27/24, and 3/26/24. R2's progress note (PN) dated 10/3/23 indicated R2 came to the desk in tears stating she had a sore area to her bottom and thighs. Noted two pinpoint reddened areas to inner R) buttocks, and			F 684			

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F 684	Continued From page 7 five pinpoint open areas scattered to area of inner R) thigh. A Mepilex was placed to inner R) thigh. R2's PN dated 10/21/23 indicated to place Mepilex to R) inner thigh for multiple raw skin irritations every three days, replace PRN. Discontinue when healed. Replaced dressing for comfort. Not open. R2's PN dated 11/20/23 indicated mepilex to R) inner thigh replaced effectively. R2's PN dated 11/24/23 an open area to R) crease of buttocks and a mepilex applied to both sides. Put in provider book and report given to oncoming nurse. R2's Skin and Wound Evaluation V7.0 dated 12/13/23, identified location R) medial thigh, middle with wound measurements of area 10 cm2, length 4.8cm and width 2.6cm. In red lettering it stated Note: wound is not open per CNP notes on 12/13/23. Measurements are incorrect. Resolved. R2's Extended Care Visit Note dated 12/13/23, identified at last visit resident reporting that her posterior right thigh is very painful. Reports she has been sitting in her recliner more because after 10 minutes or so in her wheelchair she wants to pass out from the pain in her thigh. The degree of breakdown in her skin is difficult to assess today due to the thick layer of paste over the area. Area is tender and would require the paste to be softened up by soaking the area. Resident reports that she could not take a shower yesterday because sitting on the shower chair hurts too much. Today, reports that pain is slightly less but she continues to notice some blood on			F 684			

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F 684	Continued From page 8 pad in the morning that covers her recliner. She is concerned about getting an infection in that area. The area of concern is located on the right leg (posterior R) thigh). The last clinic visit was 1 week ago. The patient is currently experiencing symptoms which include pain. The patient describes the pain as tenderness. Exacerbating factors include chronic friction, chronic trauma, and chronic moisture. Current treatment includes daily skin care. Due to having an electric wheelchair does not have a pressure reduction cushion in wheelchair. Posterior R) thigh looks improved without signs/symptoms (s/s) of bleeding. No evidence of open or draining skin. Area continues to be tender per resident report. Follow up in 1 week. Orders for skin care of (B) buttocks and posterior thighs: gently cleanse skin with warm wash cloth and soap if resident will allow, pat dry. Apply a THIN layer of triad hydrophilic wound paste twice daily and PRN alternating with Calmoseptine twice daily and PRN. Recommendations that in order for residents' skin of buttocks and thighs to heal, resident needs to get the pressure off of them. This is difficult given that she does not want to lay down in a bed and is constantly sitting on them in addition to friction/shearing forces that happen when she slides in chair or tries to reposition self and does not completely lift skin off the surface she is sitting on due to her body habitus and poor upper extremity strength. Also, brought up that the electric wheelchair appears to be getting too small for her and could be the cause of some of her skin problems if the seat is not deep enough. Resident frequently has to push her weight back for repositioning when she starts to feel to forward. Resident disagrees and feels that her wheelchair is large enough.	F 684			

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F 684	Continued From page 9 R2's PN dated 12/18/23 indicated nutrition follow-up related to (r/t) wound. Resident has a friction injury on R) posterior thigh. Resident refused protein supplements, staff continue to encourage protein intake at meals. R2's Extended Care Visit note dated 12/19/23, identified posterior R) thigh looks to have partial thickness skin loss near the medial edge of the friction injury. Area continues to be tender per resident report. Orders changed to skin care of posterior R) thigh-d/c all previous wound care orders! Gently cleanse skin with warm wash cloth and soap if resident will allow, pat dry. Apply a THIN layer of Triad Hydrophilic Wound Paste over affected skin followed by a large border foam dressing. Change every 3 days and as needed. New recommendations that resident does not want a wheelchair evaluation for evaluation for a larger wheelchair. Current wheelchair appears to be getting too small for her and could be the cause of some of her skin problems if the seat is not deep enough. Resident frequently has to push her weight back for repositioning when she starts to feel too forward. Resident disagrees and feels that her wheelchair is large enough. Turn and reposition/offload at least every 2 hours or as indicated on Tissue Tolerance Evaluation if interval is more frequent. Resident will need assistance with major repositioning changes since she is unable to do this on her own. Follow up in one week to re-evaluate per facility request. No measurements done. R2's PN dated 12/31/23 indicated R2 complained of upper thigh pain under buttocks. Skin is dry and irritated. Skin cleansed and barrier cream applied. Pillow offered to help offload from	F 684			

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F 684	Continued From page 10 bottom, patient refused. R2's PN dated 1/22/24 indicated nutrition follow-up r/t wound. Resident has an ongoing friction injury on R) posterior thigh. R2's PN dated 2/22/24, indicated skin care of posterior R) thigh cleaned and treated as ordered. Area of skin is rough and sore in it. R2's Skin and Wound Evaluation V7.0 dated 3/28/24, identified R) medial thigh, new wound-minutes old, in-house acquired friction. Area 0.24cm2, length 1.4cm and width 0.47cm. Granulation (small red granules of new capillaries on a wound surface) 100%, surrounding tissue with erythema (superficial reddening of the skin as a result of injury or irritation causing dilatation of the blood capillaries). Treatment included normal saline, triad with no secondary dressing. Additional care included cushion, incontinence management, moisture barrier and turning/repositioning program, added to weekly wound rounds for next week. Notified dietician, practitioner, and resident/responsible party. On 3/26/24 at 12:28 p.m., R2 was laying in her recliner. "I have a little wound on the side of my right thigh, but they are taking care of it.", "I prefer to sleep in my recliner, it makes a beautiful bed, I sleep in it perfectly." R2 demonstrated how to raise and lower the recliner. No bed in room. No pressure reduction cushions in recliner or electric wheelchair. During an interview on 3/26/24 at 2:34 p.m., nursing assistant (NA)-A and NA-B indicated that there were usually two staff working on R2's hall and that there were 23 rooms on that hall. They	F 684			

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F 684	Continued From page 11 get the information to care for the residents from the care plan and toileting and care sheets. NA-A indicated that it did make it harder to get cares done if there was only one staff member working the hall. On 3/27/24 from 7:32 A.M. to 10:35 A.M., observed wound care rounds with CNP and LPNMC. Wound care and observation were not performed on R2. On 3/28/24 at 10:41 A.M, CNC verified there were no measurements included in the 12/27/24 skin and wound assessment and that skin assessments had not been completed weekly. On 3/28/24 at 11:06 A.M., R2 was using the commode with NA-D in room. R2 stated "I've had the wound on my inner R) thigh for a long, long time. If they put a bandage on it, its ok." R2 stated "last night it hurt so bad they came in and put stuff on it." R2 continued "It's been a long time since I've seen [CNP]." NA-D stated that R2 had this wound for a while and "they try so many creams, mepilex and it seems to get a little better and then it gets worse, it is worse now." There was no pressure reduction cushion in the wheelchair or the recliner. DON came in and observed the wound and verified that there was no pressure reduction cushion in the wheelchair or the recliner. On 3/28/24 at 2:42 P.M., R2 was observed for wound care. DON took barrier cream out of R2's drawer. NA-C and R2 verified that was the cream that has been applied to R) posterior thigh, not the triad paste. DON educated R2 and NA-C the barrier cream was not what the order says to use and that they were to be using triad paste. DON	F 684			

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F 684	Continued From page 12 left room. R2 was on the commode with a washcloth placed on the R) side front of the commode. NA-C stated it was per R2's request so it did not hurt so much. No pressure reduction cushion in the recliner or wheelchair, a chux pad (for urinary incontinence) was on the wheelchair. NA-C stated that the pressure reduction cushion for R2 was over by the nurse's station drying because they just got it and "I used the purple wipes on it". DON returned with a tube of triad paste. DON did not date the triad upon opening it. NA-C stood R2 with the EZ-stand and DON used a piece of gauze and wiped the R) posterior thigh with sterile water. R2 stated "my left side is starting to get one". DON stated that there were two little areas of red, superficial, no slough, no drainage, and no redness around it. R2 stated "It bleeds at night and the chux has blood in it". DON applied triad paste, no foam dressing over. R2 stated "I'm starting to get one on the other side [DON], it hurt over there." DON did not assess or acknowledge R2's comments. During a phone interview on 3/27/24 at 1:23 P.M., Family member (FM)-A stated family had not been notified about R2's R) posterior thigh wound and they were also not aware of the wheelchair being too small. FM-A stated they put a new seat cushion on R2's power wheelchair with a seat cushion. During a phone interview on 3/29/24 at 9:43 A.M., CNP stated that R2's assessment from 12/27/23 indicated that the R) posterior thigh had a skin loss and to follow up in one week. CNP unsure what happened that R2 dropped off the schedule when she was supposed to continue to be seen. CNP stated that facility staff were to keep her informed if a wound reopens so that the	F 684			

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F 684	Continued From page 13 treatment can be changed. If something was open and not healing in 2-4 weeks, the treatment should be changed. R3's face sheet undated identified R3 admitted on 1/31/24. Diagnoses included adult failure to thrive, dementia (loss of memory), type 2 diabetes, stage 1 pressure ulcer of right upper back, pressure ulcer of other site, pressure ulcer of other site unstageable, Alzheimer's (brain disorder that causes problems with memory, thinking and behavior). R3's care plan identified an alteration in skin integrity with current pressure ulcers left (L) lateral knee. Interventions included to put pillows between knees when in bed, resident to wear heel lift boots at all times, monitor skin integrity daily during cares and weekly skin inspection by nurse. Treatment to open areas per order, pressure redistribution cushion to wheelchair and chair, low air loss air bed, weekly measurements, and assessment of wound. R3's Admission date collection form dated 1/31/24, identified no amputations and pedal pulses present in both feet. Wounds included the L) scapula 3cm x 2.5cm, right knee front 1cm x 0.5cm, right ankle outer 1.5cm x 0.5cm, left ankle outer 0.7cm. Skin comments identified small scabs on ankles, sores in the process of healing, both knees still open a small size. Back has a healing older red mark. Mepilex applied as directed. R3's weekly skin inspection by licensed nurses on the summary of current skin conditions identified: -2/7/24 R3 had several foam mepilex to bilateral			F 684			

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F 684	Continued From page 14 lower extremities (BLE) that were just changed this morning. Foams left in place and remain intact. -2/14/24 wound care dressings in place from wound nurse today. -3/6/24 skin breakdown on left lateral knee, right ankle, and front of right knee. All already noted by wound care and addressed. -3/13/24 mepilex on knees bilaterally and ankle did not need changing. Stayed clean and dry during bathing. R3's weekly Skin and Wound Evaluation V7.0 with sections available to mark the description of wound, location, where acquired, how long the wound has been present, staging, measurements, description of the wound bed, other issues including bleeding, bone, fibrin, gangrene, hematoma, hypergranulated, intact blister, islands of epithelium, pink/red, ruptured blister, scab, other, amount of exudate, odor, periwound, induration, edema, periwound temperature, wound pain, goal of care; treatment which included dressing appearance, cleansing solution, debridement, primary dressing, secondary dressing, modalities, additional care; progress, infection, notes, education, and notifications. These assessments were completed on and included the following information: -2/7/24 unknown location of pressure measured 1cm x 0.6cm. Physician note dated 2/7/24, identified R) ankle unstageable ulcer measured 0.97cm x 0.62cm x			F 684			

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F 684	Continued From page 15 0.1cm and had minimal drainage and 100% devitalized tissue. L) lateral knee unstageable ulcer measured 0.91cm x 0.81cm x 0.1cm and had 100% devitalized tissue. The surrounding tissue was noted to have erythema but no increased warmth. Wound care ordered to L) lateral knee: cleanse wound bed with wound cleanser. Treat periwound with skin barrier prep. Apply medihoney to the wound bed. Cover with mepilex, ok to reinforce with tape as needed, recommend to use cast padding and coban with no compression in attempt to keep dressing in place, change every 3 days, sooner if greater that 50% saturated. R) lateral knee: cleanse wound bed with wound cleanser, treat periwound with skin barrier prep, apply medihoney to the wound bed, cover with mepilex and okay to reinforce with tape as needed-recommend use of cast padding and coban with no compression in attempt to keep dressing in place. change every 3 days, sooner if greater than 50% saturated. Recommendations included heel lift boots on in bed, turn and reposition at least every 2 hours, air overlay or other specialty mattress if available due to high risk for pressure sore development, cushion in wheelchair at all times, follow up in one week. Resolved scapula wound. -2/14/24 R) lateral malleolus measured 1cm x 0.7cm. -2/20/24 R) lateral malleolus measured 0.8cm x 0.5cm, front R) knee stage 2 pressure injury no measurement-resolved. -2/28/24 R) lateral malleolus measured 0.8cm x 0.5cm-see Certified Nurse Practitioner (CNP) note from 2/28/24.	F 684			

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F 684	Continued From page 16 Physician note dated 2/28/24, identified R) ankle measured 0.52cm x 0.82cm. the wound had decreased in size and noted to be dry, brown scab. Dry and 100% devitalized tissue. L) lateral knee measured 0.47 x 0.43 x 0.1cm with 100% granular tissue and a decrease in size. R) lateral knee measured 0.85 x 1.24 x 0.1cm depth and noted to be 100% granular tissue. The surrounding tissue noted to have erythema. Wound orders to knees were to cleanse wound and surrounding skin with normal saline or wound cleanser and pat dry, apply skin prep to periwound skin and allow to dry, apply a dab of iodisorb gel to wound beds, cover with border foam dressing and change every other day and as needed. R) lateral ankle cleanse wound and surrounding skin with normal saline or wound cleanser and pat dry, paint with betadine and allow to dry, cover with border foam dressing and change every other day and as needed. -3/6/24 R) lateral malleolus measured 1.5cm x 0.8cm-see CNP note. Front R) knee 1.4cm x 0.9cm status resolved. -3/13/24 R) lateral malleolus measured 1.3cm x 0.6cm-see CNP note, L) above knee amputation site measured 1.4cm x 1cm-see CNP note. Physician note dated 3/13/24, identified R) ankle measured 1.32cm x 0.56cm, the wound had decreased in size, noted to have red discoloration and dry. L) proximal lateral knee ulcer measured 0.98cm x 1.37cm x 0.1cm with moderate drainage and 100% devitalized tissue. L) distal lateral knee ulcer measured 1.39cm x 0.79 cm x 0.1cm and had moderate drainage and 50% granular and 50% devitalized tissue. Ordered for L) lateral knee to cleanse with wound cleanser,	F 684			

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F 684	Continued From page 17 apply skin prep to periwound skin, apply cut to fit calcium alginate to wound bed, cover with border foam dressing and change every other day and PRN. R) lateral ankle-no changes, R) lateral knee cleanse wound and surrounding skin and pat dry, cover with border foam dressing for protection, change every 3 days and PRN. -3/18/24 R) lateral malleolus measured 1.7cm x 1.1cm status marked resolved, L) above knee amputation site 1.3cm x 0.8cm, L) shin medial measured 0.8cm x 0.6cm status marked stable. Physician note dated 3/18/24, identified R) ankle unstageable ulcer measured 1.72cm x 1.07cm. cleansed with saline. The wound has increased in size and had red discoloration and was dry. L) proximal lateral knee unstageable ulcer measured 0.81cm x 0.59cm. minimal amount of drainage and had 100% devitalized tissue with intact margins. L) distal knee unstageable ulcer measured 1.33cm x 0.77cm and noted to be 50% granular and 50% devitalized tissue. The surrounding skin was noted to have induration. Continue dressing leg wounds as ordered. -3/22/24 front L) knee lateral measured 3.2cm x 0.9cm status resolved. -3/27/24 description of wound is pressure. Location is left above knee amputation site. Wound measured 0.6cm x 0.4cm. Granulation tissue in wound bed 100%. Progress was improving-see CNP note. Physician note dated 3/27/24, identified R) ankle measured 0.8cm x 2cm and had red discoloration and was dry. L) proximal lateral knee measured approximately 0.2cm x 0.2cm x <0.1cm. The			F 684			

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F 684	Continued From page 18 wound had decreased in size. Scant drainage after removal of devitalized tissue wound was 100% granular. L) distal knee resolved. Wound order to L) lateral knee to cleanse open wound and surrounding skin with cleanser, paint with betadine and allow to dry, cover with bordered foam and change every other day and PRN. R) lateral ankle cleanse wound and surrounding skin, cover with border foam for protection, change every 3 days and PRN. On 3/26/24 at 3:46 P.M., R3 was not in room. Bed was unmade. TAR wound care was not signed out. On 3/27/24 at 10:22 A.M., R3 was laying in bed with a second mattress on the floor next to the bed. Air mattress was on the bed. Fall mat was tucked into the wall side of the bed. Body pillow was against the wall. Two pillows were tucked under the fitted sheet of the mattress on the outside of the bed. R3 is not wearing heel lift boots and there are no pillows between the legs. LPN-A stated "it's a body pillow, I know they aren't supposed to be under the sheet. I'll make sure to re-educate the aides." CNP stated R3's sheet is wet and smelled of urine. CNP, LPNMC, and LPN-A removed the four corners of the fitted sheet to aid in repositioning R3 and for the aides to change the sheet. CNP kept the heel protectors off since R3 needed a clothing change but stated "I worry how long he'll be without his boots?" CNP turned call light on, and they left the room. On 3/27/24 at 10:35 A.M., NA-E stated the front pillow is so R3 doesn't crawl out of bed. R3 was lying in a fetal position on his right side. NA-E and NA-D applied the four corners of the bed sheet			F 684			

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F 684	Continued From page 19 back to the mattress. NA-E and NA-D changed R3's brief and pants. NA-E and NA-D did not apply heel protectors or place a pillow between his knees. On 3/27/24 at 11:14 A.M., NA-E and NA-D assisted R3 to his wheelchair. At 11:19 A.M., R3 was in the hallway with heel protectors. On 3/27/24 at 1:01 P.M., R3 was lying in bed. Heel boots off, secondary mattress on floor, no pillow between his knees. During an interview on 3/27/24at 1:15 P.M., LPN-A verified R3 did not have heel protectors on, a pillow was not between his knees. LPN-A stated, "I'm sorry, it's disheartening, he is supposed to have the heel boots on at all times and the pillow between his legs." LPN-A verified that care sheets are located in the closet door, so staff know what cares need to be done. R4's face sheet identified an admission date of 10/23. Diagnoses included cellulitis (bacterial infection of the skin), peripheral vascular disease (blood circulation disorder), non-pressure chronic ulcer of lower leg, L) leg above knee amputation, methicillin resistant staphylococcus aureus (infection caused by specific bacteria that are resistant to commonly used antibiotics). R4's care plan identified alteration in skin integrity with interventions to monitor skin daily during cares and weekly inspection by nurse, turn and reposition with offloading every 2-3 hours and PRN, pressure redistribution mattress to bed, pressure redistribution cushion to wheelchair and chair, monitor for skin breakdown and document on skin condition and report to doctor.	F 684			

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F 684	Continued From page 20 R4's weekly skin inspection by licensed nurses on the summary of current skin conditions identified: -12/24/23 R) leg was wrapped and covered for shower, unable to see wounds. R4's weekly Skin and Wound Evaluation V7.0 with sections available to mark the description of wound, location, where acquired, how long the wound has been present, staging, measurements, description of the wound bed, other issues including bleeding, bone, fibrin, gangrene, hematoma, hypergranulated, intact blister, islands of epithelium, pink/red, ruptured blister, scab, other, amount of exudate, odor, periwound, induration, edema, periwound temperature, wound pain, goal of care; treatment which included dressing appearance, cleansing solution, debridement, primary dressing, secondary dressing, modalities, additional care; progress, infection, notes, education, and notifications. These assessments were completed on and included the following information: -1/16/24 front right lateral lower leg 4.1cm x 3cm progress marked stable. See Certified Nurse Practitioner (CNP) notes. No CNP note for 1/16/24. -1/24/24 front right lateral lower leg 2.8cm x 1.8cm progress marked improving. -1/31/24 front right lateral lower leg 2.5cm x 1.3cm. See orders from CNP. Physician note dated 1/31/24, identified R) lower extremity mid-tibial wound had decreased in size, had moderate drainage, 10% granular and 90%	F 684			

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F 684	Continued From page 21 devitalized tissue with margins intact. Distal to wound was skin loss due to moisture. R) dorsal foot wound resolved. Medial distal R) foot dorsal surface resolved. -2/7/24 front right lateral lower leg 2cm x 1.4cm Progress improving. See CNP dictation. Physician note dated 2/7/24, identified R) lower extremity mid-tibial wound had moderate drainage, and was 20% granular and 80% devitalized tissue. -2/14/24 front right lateral lower leg 1.5cm x 0.9cm granulation marked 100% of wound filled. Moderate amount of drainage. No odor. Attached edges. Surrounding skin dry and flaky. No swelling, edema, or induration. Periwound normal. Progress improving. See CNP note. Physician note dated 2/14/24, identified R) lower extremity mid-tibial wound decreased in size, moderate drainage and 100% granular. -2/23/24 front right lateral lower leg 1/1cm x 0.8cm progress marked improving. See CNP notes. No notes from physician visit. -2/28/24 front right lateral lower leg 1.3cm x 1.2cm progress marked improving. See CNP notes. Physician note dated 2/28/24, identified R) lower extremity mid-tibial wound appeared smaller, had serosanguineous drainage and was 100% granular with blistering skin surrounding wound. -3/6/24 front right lateral lower leg 0.7cm x 0.6cm, progress marked improving. See CNP notes. R4's Physician note dated 3/6/2 identified a new ulceration on R) lower extremity partially	F 684			

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F 684	Continued From page 22 circumferential and distal to primary wound. Wound measured 5.98cm x 3.09cm x 0.1cm. Margins were intact, 100% granulation tissue and minimal amount of drainage. R) lower extremity mid-tibial wound had minimal drainage and 100% granular with blistering surrounding wound. -3/13/24 front right lateral lower leg not measured-see CNP note. Physician note dated 3/13/24, identified R) lower extremity mid-tibial wound resolved. R) lower extremity blistering ulceration approximated measurement 5.66cm x 2.48cm x 0.1cm and had decreased in size, had minimal drainage and 100% granular with intact margins. -Physician note dated 3/20/24 identified the wound was almost completely healed at this time. No assessment or measurements included in note. R4's TAR for March 2024 identified acetic acid, collagenase ointment, xerofoam with hydrofera blue, R) lower extremity dressings, rooke vascular boots, and tubigrips on leg treatments not completed on 3/12/24. On 3/27/24 at 8:07 A.M., CNP and LPNMC assessed R4's wound. R4 had an open, undated package of xeroform dressing in container of wound supplies. LPNMC stated it is common practice at the facility to reuse opened dressings. LPNMC threw away the opened dressing. CNP stated wound is a venous/mixed arterial ulcer on the front of R) shin that appeared as an upside-down rainbow in shape. R5's face sheet identified admission date of 2/24.	F 684			

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F 684	Continued From page 23 Diagnoses anemia (deficiency of red blood cells), peripheral vascular disease (slow and progressive disorder of blood vessels), hemiparesis (one sided muscle weakness), occlusion of R) artery with stenosis (narrow or blockage of artery), tobacco use, R) knee prepatellar bursitis (inflammation of the bursa located within the kneecap). -2/13/24 admission assessment: right knee surgical incision, no measurements, skin tear o.4 x o.1 cm left forearm, skin tear 0.2 cm x 0.1 cm left forearm R5's admission assessment dated 2/13/24, identified Resident's skin is without blemish. Right knee was operated upon to clean out pus that pooled in a hole in his knee following an accidental fall. Resident is alert and oriented x3. Has both upper and lower dentures. He is assist of 1 with pivot for transfers. Sustained an unwitnessed skin tear to lateral left forearm shortly after admission. Site of Mantoux administration bled out shortly after administration. These new areas were cleansed and covered up with island dressings. Resident did not want dressing covering knee wound to be taken off so - not yet assessed. Nurse at Abbot north western reports that no dressing changes necessary for right knee until resident's follow up appointment with ortho. R5's weekly skin inspection by licensed nurses on the summary of current skin conditions identified: -2/15/24 Skin is clear, dry and intact with the exception of skin tears on left forearm and surgical incision on right knee.	F 684			

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F 684	Continued From page 24 -2/22/24 Skin shows minor small bruising on his arms. Wounds on his right knee. Treated. -3/6/24 Right knee surgical incision covered with wound vac dressing and also wrapped before shower. Other skin appears clean, dry and intact. Generalized bruising on bilateral upper extremities. -3/13/24 R knee surgical site not visualized, covered with wound vac. Otherwise rest of the skin is clean, dry and intact. -3/27/24 refused shower dressing intact Weekly skin assessments not completed on skin tears to L) forearm. R5's readmission from hospital on 3/21/24, identified a new pressure injury to left (L) heel. Readmission assessment included documentation on L) heel but did not include documentation of R) knee prepatellar bursitis which included a wound vac. No measurements for either wound included in document. R5's physician note dated 3/28/24, identified wound care to L) heel -Cleanse wound and surrounding skin with wound cleanser, pat dry -Apply skin prep to periwound skin and allow to dry -Apply a 50/50 mixture of Iodosorb gel with Hydrogel on a dry 2x2 gauze -Apply this gauze directly to the ulceration on heel -Cover with border foam dressing (do not cut foam dressing) -Change every other day and as needed. Rooke boots on at all times. wound care to R) knee -Cleanse wound with NS or wound cleanser, pat dry -Apply skin prep to periwound skin and allow to dry -Cover wound bed with Adaptic cut to fit	F 684			

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F 684	Continued From page 25 into wound bed -Apply a nickel thick layer of Hydrogel over the Adaptic -Cover with ABD pad -Secure with Kerlix and tape -Further secure with Tubigrip to hold in place -Change twice daily and as needed. If wound is drying out before next change, increase changes to three times a day. R5's care plan did not address either wound for care or treatment. On 3/27/24 at 9:01 A.M., R5 laying in bed. CNP, LPNMC, and LPN-B in room. R5's wound vac tubing was pulled from being stuck on wheelchair. Lambs wool boots on bilateral legs. Wound vac dressing labeled 2 is open and half the size of the other one and undated. Wound vac is on R) knee. Two sheets of wound vac dressings were opened in the package and undated. CNP and LPNMC verified that the dressings should not have been out and used and that they should be disposed of after cutting them for the initial use. Iodosorb and hydrogel containers are opened, unlabeled and undated in R5's wound container. CNP stated "I told them two weeks ago to call the surgeon because there wasn't a lot of drainage. It could benefit from the white foam instead of the gray foam." CNP changed dressing to R) knee. LPN-B stated the R) knee was the only wound and left the room. R5 stated he had a wound on his L) heel from hitting the metal holder for the foot pedals on his wheelchair. R5 stated the wound had been present for approximately one week. The L) heel mepilex was cut almost all the way in half. CNP stated that defeats the purpose of the mepilex. L) heel wound was tender and dry skin on the side of it. R5 stated "I was just climbing out of bed when it happened. The wound measured 2cm x 2cm x 1.2cm. During the dressing change R5 stated "the stuff they put on			F 684			

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F 684	Continued From page 26 big time burns me on my heel. I tell them when I am in pain, they don't give me enough. I can tell." Pressure relief cushion in wheelchair is visibly soiled with white spots and spill stains. During an interview on 3/28/24 at 11:50 A.M., with Administrator, DON and CNC it was stated that the nurse managers are responsible for the weekly wound assessments. This is completed on the skin and wound app. This will automatically populate onto a form that is in the medical record. The measurements are auto measured by a picture. In order for the assessment to go to the medical record it must be locked. DON audits the process. Skin is talked about in our morning meeting that includes nurse leaders, social workers, dietary, therapy, therapeutic recreation and administration staff. Not all wounds are documented in Point Click Care (PCC), only significant wounds. Not every wound would have a picture or an evaluation in PCC through the skin and wound form. CNC stated that "if a pressure ulcer of a significant wound, we don't have a specific significant wound, use nursing judgement but if it is large, skin tear, non-healing, dehiscing, you look at it and it doesn't look right. Little tiny skin tears or nothing significant about it. Its not a significant concern to take a pic to see at each point in the game. If we were to take a pic of every little thing on a person we would not be able to do any other patient care." DON stated that a new superficial wound the provider would be updated and the resident would be put on the wound round list for the following week, family updated, care plan updated and any other discipline that would be involved would be updated. CNC stated that they do not do a Tissue Tolerance Test but a skin evaluation and risk factors which is done on	F 684			

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F 684	Continued From page 27 admission, annually, with a significant change and new significant wounds. During a phone interview on 3/29/24 at 9:28 A.M., MD stated that wounds and skin assessments should be conducted weekly by licensed nursing staff. During a phone interview on 3/29/24 at 9:43 A.M., CNP stated that wounds are to be comprehensively assessed weekly and skin assessments done weekly by licensed nursing staff. During an interview on 3/29/24 at 12:25 P.M., with Administrator, DON and AIT, DON stated it is the facility policy for the staff to do the skin and wound evaluations weekly, and dressings to be completed as directed by the written orders. Administrator stated that if there is a resident that CNP no longer needed to follow, she would give recommendations on what would be done for prevention. Interdisciplinary Team (IDT) would watch for another week by discussion during meeting and through interviews with floor staff, evaluations, and progress notes. Daily IDT minutes Clinical Portion, undated, review from the dates 12/11/23-3/29/24, document identified the following were discussed during daily clinical meeting. Area of concern is listed, further detail is discussed. This form summarizes the requested residents skin areas of discussion: -R2 wounds addressed were legs and bottom on dates 12/11/23-12/14/23, 3/29/23. -R3's wounds addressed were knees, ankles, R) shoulder on dates 1/31/24-3/29/24. -R4's wounds addressed were R) lower extremity	F 684			

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F 684	Continued From page 28 ulcers on 12/11/23-3/29/24. -R5's wounds addressed were R) knee incision 2/13/24-3/29/24 and L) heel 3/29/24. Policies The facilities Skin Assessment & Wound Management policy revised 3/2024 directed guidelines for assessing and monitoring wounds for Prevention and Identification: Non-Pressure Wounds and Altered Skin Integrity with a New Skin Problem when a significant alteration in skin integrity is noted; (i.e., large, or multiple bruising, large skin tear, or other non-pressure related wounds such as diabetic, venous, or arterial ulcers), the following actions will be taken: 1. Notify Provider/Treatment Ordered 2. Notify resident representative 3. Initiate Skin and Wound Evaluation 4. Notify Nurse Manager/Wound Nurse 5. Review and update care plan including interventions. 6. Update resident care lists 7. Update Care Plan to identify risks for skin breakdown For Ongoing Skin Issues directed to update provider and resident/representatives as needed and update Care Plan as needed. The facility policy titled Wound Care Treatment Procedure revised 2/2024 directed that wound care is essential to ensure that our residents wounds (skin tears, lacerations, surgical incisions, pressure ulcerations, venous/arterial, diabetic ulceration, etc.) are being taken care of properlypost dressing change if there are any changes noted to the residents wound appearance, pain, ability to tolerate the dressing	F 684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245507	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/29/2024
NAME OF PROVIDER OR SUPPLIER HILLCREST CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 714 SOUTHBEND AVENUE MANKATO, MN 56001		
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F 684	Continued From page 29 change, or resident refusal; notify the provider immediately to collaborate on a new plan of care/treatment.	F 684			

Minnesota Department of Health

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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 3/26/24, 3/27/24, 3/28/24, and 3/29/24, 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 orders were issued. Please indicate in your electronic plan of correction you have	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

04/25/24

Minnesota Department of Health

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2 000	Continued From page 1 reviewed these orders and identify the date when they will be completed. The following complaints were reviewed. H55072346C (MN00096558) and H55073221C (MN00096558) with a licensing order issued at 0830 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 evidenced by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000			

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to accurately reflect the individual need of each resident discussed above. It could also address other residents that may be at risk for the same concern. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. Random audits for an amount of time determined by the quality assessment and performance improvement (QAPI) committee could ensure compliance. The administrator, DON, or designee could then take that information back to QAPI to assess need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 000			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out	2 830			5/1/24

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2 830	Continued From page 3 of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to initiate, comprehensively assess, monitor, and treat skin conditions for 4 of 4 residents (R2, R3, R4, and R5) reviewed for impaired skin integrity. R2's face sheet undated identified an admission date of 7/2021. Diagnoses morbid obesity (obesity categorized by a body mass index greater than 40), type 2 diabetes, urinary incontinence, and erythema intertrigo (inflammatory skin condition caused by skin-to-skin friction (rubbing) that is intensified by heat and moisture). R2's Minimum Data Set (MDS) dated 3/7/24, identified R2 needed maximum assistance with movement and complete dependence with toileting. R2 used a motorized wheelchair. R2's current care plan identified an alteration in skin integrity with a goal to remain free of skin breakdown. Interventions included: followed by wound care, monitor skin integrity daily during cares, weekly skin inspection by nurse, treatment to open areas per order, turn and reposition or reminders to offload every 2-3 hours and as needed, pressure redistribution cushion to wheelchair and chair, weekly measurements and assessment of wound, monitor for skin	2 830	corrected		

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2 830	Continued From page 4 breakdown for signs/symptoms of infection and report to doctor, document on skin condition and keep doctor informed of changes. R2's December orders identified skin care of buttocks and posterior thighs to gently cleanse skin with warm washcloth and soap if resident will allow and pat dry. Apply a thin layer of triad hydrophilic wound paste twice daily and as needed alternating with calmoseptine twice daily and as needed two times daily for skin care from 11/30/23-12/13/23 and from 12/14/23-12/20/23. Additionally, and as needed (PRN) order to apply a Mepilex (soft, silicone foam dressing for wounds) to right inner thigh for multiple raw skin irritations every three days, replace PRN. Discontinue when healed began 10/30/23 and discontinued 12/22/23. R2's treatment administration record (TAR) identified the aforementioned treatments were not completed on 12/6/23, and 12/20/23. R2's Occupational Therapy (OT) notes from 12/4/23-1/2/24 identified wheelchair dependence and EZ stand for transfers (mechanical lift that assists caregivers to move a resident from sitting to standing and from one place to another with the resident not using 100% of their body strength). Baseline objectives on 12/4/24 identified that between the scooter and recliner R2 can only sit one hour, extremely uncomfortable, putting pressure on wound without noticing it. Relies on pain level to get out of scooter. R2 does not understand why sitting in scooter hurts so much, does not want to recline self when in recliner, and a poor overall awareness of positioning needs and pressure relief for healing of wounds. R2's reason for referral identified that R2 had a new blister/wound	2 830			

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2 830	Continued From page 5 in right (r) crease of buttock, sliding in the scooter and inability to reposition self without shearing due to (d/t) decrease in upper body strength, and a recommendation for a pressure reduction device for the recliner as R2 only sleeps in a recliner. Current recliner 28" wide, 28" depth; current scooter 18" depth, can be 21" if reclined seat, 24" wide. Current scooter does not fit R2's body size, especially depth. OT goal is R2 can sit in scooter without pain. Discharge short term goals on 1/2/24 identified R2 is now able to sit several hours a day in scooter, changes position while sitting from hip to the other, denied pain, and is aware of pressure put on wounds and with new padding and pressure relief, met this goal. Long term goal met 1/2/24 identified that R2 can request to be transferred into recliner, staff is able to position R2 more in back of the seat for better positioning, R2 is aware of wounds and able to request staff to reposition and not put pressure directly on wound. R2's current orders included Triad hydrophilic wound dress external paste to apply to right posterior thigh topically one time a day every Monday, Wednesday, and Friday for wound care beginning 12/29/23. Additionally, for skin care of posterior right thigh: gently cleanse skin with warm wash cloth and soap if resident will allow, pat dry; apply a THIN layer of Triad hydrophilic wound paste over affected skin followed by a large border foam dressing; change every three days and PRN one time a day. R2's TAR identified the aforementioned treatment was not completed on 12/21/23, 12/30/23, 1/2/24, 2/7/24, 2/10/24, 2/16/24, 2/25/24, and 3/5/24. R2's weekly skin inspection by licensed nurses on the summary of current skin conditions identified:	2 830			

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2 830	Continued From page 6 -12/12/23 right (R) thigh red and open, small amount of bleeding noted. -12/19/23 open area on R) inner thigh improving, R2 reports decreased pain. -12/26/23 R) thigh dressing intact. -1/2/24 no changes. -1/9/24 wound on R) thigh unchanged. -1/16/24 no documentation of R) thigh wound. -1/23/24-refused shower, no skin assessment completed. -1/30/24 no new skin condition. -2/6/24 wound on R) thigh, posteriors. Unchanged. -2/20/24 no changes to skin. -3/5/24 red on R) posterior thigh. 3/12/24 thighs just below buttocks are tender and Mepilex applied. Put on the list for wound nurse. 3/19/24 no documentation of R) posterior thigh. No weekly skin assessments completed by licensed nursing staff on 2/13/24, 2/27/24, and 3/26/24. R2's progress note (PN) dated 10/3/23 indicated R2 came to the desk in tears stating she had a sore area to her bottom and thighs. Noted two pinpoint reddened areas to inner R) buttocks, and five pinpoint open areas scattered to area of inner R) thigh. A Mepilex was placed to inner R) thigh. R2's PN dated 10/21/23 indicated to place Mepilex to R) inner thigh for multiple raw skin irritations every three days, replace PRN. Discontinue when healed. Replaced dressing for comfort. Not open. R2's PN dated 11/20/23 indicated mepilex to R) inner thigh replaced effectively. R2's PN dated 11/24/23 an open area to R)	2 830			

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2 830	Continued From page 7 crease of buttocks and a mepilex applied to both sides. Put in provider book and report given to oncoming nurse. R2's Skin and Wound Evaluation V7.0 dated 12/13/23, identified location R) medial thigh, middle with wound measurements of area 10 cm2, length 4.8cm and width 2.6cm. In red lettering it stated Note: wound is not open per CNP notes on 12/13/23. Measurements are incorrect. Resolved. R2's Extended Care Visit Note dated 12/13/23, identified at last visit resident reporting that her posterior right thigh is very painful. Reports she has been sitting in her recliner more because after 10 minutes or so in her wheelchair she wants to pass out from the pain in her thigh. The degree of breakdown in her skin is difficult to assess today due to the thick layer of paste over the area. Area is tender and would require the paste to be softened up by soaking the area. Resident reports that she could not take a shower yesterday because sitting on the shower chair hurts too much. Today, reports that pain is slightly less but she continues to notice some blood on pad in the morning that covers her recliner. She is concerned about getting an infection in that area. The area of concern is located on the right leg (posterior R) thigh). The last clinic visit was 1 week ago. The patient is currently experiencing symptoms which include pain. The patient describes the pain as tenderness. Exacerbating factors include chronic friction, chronic trauma, and chronic moisture. Current treatment includes daily skin care. Due to having an electric wheelchair does not have a pressure reduction cushion in wheelchair. Posterior R) thigh looks improved without signs/symptoms (s/s) of bleeding. No evidence of open or draining skin.	2 830			

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2 830	Continued From page 8 Area continues to be tender per resident report. Follow up in 1 week. Orders for skin care of (B) buttocks and posterior thighs: gently cleanse skin with warm wash cloth and soap if resident will allow, pat dry. Apply a THIN layer of triad hydrophilic wound paste twice daily and PRN alternating with Calmoseptine twice daily and PRN. Recommendations that in order for residents' skin of buttocks and thighs to heal, resident needs to get the pressure off of them. This is difficult given that she does not want to lay down in a bed and is constantly sitting on them in addition to friction/shearing forces that happen when she slides in chair or tries to reposition self and does not completely lift skin off the surface she is sitting on due to her body habitus and poor upper extremity strength. Also, brought up that the electric wheelchair appears to be getting too small for her and could be the cause of some of her skin problems if the seat is not deep enough. Resident frequently has to push her weight back for repositioning when she starts to feel to forward. Resident disagrees and feels that her wheelchair is large enough. R2's PN dated 12/18/23 indicated nutrition follow-up related to (r/t) wound. Resident has a friction injury on R) posterior thigh. Resident refused protein supplements, staff continue to encourage protein intake at meals. R2's Extended Care Visit note dated 12/19/23, identified posterior R) thigh looks to have partial thickness skin loss near the medial edge of the friction injury. Area continues to be tender per resident report. Orders changed to skin care of posterior R) thigh-d/c all previous wound care orders! Gently cleanse skin with warm wash cloth and soap if resident will allow, pat dry. Apply a THIN layer of Triad Hydrophilic Wound Paste	2 830			

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2 830	Continued From page 9 over affected skin followed by a large border foam dressing. Change every 3 days and as needed. New recommendations that resident does not want a wheelchair evaluation for evaluation for a larger wheelchair. Current wheelchair appears to be getting too small for her and could be the cause of some of her skin problems if the seat is not deep enough. Resident frequently has to push her weight back for repositioning when she starts to feel too forward. Resident disagrees and feels that her wheelchair is large enough. Turn and reposition/offload at least every 2 hours or as indicated on Tissue Tolerance Evaluation if interval is more frequent. Resident will need assistance with major repositioning changes since she is unable to do this on her own. Follow up in one week to re-evaluate per facility request. No measurements done. R2's PN dated 12/31/23 indicated R2 complained of upper thigh pain under buttocks. Skin is dry and irritated. Skin cleansed and barrier cream applied. Pillow offered to help offload from bottom, patient refused. R2's PN dated 1/22/24 indicated nutrition follow-up r/t wound. Resident has an ongoing friction injury on R) posterior thigh. R2's PN dated 2/22/24, indicated skin care of posterior R) thigh cleaned and treated as ordered. Area of skin is rough and sore in it. R2's Skin and Wound Evaluation V7.0 dated 3/28/24, identified R) medial thigh, new wound-minutes old, in-house acquired friction. Area 0.24cm2, length 1.4cm and width 0.47cm. Granulation (small red granules of new capillaries on a wound surface) 100%, surrounding tissue	2 830			

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2 830	Continued From page 10 with erythema (superficial reddening of the skin as a result of injury or irritation causing dilatation of the blood capillaries). Treatment included normal saline, triad with no secondary dressing. Additional care included cushion, incontinence management, moisture barrier and turning/repositioning program, added to weekly wound rounds for next week. Notified dietician, practitioner, and resident/responsible party. On 3/26/24 at 12:28 p.m., R2 was laying in her recliner. "I have a little wound on the side of my right thigh, but they are taking care of it.", "I prefer to sleep in my recliner, it makes a beautiful bed, I sleep in it perfectly." R2 demonstrated how to raise and lower the recliner. No bed in room. No pressure reduction cushions in recliner or electric wheelchair. During an interview on 3/26/24 at 2:34 p.m., nursing assistant (NA)-A and NA-B indicated that there were usually two staff working on R2's hall and that there were 23 rooms on that hall. They get the information to care for the residents from the care plan and toileting and care sheets. NA-A indicated that it did make it harder to get cares done if there was only one staff member working the hall. On 3/27/24 from 7:32 A.M. to 10:35 A.M., observed wound care rounds with CNP and LPNMC. Wound care and observation were not performed on R2. On 3/28/24 at 10:41 A.M, CNC verified there were no measurements included in the 12/27/24 skin and wound assessment and that skin assessments had not been completed weekly. On 3/28/24 at 11:06 A.M., R2 was using the	2 830			

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2 830	Continued From page 11 commode with NA-D in room. R2 stated "I've had the wound on my inner R) thigh for a long, long time. If they put a bandage on it, its ok." R2 stated "last night it hurt so bad they came in and put stuff on it." R2 continued "It's been a long time since I've seen [CNP]." NA-D stated that R2 had this wound for a while and "they try so many creams, mepilex and it seems to get a little better and then it gets worse, it is worse now." There was no pressure reduction cushion in the wheelchair or the recliner. DON came in and observed the wound and verified that there was no pressure reduction cushion in the wheelchair or the recliner. On 3/28/24 at 2:42 P.M., R2 was observed for wound care. DON took barrier cream out of R2's drawer. NA-C and R2 verified that was the cream that has been applied to R) posterior thigh, not the triad paste. DON educated R2 and NA-C the barrier cream was not what the order says to use and that they were to be using triad paste. DON left room. R2 was on the commode with a washcloth placed on the R) side front of the commode. NA-C stated it was per R2's request so it did not hurt so much. No pressure reduction cushion in the recliner or wheelchair, a chux pad (for urinary incontinence) was on the wheelchair. NA-C stated that the pressure reduction cushion for R2 was over by the nurse's station drying because they just got it and "I used the purple wipes on it". DON returned with a tube of triad paste. DON did not date the triad upon opening it. NA-C stood R2 with the EZ-stand and DON used a piece of gauze and wiped the R) posterior thigh with sterile water. R2 stated "my left side is starting to get one". DON stated that there were two little areas of red, superficial, no slough, no drainage, and no redness around it. R2 stated "It bleeds at night and the chux has blood in it". DON	2 830			

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2 830	Continued From page 12 applied triad paste, no foam dressing over. R2 stated "I'm starting to get one on the other side [DON], it hurt over there." DON did not assess or acknowledge R2's comments. During a phone interview on 3/27/24 at 1:23 P.M., Family member (FM)-A stated family had not been notified about R2's R) posterior thigh wound and they were also not aware of the wheelchair being too small. FM-A stated they put a new seat cushion on R2's power wheelchair with a seat cushion. During a phone interview on 3/29/24 at 9:43 A.M., CNP stated that R2's assessment from 12/27/23 indicated that the R) posterior thigh had a skin loss and to follow up in one week. CNP unsure what happened that R2 dropped off the schedule when she was supposed to continue to be seen. CNP stated that facility staff were to keep her informed if a wound reopens so that the treatment can be changed. If something was open and not healing in 2-4 weeks, the treatment should be changed. R3's face sheet undated identified R3 admitted on 1/31/24. Diagnoses included adult failure to thrive, dementia (loss of memory), type 2 diabetes, stage 1 pressure ulcer of right upper back, pressure ulcer of other site, pressure ulcer of other site unstageable, Alzheimer's (brain disorder that causes problems with memory, thinking and behavior). R3's care plan identified an alteration in skin integrity with current pressure ulcers left (L) lateral knee. Interventions included to put pillows between knees when in bed, resident to wear heel lift boots at all times, monitor skin integrity daily during cares and weekly skin inspection by	2 830			

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2 830	Continued From page 13 nurse. Treatment to open areas per order, pressure redistribution cushion to wheelchair and chair, low air loss air bed, weekly measurements, and assessment of wound. R3's Admission date collection form dated 1/31/24, identified no amputations and pedal pulses present in both feet. Wounds included the L) scapula 3cm x 2.5cm, right knee front 1cm x 0.5cm, right ankle outer 1.5cm x 0.5cm, left ankle outer 0.7cm. Skin comments identified small scabs on ankles, sores in the process of healing, both knees still open a small size. Back has a healing older red mark. Mepilex applied as directed. R3's weekly skin inspection by licensed nurses on the summary of current skin conditions identified: -2/7/24 R3 had several foam mepilex to bilateral lower extremities (BLE) that were just changed this morning. Foams left in place and remain intact. -2/14/24 wound care dressings in place from wound nurse today. -3/6/24 skin breakdown on left lateral knee, right ankle, and front of right knee. All already noted by wound care and addressed. -3/13/24 mepilex on knees bilaterally and ankle did not need changing. Stayed clean and dry during bathing. R3's weekly Skin and Wound Evaluation V7.0 with sections available to mark the description of wound, location, where acquired, how long the wound has been present, staging, measurements, description of the wound bed,	2 830			

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2 830	Continued From page 14 other issues including bleeding, bone, fibrin, gangrene, hematoma, hypergranulated, intact blister, islands of epithelium, pink/red, ruptured blister, scab, other, amount of exudate, odor, periwound, induration, edema, periwound temperature, wound pain, goal of care; treatment which included dressing appearance, cleansing solution, debridement, primary dressing, secondary dressing, modalities, additional care; progress, infection, notes, education, and notifications. These assessments were completed on and included the following information: -2/7/24 unknown location of pressure measured 1cm x 0.6cm. Physician note dated 2/7/24, identified R) ankle unstageable ulcer measured 0.97cm x 0.62cm x 0.1cm and had minimal drainage and 100% devitalized tissue. L) lateral knee unstageable ulcer measured 0.91cm x 0.81cm x 0.1cm and had 100% devitalized tissue. The surrounding tissue was noted to have erythema but no increased warmth. Wound care ordered to L) lateral knee: cleanse wound bed with wound cleanser. Treat periwound with skin barrier prep. Apply medihoney to the wound bed. Cover with mepilex, ok to reinforce with tape as needed, recommend to use cast padding and coban with no compression in attempt to keep dressing in place, change every 3 days, sooner if greater than 50% saturated. R) lateral knee: cleanse wound bed with wound cleanser, treat periwound with skin barrier prep, apply medihoney to the wound bed, cover with mepilex and okay to reinforce with tape as needed-recommend use of cast padding and coban with no compression in attempt to keep dressing in place. change every 3 days, sooner if greater than 50% saturated.	2 830			

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2 830	Continued From page 15 Recommendations included heel lift boots on in bed, turn and reposition at least every 2 hours, air overlay or other specialty mattress if available due to high risk for pressure sore development, cushion in wheelchair at all times, follow up in one week. Resolved scapula wound. -2/14/24 R) lateral malleolus measured 1cm x 0.7cm. -2/20/24 R) lateral malleolus measured 0.8cm x 0.5cm, front R) knee stage 2 pressure injury no measurement-resolved. -2/28/24 R) lateral malleolus measured 0.8cm x 0.5cm-see Certified Nurse Practitioner (CNP) note from 2/28/24. Physician note dated 2/28/24, identified R) ankle measured 0.52cm x 0.82cm. the wound had decreased in size and noted to be dry, brown scab. Dry and 100% devitalized tissue. L) lateral knee measured 0.47 x 0.43 x 0.1cm with 100% granular tissue and a decrease in size. R) lateral knee measured 0.85 x 1.24 x 0.1cm depth and noted to be 100% granular tissue. The surrounding tissue noted to have erythema. Wound orders to knees were to cleanse wound and surrounding skin with normal saline or wound cleanser and pat dry, apply skin prep to periwound skin and allow to dry, apply a dab of iodosorb gel to wound beds, cover with border foam dressing and change every other day and as needed. R) lateral ankle cleanse wound and surrounding skin with normal saline or wound cleanser and pat dry, paint with betadine and allow to dry, cover with border foam dressing and change every other day and as needed. -3/6/24 R) lateral malleolus measured 1.5cm x	2 830			

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2 830	Continued From page 16 0.8cm-see CNP note. Front R) knee 1.4cm x 0.9cm status resolved. -3/13/24 R) lateral malleolus measured 1.3cm x 0.6cm-see CNP note, L) above knee amputation site measured 1.4cm x 1cm-see CNP note. Physician note dated 3/13/24, identified R) ankle measured 1.32cm x 0.56cm, the wound had decreased in size, noted to have red discoloration and dry. L) proximal lateral knee ulcer measured 0.98cm x 1.37cm x 0.1cm with moderate drainage and 100% devitalized tissue. L) distal lateral knee ulcer measured 1.39cm x 0.79 cm x 0.1cm and had moderate drainage and 50% granular and 50% devitalized tissue. Ordered for L) lateral knee to cleanse with wound cleanser, apply skin prep to periwound skin, apply cut to fit calcium alginate to wound bed, cover with border foam dressing and change every other day and PRN. R) lateral ankle-no changes, R) lateral knee cleanse wound and surrounding skin and pat dry, cover with border foam dressing for protection, change every 3 days and PRN. -3/18/24 R) lateral malleolus measured 1.7cm x 1.1cm status marked resolved, L) above knee amputation site 1.3cm x 0.8cm, L) shin medial measured 0.8cm x 0.6cm status marked stable. Physician note dated 3/18/24, identified R) ankle unstageable ulcer measured 1.72cm x 1.07cm. cleansed with saline. The wound has increased in size and had red discoloration and was dry. L) proximal lateral knee unstageable ulcer measured 0.81cm x 0.59cm. minimal amount of drainage and had 100% devitalized tissue with intact margins. L) distal knee unstageable ulcer measured 1.33cm x 0.77cm and noted to be 50% granular and 50% devitalized tissue. The	2 830			

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2 830	Continued From page 17 surrounding skin was noted to have induration. Continue dressing leg wounds as ordered. -3/22/24 front L) knee lateral measured 3.2cm x 0.9cm status resolved. -3/27/24 description of wound is pressure. Location is left above knee amputation site. Wound measured 0.6cm x 0.4cm. Granulation tissue in wound bed 100%. Progress was improving-see CNP note. Physician note dated 3/27/24, identified R) ankle measured 0.8cm x 2cm and had red discoloration and was dry. L) proximal lateral knee measured approximately 0.2cm x 0.2cm x <0.1cm. The wound had decreased in size. Scant drainage after removal of devitalized tissue wound was 100% granular. L) distal knee resolved. Wound order to L) lateral knee to cleanse open wound and surrounding skin with cleanser, paint with betadine and allow to dry, cover with bordered foam and change every other day and PRN. R) lateral ankle cleanse wound and surrounding skin, cover with border foam for protection, change every 3 days and PRN. On 3/26/24 at 3:46 P.M., R3 was not in room. Bed was unmade. TAR wound care was not signed out. On 3/27/24 at 10:22 A.M., R3 was laying in bed with a second mattress on the floor next to the bed. Air mattress was on the bed. Fall mat was tucked into the wall side of the bed. Body pillow was against the wall. Two pillows were tucked under the fitted sheet of the mattress on the outside of the bed. R3 is not wearing heel lift boots and there are no pillows between the legs. LPN-A stated "it's a body pillow, I know they aren't	2 830			

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2 830	Continued From page 18 supposed to be under the sheet. I'll make sure to re-educate the aides." CNP stated R3's sheet is wet and smelled of urine. CNP, LPNMC, and LPN-A removed the four corners of the fitted sheet to aid in repositioning R3 and for the aides to change the sheet. CNP kept the heel protectors off since R3 needed a clothing change but stated "I worry how long he'll be without his boots?" CNP turned call light on, and they left the room. On 3/27/24 at 10:35 A.M., NA-E stated the front pillow is so R3 doesn't crawl out of bed. R3 was lying in a fetal position on his right side. NA-E and NA-D applied the four corners of the bed sheet back to the mattress. NA-E and NA-D changed R3's brief and pants. NA-E and NA-D did not apply heel protectors or place a pillow between his knees. On 3/27/24 at 11:14 A.M., NA-E and NA-D assisted R3 to his wheelchair. At 11:19 A.M., R3 was in the hallway with heel protectors. On 3/27/24 at 1:01 P.M., R3 was lying in bed. Heel boots off, secondary mattress on floor, no pillow between his knees. During an interview on 3/27/24at 1:15 P.M., LPN-A verified R3 did not have heel protectors on, a pillow was not between his knees. LPN-A stated, "I'm sorry, it's disheartening, he is supposed to have the heel boots on at all times and the pillow between his legs." LPN-A verified that care sheets are located in the closet door, so staff know what cares need to be done. R4's face sheet identified an admission date of 10/23. Diagnoses included cellulitis (bacterial infection of the skin), peripheral vascular disease	2 830			

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2 830	Continued From page 19 (blood circulation disorder), non-pressure chronic ulcer of lower leg, L) leg above knee amputation, methicillin resistant staphylococcus aureus (infection caused by specific bacteria that are resistant to commonly used antibiotics). R4's care plan identified alteration in skin integrity with interventions to monitor skin daily during cares and weekly inspection by nurse, turn and reposition with offloading every 2-3 hours and PRN, pressure redistribution mattress to bed, pressure redistribution cushion to wheelchair and chair, monitor for skin breakdown and document on skin condition and report to doctor. R4's weekly skin inspection by licensed nurses on the summary of current skin conditions identified: -12/24/23 R) leg was wrapped and covered for shower, unable to see wounds. R4's weekly Skin and Wound Evaluation V7.0 with sections available to mark the description of wound, location, where acquired, how long the wound has been present, staging, measurements, description of the wound bed, other issues including bleeding, bone, fibrin, gangrene, hematoma, hypergranulated, intact blister, islands of epithelium, pink/red, ruptured blister, scab, other, amount of exudate, odor, periwound, induration, edema, periwound temperature, wound pain, goal of care; treatment which included dressing appearance, cleansing solution, debridement, primary dressing, secondary dressing, modalities, additional care; progress, infection, notes, education, and notifications. These assessments were completed on and included the following information:	2 830			

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2 830	Continued From page 20 -1/16/24 front right lateral lower leg 4.1cm x 3cm progress marked stable. See Certified Nurse Practitioner (CNP) notes. No CNP note for 1/16/24. -1/24/24 front right lateral lower leg 2.8cm x 1.8cm progress marked improving. -1/31/24 front right lateral lower leg 2.5cm x 1.3cm. See orders from CNP. Physician note dated 1/31/24, identified R) lower extremity mid-tibial wound had decreased in size, had moderate drainage, 10% granular and 90% devitalized tissue with margins intact. Distal to wound was skin loss due to moisture. R) dorsal foot wound resolved. Medial distal R) foot dorsal surface resolved. -2/7/24 front right lateral lower leg 2cm x 1.4cm Progress improving. See CNP dictation. Physician note dated 2/7/24, identified R) lower extremity mid-tibial wound had moderate drainage, and was 20% granular and 80% devitalized tissue. -2/14/24 front right lateral lower leg 1.5cm x 0.9cm granulation marked 100% of wound filled. Moderate amount of drainage. No odor. Attached edges. Surrounding skin dry and flaky. No swelling, edema, or induration. Periwound normal. Progress improving. See CNP note. Physician note dated 2/14/24, identified R) lower extremity mid-tibial wound decreased in size, moderate drainage and 100% granular. -2/23/24 front right lateral lower leg 1/1cm x 0.8cm progress marked improving. See CNP notes. No notes from physician visit. -2/28/24 front right lateral lower leg 1.3cm x	2 830			

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2 830	Continued From page 21 1.2cm progress marked improving. See CNP notes. Physician note dated 2/28/24, identified R) lower extremity mid-tibial wound appeared smaller, had serosanguineous drainage and was 100% granular with blistering skin surrounding wound. -3/6/24 front right lateral lower leg 0.7cm x 0.6cm, progress marked improving. See CNP notes. R4's Physician note dated 3/6/24 identified a new ulceration on R) lower extremity partially circumferential and distal to primary wound. Wound measured 5.98cm x 3.09cm x 0.1cm. Margins were intact, 100% granulation tissue and minimal amount of drainage. R) lower extremity mid-tibial wound had minimal drainage and 100% granular with blistering surrounding wound. -3/13/24 front right lateral lower leg not measured-see CNP note. Physician note dated 3/13/24, identified R) lower extremity mid-tibial wound resolved. R) lower extremity blistering ulceration approximated measurement 5.66cm x 2.48cm x 0.1cm and had decreased in size, had minimal drainage and 100% granular with intact margins. -Physician note dated 3/20/24 identified the wound was almost completely healed at this time. No assessment or measurements included in note. R4's TAR for March 2024 identified acetic acid, collagenase ointment, xerofoam with hydrofera blue, R) lower extremity dressings, rooke vascular boots, and tubigrips on leg treatments not completed on 3/12/24.	2 830			

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2 830	Continued From page 22 On 3/27/24 at 8:07 A.M., CNP and LPNMC assessed R4's wound. R4 had an open, undated package of xeroform dressing in container of wound supplies. LPNMC stated it is common practice at the facility to reuse opened dressings. LPNMC threw away the opened dressing. CNP stated wound is a venous/mixed arterial ulcer on the front of R) shin that appeared as an upside-down rainbow in shape. R5's face sheet identified admission date of 2/24. Diagnoses anemia (deficiency of red blood cells), peripheral vascular disease (slow and progressive disorder of blood vessels), hemiparesis (one sided muscle weakness), occlusion of R) artery with stenosis (narrow or blockage of artery), tobacco use, R) knee prepatellar bursitis (inflammation of the bursa located within the kneecap). -2/13/24 admission assessment: right knee surgical incision, no measurements, skin tear o.4 x o.1 cm left forearm, skin tear 0.2 cm x 0.1 cm left forearm R5's admission assessment dated 2/13/24, identified Resident's skin is without blemish. Right knee was operated upon to clean out pus that pooled in a hole in his knee following an accidental fall. Resident is alert and oriented x3. Has both upper and lower dentures. He is assist of 1 with pivot for transfers. Sustained an unwitnessed skin tear to lateral left forearm shortly after admission. Site of Mantoux administration bled out shortly after administration. These new areas were cleansed and covered up with island dressings. Resident did not want dressing covering knee wound to be taken off so - not yet assessed. Nurse at Abbot north western reports that no dressing changes	2 830			

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2 830	Continued From page 23 necessary for right knee until resident's follow up appointment with ortho. R5's weekly skin inspection by licensed nurses on the summary of current skin conditions identified: -2/15/24 Skin is clear, dry and intact with the exception of skin tears on left forearm and surgical incision on right knee. -2/22/24 Skin shows minor small bruising on his arms. Wounds on his right knee. Treated. -3/6/24 Right knee surgical incision covered with wound vac dressing and also wrapped before shower. Other skin appears clean, dry and intact. Generalized bruising on bilateral upper extremities. -3/13/24 R knee surgical site not visualized, covered with wound vac. Otherwise rest of the skin is clean, dry and intact. -3/27/24 refused shower dressing intact Weekly skin assessments not completed on skin tears to L) forearm. R5's readmission from hospital on 3/21/24, identified a new pressure injury to left (L) heel. Readmission assessment included documentation on L) heel but did not include documentation of R) knee prepatellar bursitis which included a wound vac. No measurements for either wound included in document. R5's physician note dated 3/28/24, identified wound care to L) heel -Cleanse wound and surrounding skin with wound cleanser, pat dry -Apply skin prep to periwound skin and allow to	2 830			

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2 830	Continued From page 24 dry -Apply a 50/50 mixture of Iodosorb gel with Hydrogel on a dry 2x2 gauze -Apply this gauze directly to the ulceration on heel -Cover with border foam dressing (do not cut foam dressing) -Change every other day and as needed. Rooke boots on at all times. wound care to R) knee -Cleanse wound with NS or wound cleanser, pat dry -Apply skin prep to periwound skin and allow to dry -Cover wound bed with Adaptic cut to fit into wound bed -Apply a nickel thick layer of Hydrogel over the Adaptic -Cover with ABD pad -Secure with Kerlix and tape -Further secure with Tubigrip to hold in place -Change twice daily and as needed. If wound is drying out before next change, increase changes to three times a day. R5's care plan did not address either wound for care or treatment. On 3/27/24 at 9:01 A.M., R5 laying in bed. CNP, LPNMC, and LPN-B in room. R5's wound vac tubing was pulled from being stuck on wheelchair. Lambs wool boots on bilateral legs. Wound vac dressing labeled 2 is open and half the size of the other one and undated. Wound vac is on R) knee. Two sheets of wound vac dressings were opened in the package and undated. CNP and LPNMC verified that the dressings should not have been out and used and that they should be disposed of after cutting them for the initial use. Iodosorb and hydrogel containers are opened, unlabeled and undated in R5's wound container. CNP stated "I told them two weeks ago to call the surgeon because there wasn't a lot of drainage. It could benefit from the white foam instead of the gray foam." CNP changed dressing to R) knee. LPN-B stated the R) knee was the only wound and left the room. R5 stated he had a wound on his L) heel from hitting the metal holder for the foot pedals on his wheelchair. R5 stated the	2 830			

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2 830	Continued From page 25 wound had been present for approximately one week. The L) heel mepilex was cut almost all the way in half. CNP stated that defeats the purpose of the mepilex. L) heel wound was tender and dry skin on the side of it. R5 stated "I was just climbing out of bed when it happened. The wound measured 2cm x 2cm x 1.2cm. During the dressing change R5 stated "the stuff they put on big time burns me on my heel. I tell them when I am in pain, they don't give me enough. I can tell." Pressure relief cushion in wheelchair is visibly soiled with white spots and spill stains. During an interview on 3/28/24 at 11:50 A.M., with Administrator, DON and CNC it was stated that the nurse managers are responsible for the weekly wound assessments. This is completed on the skin and wound app. This will automatically populate onto a form that is in the medical record. The measurements are auto measured by a picture. In order for the assessment to go to the medical record it must be locked. DON audits the process. Skin is talked about in our morning meeting that includes nurse leaders, social workers, dietary, therapy, therapeutic recreation and administration staff. Not all wounds are documented in Point Click Care (PCC), only significant wounds. Not every wound would have a picture or an evaluation in PCC through the skin and wound form. CNC stated that "if a pressure ulcer of a significant wound, we don't have a specific significant wound, use nursing judgement but if it is large, skin tear, non-healing, dehiscing, you look at it and it doesn't look right. Little tiny skin tears or nothing significant about it. Its not a significant concern to take a pic to see at each point in the game. If we were to take a pic of every little thing on a person we would not be able to do any other patient care." DON stated that a new superficial	2 830			

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2 830	Continued From page 26 wound the provider would be updated and the resident would be put on the wound round list for the following week, family updated, care plan updated and any other discipline that would be involved would be updated. CNC stated that they do not do a Tissue Tolerance Test but a skin evaluation and risk factors which is done on admission, annually, with a significant change and new significant wounds. During a phone interview on 3/29/24 at 9:28 A.M., MD stated that wounds and skin assessments should be conducted weekly by licensed nursing staff. During a phone interview on 3/29/24 at 9:43 A.M., CNP stated that wounds are to be comprehensively assessed weekly and skin assessments done weekly by licensed nursing staff. During an interview on 3/29/24 at 12:25 P.M., with Administrator, DON and AIT, DON stated it is the facility policy for the staff to do the skin and wound evaluations weekly, and dressings to be completed as directed by the written orders. Administrator stated that if there is a resident that CNP no longer needed to follow, she would give recommendations on what would be done for prevention. Interdisciplinary Team (IDT) would watch for another week by discussion during meeting and through interviews with floor staff, evaluations, and progress notes. Daily IDT minutes Clinical Portion, undated, review from the dates 12/11/23-3/29/24, document identified the following were discussed during daily clinical meeting. Area of concern is listed, further detail is discussed. This form summarizes the requested residents skin areas	2 830			

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2 830	Continued From page 27 of discussion: -R2 wounds addressed were legs and bottom on dates 12/11/23-12/14/23, 3/29/23. -R3's wounds addressed were knees, ankles, R) shoulder on dates 1/31/24-3/29/24. -R4's wounds addressed were R) lower extremity ulcers on 12/11/23-3/29/24. -R5's wounds addressed were R) knee incision 2/13/24-3/29/24 and L) heel 3/29/24. Policies The facilities Skin Assessment & Wound Management policy revised 3/2024 directed guidelines for assessing and monitoring wounds for Prevention and Identification: Non-Pressure Wounds and Altered Skin Integrity with a New Skin Problem when a significant alteration in skin integrity is noted; (i.e., large, or multiple bruising, large skin tear, or other non-pressure related wounds such as diabetic, venous, or arterial ulcers), the following actions will be taken: 1. Notify Provider/Treatment Ordered 2. Notify resident representative 3. Initiate Skin and Wound Evaluation 4. Notify Nurse Manager/Wound Nurse 5. Review and update care plan including interventions. 6. Update resident care lists 7. Update Care Plan to identify risks for skin breakdown For Ongoing Skin Issues directed to update provider and resident/representatives as needed and update Care Plan as needed. The facility policy titled Wound Care Treatment Procedure revised 2/2024 directed that wound care is essential to ensure that our residents wounds (skin tears, lacerations, surgical	2 830			

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2 830	Continued From page 28 incisions, pressure ulcerations, venous/arterial, diabetic ulceration, etc.) are being taken care of properlypost dressing change if there are any changes noted to the residents wound appearance, pain, ability to tolerate the dressing change, or resident refusal; notify the provider immediately to collaborate on a new plan of care/treatment. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for impaired skin integrity to assure they are receiving the necessary treatment/services The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830			