DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 24, 2020

Administrator
Littlefork Medical Center
912 Main Street
Littlefork, MN 56653

RE: CCN: 245542
Cycle Start Date: November 6, 2020

Dear Administrator:

On December 3, 2020, we notified you a remedy was imposed. On December 17, 2020 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 16, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 18, 2020 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 3, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 18, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 16, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 24, 2020

Administrator
Littlefork Medical Center
912 Main Street
Littlefork, MN 56653

Re: Reinspection Results
Event ID: N3XY12

Dear Administrator:

On December 17, 2020 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 November 6, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sincerely,

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

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Electronically delivered
December 3, 2020

Administrator
Littlefork Medical Center
912 Main Street
Littlefork, MN 56653

RE: CCN: 245542
Cycle Start Date: November 6, 2020

Dear Administrator:

On November 6, 2020, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 18, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 18, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 18, 2020.

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 18, 202, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Littlefork Medical Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 18, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.
However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care

deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 6, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING _____ B. WING _____	C 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK MEDICAL CENTER	**912 MAIN STREET LITTLEFORK, MN 56653**

(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 11/2/20 through 11/6/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5542024C with a deficiency cited at F686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		12/16/20

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

Electronically Signed | 12/08/2020

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F 686	Continued From page 1 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess facility acquired pressure ulcers and provide consistent weekly pressure ulcer monitoring for 2 of 3 residents (R1, R2) reviewed for pressure ulcers. In addition, the facility failed to identify and implement new and timely interventions to promote the healing of pressure ulcer(s) for R1. This caused actual harm to R1 whose stage 2 left buttock pressure ulcer worsened to an unstageable pressure ulcer and acquired a second pressure ulcer. Findings include: R1's quarterly Minimum Data Set (MDS) dated 9/1/20, identified R1 was cognitively intact and required limited assistance with bed mobility and transfers. The MDS included diagnoses of cancer, generalized muscle weakness, and chronic pain. R1 had no symptoms of psychosis or behavioral symptoms and exhibited no rejection of care. Further, the MDS identified R1 had two, unhealed stage 2 pressure ulcers (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister) which were not present upon admission. R1 required a pressure relieving device for the chair, a turning and repositioning program and pressure ulcer care. A subsequent MDS tracking record identified R1 died in the facility on 10/24/20.	F 686	1. R1 died on 10/24. R2 was referred to Rainy Lake Medical Center on 11/11/20 for further evaluation/treatment of the pressure ulcer. She was transferred to a higher level of care and has discharged from facility. 2. All residents at risk for pressure ulcers have the potential to be effected by deficient practice. 3. All residents with a current pressure ulcer or at risk for pressure ulcer development will be reassessed to ensure the appropriate interventions have been developed/implemented by the DON and the wound nurse took over this role on December 9th. 4. The Skin Ulcer Protocol policy has been reviewed and revised as appropriate by the DON, and two floor RNs (Sandy Sundin and Anna Bortnik) involved in the assessment process have been re-educated on the pressure ulcer assessment process by the DON. -Staff (LPN and TMAs) were also re-educated on pressure ulcer treatment and prevention as it relates to their role/responsibility by the DON. -A facility RN was identified and received training through Wound Care Educational Institute and is in the process of becoming certified. She will be conducting wound rounds weekly. -The Director of Nursing (DON)	

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F 686	Continued From page 2 R1's Pressure Ulcer Care Area Assessment (CAA) dated 6/2/20, indicated R1 was independent with bed mobility and R1's Tissue Tolerance (TT) (the ability of the skin to withstand the effects of unrelieved pressure) was 4 hours sitting. R1 transferred surface to surface with assist of one and utilized CPAP [continuous positive airway pressure] throughout the night. R1 had history of skin breakdown. Currently, R1 had a stage 2 pressure ulcer on coccyx, covered with Mepilex (absorbent foam dressing), 1 centimeter (cm) X 1 cm, wound bed 100% white, drainage moderate, tan in color; presented on admission with stage 2 pressure ulcer on coccyx which healed; pressure ulcer on left heel, 1 cm X 1 cm-skin will not blanche; left lower buttocks macular denudation-blanches, no odor, moderate thin drainage. R1 was at risk for skin breakdown, related to decreased mobility. A goal was identified for R1 to remain independent in all toileting tasks; pressure ulcer(s) would heal without signs & symptoms of infection; would be free of clinical signs/symptoms of breakdown. Approaches included: observe skin daily with cares; inspect skin weekly; moisturizing lotions with cares; monitor pressure ulcer-report any changes; occupational therapy evaluation & treatment for positioning & as indicated per order; physical therapy & evaluation as indicated & per orders. Further, R1 had a pressure reducing mattress on bed R1's Care Plan History (Entire) provided 11/6/20, identified R1 had a pressure ulcer, stage 2 to coccyx. Interventions implemented on 4/7/20 included: inspect skin weekly, observe skin daily with cares, encourage and assist resident to turn and reposition self at least every two hours and	F 686	implemented weekly wound rounds with facility medical director to insure the physicians review all pressure ulcers on a weekly basis until the Medical Director is confident the wound nurse is assessing/dressing competently on her own. 5. DON or designee will review wound round notes related to pressure ulcers weekly for comprehensive pressure ulcer assessments and appropriate development of interventions, including auditing the care plan for appropriate interventions. Random observational audits will be completed to ensure appropriate skin interventions are implemented for at risk residents and those with current pressure ulcers 4x/week x4 weeks, then 3x/week x 2 weeks, then weekly. Auditing began on December 8th. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported to the quarterly QAPI team. The QAPI team will make recommendations for ongoing monitoring. 6. Completion date for F686 is December 16th, 2020.	

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F 686	Continued From page 3	F 686		

as needed for comfort, monitor for clinical signs and symptoms of wound infection and report, Occupational therapy (OT) evaluation and treatment for positioning and other as indicated and per orders, Physical therapy (PT) evaluation and treatment as indicated and per orders, pressure reducing cushion on wheelchair, pressure reducing mattress on bed, treatments as ordered/monitor effectiveness and report, treatments per physician (MD) order. An additional intervention dated 4/15/20, directed staff to encourage to turn/reposition every two hours due to pressure sore to coccyx (TT dated 4/13/20 indicated every 4 hours).

R1's care plan lacked identification of further pressure related injuries and lacked any further interventions related to the care of R1's pressure ulcer or to minimize the risk of additional pressure ulcer development until R1's admission to Hospice services on 10/20/20. At that time the care plan identified alteration in skin integrity actual or potential related to terminal illness and indicated Hospice would provide a specialty mattress and Hospice would assess pain during each visit. R1's care plan did not include wedge pillows, keep heels off bed, boots or any further intervention.

On 11/3/20, at 7:28 a.m. family member (FM)-A stated the pressure ulcer care R1 had received at the facility had been inadequate. FM-A indicated she was not exactly sure when R1's pressure ulcer had started; however, had been able to physically see R1 on 10/12/20. When FM-A entered R1's room, FM-A stated the smell from his pressure ulcer was horrible; "It smelled like necrotic (dead) flesh and could be smelled all the way down the hallway." FM-A stated she had

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F 686	Continued From page 4	F 686		

previously contacted a facility RN about R1's pressure ulcer and wound care on 10/13/20, but was not given any answers at that time. FM-A stated she did not believe a medical provider had been contacted about R1's pressure ulcer and stated she had contacted nurse practitioner (NP) -A regarding R1's pressure ulcer and the odor she had noticed during her 10/12/20, visit. FM-A stated to her understanding NP-A looked at the pressure ulcer, a culture had been done due to concern about bacteria and NP-A had ordered some treatment for the pressure ulcer. FM-A stated she did not believe anything would have been done if she had not called the provider herself. FM-A stated R1 had acquired the pressure ulcer while in the facility's care, the facility had not provided the proper care to prevent this from occurring and had not provided the proper care for the pressure ulcer after it had been acquired.

R1's Skin Condition/Wound Progression documentation from 2/26/20 to 11/3/20, included the following pressure ulcer monitoring/assessments:

Coccyx
On 5/25/20, a recurrence of a pressure ulcer to R1's coccyx was identified as a stage 1 pressure ulcer (intact skin with non-blanchable redness of a localized area usually over a bony prominence) measuring 1 cm x 0.5 cm. On 6/1/20, the staging of the coccyx pressure ulcer was identified as stage 2 and the pressure ulcer measured 1 cm x 1 cm. Wound monitoring/assessments were completed weekly through 9/28/20. On 9/28/20, the pressure ulcer measured 1 cm x 0.5 cm x 0.2 cm. The record lacked further monitoring or assessment of the coccyx pressure ulcer. In

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F 686	Continued From page 5	F 686		

addition, R1's medical record lacked a comprehensive assessment: to include the potential causative/contributing factors when the pressure ulcer developed, to ensure appropriate interventions were identified and implemented to promote pressure ulcer healing.

Left Heel
On 6/1/20, a new pressure ulcer was identified on R1's left heel as a stage 1 pressure ulcer measuring 1 cm x 1 cm. The pressure ulcer was described as a red area on the heel with a light purple spot in the middle measuring 0.25 cm x 0.25 cm. The pressure ulcer was assessed the next two weeks with changes to the size of the purple area noted. R1's left heel ulcer was assessed/monitored 4 of next 11 weeks (7/2/20, 7/23/20, 7/27/20, and 8/3/20) with measurements identified at 0.5 cm x 0.5 cm x <0.1 cm at each assessment. The record lacked assessments for 7 of 11 weeks. The record included two additional assessments of R1's left heel pressure ulcer . On 9/8/20, the pressure ulcer had increased in size to 1.5 cm x 1.5 cm x 0.1 cm. On 9/28/20, the pressure ulcer was now identified as a partial thickness, open area measuring 1.1 cm x 1.3 cm x 0.1 cm, with a white wound base, a scant amount of drainage and some complaints of pain while applying pressure to the area.
The record lacked further monitoring or assessment of the left heel pressure ulcer . In addition, R1's medical record lacked a comprehensive assessment: to include the potential causative/contributing factors when the pressure ulcer developed, to ensure appropriate interventions were identified and implemented to promote pressure ulcer healing.

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F 686	Continued From page 6 Left Lower Buttocks On 8/3/20, a recurrence of a pressure ulcer to R1's left lower buttocks was identified which measured 1 cm x 0.5 cm x 0.1 cm. With a partial thickness pressure ulcer on the fatty part of buttocks. The pressure ulcer was assessed again on 8/10/20, and then no assessment or monitoring was completed until 9/18/20, over 5 weeks later. On 9/18/20, the pressure ulcer had increased in size and measured 2.5 cm x 3.5 cm with eschar tissue (dead tissue found in a full-thickness wound) present, covering the majority of the pressure ulcer , 90%. The depth of the pressure ulcer was unable to be determined due to the presence of eschar tissue. R1 reported pain while applying pressure to the area. The pressure ulcer was assessed 9/21/20 and again measured 2.5 cm x 3.5 cm. Slough (necrotic tissue that needs to be removed from the pressure ulcer for healing to take place)/eschar tissue present, covering about 85% of pressure ulcer. The depth was unable to be determined due to cover. A scant amount of sanguineous drainage was present. On 9/28/20, the pressure ulcer had again increased in size and measured 3 cm x 4 cm x 0.2 cm with slough covering 85% of the wound bed. The record lacked further monitoring or assessment of the left buttock pressure ulcer . In addition, R1's medical record lacked a comprehensive assessment: to include the potential causative/contributing factors when the pressure ulcer developed, to ensure appropriate interventions were identified and implemented to promote pressure ulcer healing. Right Heel: On 9/28/20, a new pressure ulcer was identified on R1's right heel described as a closed,	F 686		

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blister-like area, reddish-purple with brown around the edge, located on outside of right heel measuring 3 cm x 4 cm.
The record lacked further monitoring or assessment of the right heel pressure ulcer . In addition, R1's medical record lacked a comprehensive assessment: to include the potential causative/contributing factors when the pressure ulcer developed, to ensure appropriate interventions were identified and implemented to promote pressure ulcer healing.

After 9/28/20, R1's Skin Condition/Wound Progression documentation lacked further monitoring or assessments of R1's skin integrity regarding the left buttock, coccyx and left and right heel pressure ulcers.

R1's progress notes from 9/28/20 to 10/24/20, identified the following:

-10/9/20: Resident had no dressing to his bottom, removed soiled clothing and bedding and assisted with a dressing change. The pressure ulcer had an odor and continued to deteriorate. The pressure ulcer was cleansed well and a fresh dressing was placed, this time a larger Allevyn (moist wound environment dressings designed specifically for the management of chronic and exuding wounds) was used as the smaller size did not seem to be working well. Barrier Wipe was applied to the intact skin to help with dressing staying intact as ordered. The note lacked identification of the location of the pressure ulcer.

-10/9/20: Resident's wound culture had not come back yet. Did ask we check back again on 10/12/2020. The note lacked identification of the

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wound culture location.

-10/13/20: The pressure ulcer on R1's left gluteus (buttocks) was very hard and red around the entire thing. He had a lot of pain with it.

-10/16/20: Dressing was changed to the left gluteal. No dressing present at this time, as R1 had just received a bath. There was a slight amount of purulent drainage on R1's bed protector. The wound base was covered with eschar/sloughing. Area was cleansed with warm water. Mupirocin (generic form of Bactroban a topical antibiotic) was applied to the site. Cut Silvercel (non-adherent antimicrobial alginate dressing) to fit, and placed on pressure ulcer. Covered with Allevyn dressing.

-10/17/20: There was a small amount of drainage from his dressing on R1's buttocks. There is a red area on the top of the left outer buttock. Heel boots and heels up are in place.

-10/18/20: Dressing on his bottom had some drainage and was changed. The note lacked identification of the location or description of the pressure ulcer .

-10/21/20: Resident had several black spots throughout his scrotum, some do feel "soft" to the touch as though they may break open soon.

-10/21/20: Inter-dry (moisture-wicking fabric with antimicrobial silver) was cut into a strip and applied to resident's scrotum to make a sling to help keep the scrotum dry and elevated.

-10/21/20; Resident's daughter requested that resident's pressure ulcer to his left buttock be

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F 686	Continued From page 9 inspected by a physician or resident's PCP [primary care provider]. 10/21/20: Resident's son called today to report that he was disappointed in the care his father had received, in particular the pressure ulcer care. Daughter was here and also complained no one had addressed the residents buttocks PU. NP-A agreed on 10/14/20, to have PT look at the PU and debride the pressure ulcer , if that was appropriate. Hospice admitted this resident on Monday. Hospice required different training for PT so the decision was made that our resident PT would not observe the pressure ulcer. After the daughter and son expressed their frustrations and anger in regards to the pressure ulcer [the writer] proceeded to research steps taken in regards to residents integument system. Resident was admitted with a stage two ulcer in February [2020]. The pressure ulcer was documented as healed at one point, so the pressure ulcer did close. The resident always had a pin hole type of wound on his coccyx, threatening to open up from the inside out. An RN followed his skin weekly. About 2 weeks ago it was reported the resident had a pressure ulcer that opened up and was progressing rapidly. This RN spoke with NP-A who agreed to have therapy evaluate the pressure ulcer. The repositioning documentation was reviewed and there was an evening shift on the 16th of October and R1 was not repositioned as scheduled. Education and guidance would be provided to the NA's [nursing assistants] and the LPN [licensed practical nurse] on duty was educated as well. NP-B was contacted and planned to do a visit with the resident to assess the pressure ulcer. Hospice would be involved going forward. The note did not identify which pressure ulcer.	F 686		

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-10/21/20: Received a call from [NP-B's nurse] stating to discontinue wound debridement and R1 would be seen by NP-B via Telehealth visit. Measurements would be needed prior to this appointment. Measurements were L-2.6 [cm], W-2.2 [cm], D-2.9 [cm]. The pressure ulcer was cleansed and re-dressed as per orders at 4:45 p.m. The note did not identify which pressure ulcer.

-10/22/20: Resident was seen for pressure ulcer inspection per NP-B. She inspected scrotum ulcerations, wound to left buttock, back (reddened skin) and both heals. NP-B asked that [the writer] re-dress the pressure ulcer to R1's heels with foam dressing with the surrounding skin covered with foam and eschar tissue left open to air and secured with a Kerlix (woven gauze bandage) dressing and be kept on until dressing falls off and then re-placed with the foam only on intact skin. NP-B ordered pressure ulcer care to left buttock - flush wound with 25% peroxide/0.9 normal saline (NS) solution using a 30-60 cubic centimeter (cc) syringe then pack with Iodoform gauze (cotton gauze strip impregnated with formulated Iodoform solution primarily used for sterile drainage of open and/or infected wounds) and cover with Kerlix fluff. Change the dressing twice daily and as needed if saturated. Pressure ulcer care to left heel is - surround the pressure ulcer with padding and apply Bactroban 2% to ulcer twice a day then cover with gauze. Right heel pressure ulcer would be dressed with a padded dressing and covered with gauze. Petroleum Jelly for a skin barrier to scrotum 3 times daily and as needed.

-10/23/20: Late entry for 10/21/20, Heels were

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dressed as order on the evening shift. Left inside had a callus that was open but dry. Tissue around callus was hard and starting to peel. Outside of right heel was black with no drainage.

-10/23/20: Dressing change completed at 10:30 a.m. Left buttock pressure ulcer had mucous drainage but less odor then last evening. Did flush pressure ulcer well as per MD orders and re-packed pressure ulcer with packing, covered with a loose gauze pad. Right heel dressing continued to be intact on surrounding skin - area cut out as per verbally instructed from NP to pad area surrounding callous. Left heel dressing was intact to skin surrounding wound - area still cut out as per NP orders, did apply Bactroban to callous. Resident did grimace with touch of left heel ulcer.

- 10/24/20: Resident passed away at 1:42 p.m. that afternoon.

R1's Resident Concerns form (to communicate changes to medical provider) dated 10/4/20, included a note to the provider which identified R1's pressure ulcer to left gluteal fold had increased pain and redness. "Could we please obtain a culture?" The provider responded on 10/5/20, with an order to culture pressure ulcer on left gluteal fold. The note did not provide any further information related to the deterioration of R1's pressure ulcer (s).

R1's Visit Note dated 10/14/20, completed by NP-A identified the reason for visit as an evaluation of pressure ulcer on the left buttock and the right heel. Staff and family reported malodor. R1 was lying in bed with a wedge cushion under the calves to prevent R1's heels

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from touching the bed; however, R1 had adjusted the wedge under his legs so his heels were actually touching the bed. Skin Exam Common Findings: there is a stage IV pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the pressure ulcer bed. Often includes undermining and tunneling.) on the left buttock which was approximately 5.5 cm in diameter. The entire pressure ulcer was covered in green/black slough and eschar. Undermining on the edges of the pressure ulcer. Pressure ulcer was 0.75 to 1 cm in depth. Pressure ulcer was extremely malodorous. Right heel had a a red/purple closed pressure pressure ulcer on the lateral side which was covered in hard calloused tissue. The left heel had a small pink area approximately 1.5 cm in diameter. Impression: 1. Stage IV pressure ulcer-left buttock. 2. Stage unknown pressure ulcer-right heel. 3. Stage 1 pressure ulcer - left heel. 4. Metastatic cancer. Plan: Pressure ulcer culture of the buttock was done and positive for Enterococcus faecalis. Order written temporarily for Bactroban topically until PCP [primary care physician] returns to the office. Given his condition, oral antibiotics would likely cause more harm than good. Any attempts to try to heal these areas will likely fail due to terminal condition. Order for PT debridement to remove loose slough on the left buttock. Heel protectors ordered while patient is in bed. I did discuss this with the patient who has agreed at this time to keep them in place. Will also keep wedge in place for added protection. Will discuss with PCP next week.

R1's Telehealth Visit Report dated 10/22/20, completed by NP-B, identified R1 was seen related to concerns of skin integrity. NP-B's

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physical exam observations were completed with the assistance of nursing. NP-B was able to visualize, in fairly good detail, the pressure ulcers. The left buttock pressure ulcer was a little better than 3 cm in diameter and was 3 cm deep. It had some thick areas of eschar that had partially softened. There also was some pseudomembranous mucoid appearing discharge. Most of the tissue and discharge was gray in appearance. The undersurface of R1's scrotum was red and irritated in appearance and had several areas of stage 2-3 ulcerations that spanned nearly the entire undersurface. Wherever the scrotum was in contact with the bed, essentially. There were so many different ulcerations that were confluent they essentially become one very large pressure ulcer. This area expanded greater than 10 cm in length and greater than 5 cm in width. On the left heel he had a stage 2-3 ulceration on the medial aspect. The pressure ulcer base was pink. On the right heel the lateral area had a 3 cm diameter area that was red with one area in particular that was a bit soft and mushy making this a 1-2 stage pressure ulcer. Assessment 1) Stage IV pressure ulcer left buttock 2) Stage 2-3 pressure ulcers on scrotum, and left heel. 3) Stage 1-2 pressure ulcer on right heel. 4) low urinary output. Plan 1) In an effort to ensure improved skin integrity and to keep moisture off the scrotum, apply petroleum jelly up to three times daily and will straight cath patient, if greater than 100 milliliters (ml) of urine, leave the catheter in place, remove if less than 100 ml. 2) For the stage IV pressure ulcer will flush with a diluted peroxide/saline flush and pack with Iodoform 2 inch gauze changing twice daily and as needed. Cover with large Kerlix fluff. This should help with both bacteria as well as debridement of the

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eschar. 3) For his heels, surround both pressure ulcers with a Mepilex foam cutting out the area of ulcerations to take the pressure off those. On the left heel apply Bactroban to the ulceration and cover with gauze; for the right heel simply cover with gauze and place padded boots over both heels. 4) Use wedged pillows and other padding to ensure the patient is not laying on his back and is turn side to side every 2 hours to relieve pressure and keep pressure off the scrotum as well as the left buttock. Nursing staff was instructed to be liberal with R1's pain medications especially prior to any of his dressing changes.

During interview on 11/5/20, at 9:14 a.m. NA-A stated R1 had a pressure ulcer on his left hip and for awhile also had one on his coccyx; however, indicated "that one kind of healed up". NA-A indicated R1 preferred to stay in his recliner most of the time with his feet down and indicated staff did not do anything with R1 regarding repositioning. R1 was capable of letting them know if he needed the restroom or anything. NA-A stated toward the end, approximately the last month, R1 would lay down on his bed between breakfast and lunch, otherwise his care didn't change much. NA-A denied R1 ever being on a turning/repositioning program.

When interviewed on 11/5/20, at 9:35 a.m. NA-B stated R1 was pretty mobile in bed and until the end and then staff had used a sit to stand lift for transfers. NA-B indicated R1 sat in a recliner about 95% of the time. NA-B verified R1 had sores on his bottom and stated he had a lot more pain with them toward the end as they got bigger. NA-B also indicated R1 used a wedge under his feet and booties as he got open sores on his heels. NA-B stated until the very end R1 could

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reposition himself in bed but once in his chair, he didn't like to move.

On 11/5/20, at 9:51 a.m. RN-B stated RN-C was the one responsible for doing the pressure ulcer care as RN-C had been trained by their previous wound nurse, RN-D. RN-B indicated RN-D had left employment with the facility in June 2020, and since then RN-C had been managing resident pressure ulcer care. RN-B indicated other nurses had assisted by performing dressing changes and assessments, however RN-C was the only one who measured the pressure ulcer. RN-B indicated RN-C documented his assessments in the Wound/Skin documentation section of the electronic record but when other nurses completed resident dressing changes, they signed off on the eTAR [electronic treatment administration record] and some nurses would also do a progress note. RN-B stated to her knowledge, pressure ulcers should be measured every week and assessed for signs of infection or pressure ulcer worsening. RN-B verified R1 was admitted with a pressure ulcer on his coccyx and also developed a pressure ulcer on the left buttock that healed and then came back. RN-B also verified R1's left heel ulcer started in June 2020, and a right heel ulcer developed in September 2020. RN-B stated in September 2020, over the course of a few days, the buttock pressure ulcer "really blew up" and indicated she hadn't laid eyes on it until it really opened up a couple weeks before he passed. RN-B indicated they were putting dressings on it but it kept opening up. RN-B stated the pressure ulcer was painful for R1 toward the end. RN-B indicated NP-A had seen the pressure ulcer in the beginning of October 2020, and had ordered to have PT see the pressure ulcer for debridement

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but then R1 had been admitted to Hospice and the therapist did not work with Hospice so there was "a bit of a mess over that". RN-B indicated NP-A had come in person to see R1's pressure ulcer but she was not sure if any provider had seen the pressure ulcer prior to that.

When interviewed on11/5/20, at 11:02 a.m. the quality consultant (QC) stated resident pressure ulcers should be monitored and assessed weekly. Following review of R1's record, QC stated R1's medical record lacked evidence of weekly pressure ulcer monitoring and assessments. She had addressed this concern with RN-C and had provided education on the importance of weekly documentation. QC thought R1 had been seen by NP-A and indicated she would request the documentation of the visit from the clinic. QC was not able to speak to the deterioration of R1's pressure ulcers as she had never assessed the pressure ulcers.

During interview on 11/5/20, at 2:35 p.m. NP-B identified she was R1's primary care provider prior to R1's admission to the nursing home. However, when COVID-19 hit, the facility "wouldn't let them [providers] in there". NP-B identified she saw R1 for a preoperative exam in May [2020] and at that time R1 had a small pressure ulcer on his heel and stage 2 pressure ulcer on his coccyx, in the gluteal crease. NP-B indicated the pressure ulcer was being taken care of and was getting better and also indicated R1 had no pressure ulcers on his buttocks at that time. NP-B stated she had seen R1 via telehealth on 10/22/20, after being contacted by R1's family.

- At the time of the pressure ulcer assessment,

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NP-B indicated she had been completely overwhelmed by condition of R1's skin and stated "I almost started to cry. It was impressive." NP-B indicated her examination was limited by the technology (the telehealth exam was conducted via video); however, stated the buttock pressure ulcer had eschar that was several inches thick and the pressure ulcer was quite deep. NP-B indicated she had not been contacted by the facility regarding R1's pressure ulcers prior to the telehealth visit and stated she would have expected they contact either her or the local providers regarding the condition of R1's pressure ulcers. NP-B indicated she was also contacted by the Hospice registered nurse (HRN) prior to the telehealth visit who had enquired if NP-B had been aware of the condition of R1's skin. NP-B identified HRN had contacted her as soon as she (HRN) had evaluated R1 with concerns related to the care of R1's pressure ulcers.

When interviewed on 11/5/20, at 2:57 p.m. NP-A stated she saw and evaluated R1's pressure ulcers on 10/14/20. NP-A stated she recalled the visit as she had not physically been at the nursing home except for that visit. NP-A stated neither she, nor the physician had seen R1's pressure ulcers prior to the 10/14/20, appointment. The pressure ulcer was "not good" and described it as "pretty deep and very odorous, almost gagging". The pressure ulcer edges had undermining and the pressure ulcer bed was pea green/black in color. R1 was rolled on his side and she lifted up his left foot and noted a stage 1 pressure ulcer on the left heel. She then looked at his right heel, which also had a pressure ulcer and noted it was worse than the left. NP-A stated R1 sis not like wearing heel protectors and

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stated she "had to talk him into that." NP-A stated if a resident pressure ulcer was worsening the facility usually let her know and stated she should have been contacted sooner regarding R1's pressure ulcers. NP-A stated they could have put interventions in place; she was not sure if intervention would have helped heal the pressure ulcer but could have potentially made R1 more comfortable.

On 11/5/20, at 3:08 p.m. HRN identified she had completed an initial evaluation of R1 for admission to Hospice services on 10/19/20, and stated she was concerned as R1's buttocks pressure ulcer was open, had "stringy stuff coming out if it" and a "horrible, horrible odor." HRN stated when she evaluated R1 on the 10/19/20, and again on 10/21/20. R1's pressure ulcer had smelled like stool. HRN indicated the area had "no wound care to it" and stated the last order was to apply Bactroban twice daily. HRN stated Bactroban wasn't usually applied to pressure ulcers with that depth and she had concerns regarding the adequacy of the pressure ulcer care for the condition of R1's pressure ulcer. HRN stated she did not know what pressure ulcer care the facility had been providing prior to hospice but identified on 10/19/20, there had been nothing/no dressing on the pressure ulcer and also nothing on the pressure ulcer when she returned on the 10/21/20. Further, she could not get any direction for the care of R1's pressure ulcer from the nursing home, as there were no pressure ulcer care orders, so she had contacted NP-B as she needed direction on what to do with R1's pressure ulcer. HRN stated NP-B had given the order to do wet to dry dressing changes twice daily and had faxed an order to HRN which she had faxed to the nursing home. HRN stated she

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"absolutely felt this should have been evaluated by physician."

During interview on 11/5/20, at 3:26 p.m. RN-A stated it was planned for her to have training in wound care, however she had not been trained yet. RN-A indicated RN-C was doing all of the pressure ulcer measurements and she had assisted with dressing changes. RN-A could not explain the gaps in R1's pressure ulcer documentation. R1's pressure ulcer to his buttocks "came on quickly"; within a matter of days. However, identified a progress note dated 9/20/20, which identified R1 had an open area on the left buttocks "the size of a quarter". RN-A also stated a progress note dated 10/9/20, identified R1's pressure ulcer had odor and "continued to deteriorate. RN-A stated R1 had complained of "terrible pain" in the pressure ulcer at the end. After review of R1's medical record RN-A stated R1's left buttock pressure ulcer had first been visualized on 10/14/20, by NP-A. RN-A stated a physician should be notified for new pressure ulcers, foul odor, fever, or other signs or symptoms of infection pressure ulcer, including deterioration or pain.

On 11/5/20 at 3:56 p.m. RN-C stated he was responsible for wound care in the facility until the middle of September 2020, when he had taken another job, at another facility, for a period of time. RN-C stated it was his understanding RN-A took over, the pressure ulcer monitoring; however, it appeared that had not happened. RN-C stated he had only completed pressure ulcer care monitoring from August 2020 to mid-September 2020. He worked with RN-D, the previous wound nurse, who had left at the end of August 2020 or beginning of September 2020.

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RN-C stated when he was doing pressure ulcer care for R1, the only pressure ulcer requiring a dressing change was on on his coccyx. There was only a small ulcer on R1's coccys at that time. Further, one of the LPN's later noticed a spot further down on R1's buttocks and had described it as a round, purple spot. RN-C stated he spoke with RN-D about it, who had indicated R1 had developed spots like that previously which cleared up after a while. RN-C stated RN-A would have taken over so he did not recall seeing the pressure ulcer again after that. However, RN-C stated he did not think the pressure ulcer had healed and redeveloped. RN-C identified his documentation and what had been documented by RN-D sounded like the same area. RN-C stated he had received direction from RN-D on what to use on R1's left buttock pressure ulcer when it had reappeared in August 2020. RN-C stated a medical provider had not assessed R1's pressure ulcers until NP-A had done so on 10/14/20.

During interview on 11/6/20, at 1:37 p.m. NA-C stated R1 had been pretty independent at first, however about two months before passing away, R1 required more assistance. R1 required help with transfers using a sit to stand lift, due to weakness. NA-C stated they were monitoring an open area on R1's coccyx but stated she didn't think he had other skin issues at first. NA-C indicated quite a few months ago they had a cushion they wanted R1 to try in his recliner, but he didn't like it and then within the last couple of months he was provided an air mattress as he was laying in bed more. NA-C stated R1 sat in his chair during they day but they encouraged him to lay down in the afternoon. NA-C indicated they tried to get him to move around during the day

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and confirmed he did sleep in the bed. NA-C also indicated when R1 ended up being in bed more often than not, he needed more attention at that time and they had to reposition him every two hours.

On 11/6/20 at 3:07 p.m. the director of nursing (DON) stated, following a review of R1's pressure ulcer documentation, it was not the kind of monitoring she would expect to have been provided. They had tried many different solutions for the care of R1's pressure ulcer including different cushions, pads, and encouraging him to lay down. The DON stated they probably should have provided risk versus benefit education to R1 regarding his refusal to implement the interventions. When R1's son had called her about pressure ulcer care concerns she started reviewing the care he had received, she had questioned if the care R1 received was neglect of care. Further, she probably should have been more involved in the facility's management of pressure ulcers and verified her staff needed training. The DON stated R1's care "fell through the cracks" and stated R1's pressure ulcer should have been assessed by a provider prior to 10/14/20. The DON stated "The most surprising thing is nobody came to me and asked me to look at this."

R2's admission MDS dated 8/26/20, identified R2 was cognitively intact and required extensive assistance of two for bed mobility, dressing, toilet use and personal hygiene and was totally dependent on two plus staff for transfers. The MDS included diagnoses of a stage 4 sacral pressure ulcer, morbid obesity, reduced mobility, weakness and depression. R2 had no symptoms

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of psychosis or behavioral symptoms and exhibited no rejection of care. The MDS further identified R2 had one stage 4 pressure ulcer, present on admission, and 1 venous/arterial ulcer. The MDS indicated R2 required pressure relieving devices for bed and chair, a turning and repositioning program and pressure ulcer care.

R2's Pressure Ulcer CAA dated 8/31/20, indicated R2 was overweight, fed self independently and required a wheelchair for ambulation. R2 needed encouragement to get out of bed and required assist of 1-2 for bed mobility. R2 transferred surface to surface with assist of 1-2. Present on admission, R2 had redness under both breasts; pressure ulcer of sacral region/coccyx, 4 cm x 3 cm x 2 cm - bottom thigh gluteal fold is 4 cm x 20 cm x 5 cm, right gluteal pressure ulcer in 7 cm x 3 cm x 0.1 cm, left gluteal 8 cm x 2 cm x 0.1 cm; left lower shin has two picked/scratched areas 1 inch x 0.5 inches and 1 inch x 0.5 inch (covered to prevent scratching/picking; bruising on right and left outer shoulders, left elbow, right and left back of hands; and venous ulcer on right heel 0.3 cm deep, left heel pressure ulcer inside heel - open to air. R2 had impaired skin integrity/pressure ulcer to coccyx, gluteal folds and right heel. Goal: open areas would heal without signs and symptoms of infection, as evidenced by no purulent drainage and intact skin.

R2's care plan dated 8/26/20, indicated R2 had impaired skin integrity with pressure ulcers to coccyx, gluteal fold and right heel and required a pressure reducing mattress on bed and pressure reducing cushion in wheelchair. Interventions included: staff to encourage and assist R2 to turn and reposition self at least every two hours and

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as needed for comfort, get out of bed daily as tolerated, and float heels at all times when in bed, observe skin daily with cares, monitor pressure ulcer daily for changes and sign/symptoms of infection, inspect skin weekly, provide treatment per MD orders and monitor/report effectiveness of treatment. Additionally, the Care Plan indicated R2 refused to get out of bed at this time was working with PT/OT and directed staff to inform R2 of possible complications with healing of ulcers, blood clots, and contractures and to continue to encourage R2 to get out of bed daily.

During observation on 11/2/20, at 2:58 p.m. R2 was resting in bed on her back with the head of the bed elevated approximately 30 degrees. R2's lower body was covered with a blanket and was unable to visualize R2's lower extremities.

During observation on 11/3/20, at 8:16 a.m. R2 was resting in bed on her back with the head of the bed elevated approximately 30 degrees. R2's lower body was covered with a blanket and was unable to visualize R2's lower extremities.

On 11/3/20, at 8:38 a.m. R2 remained in bed and stated she preferred to not have her dressing change observed.

During interview on 11/3/20, at 9:04 a.m. after completion of the dressing change, R2 stated she had been at the facility for approximately one month and was admitted for pressure ulcer care and PT after a hospitalization with the hope to discharge back to home. R2 indicated PT had not started as her pressure ulcers were still too deep. R2 stated she had pressure ulcer treatments twice daily after admission but it had recently changed to once daily. R2 indicated she

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has three pressure ulcers on her bottom and after she was admitted to the facility she acquired two more and she thought she now had a total of 5 pressure ulcers. R2 stated her pressure ulcers on her bottom were getting better. R2 stated she was confident in the staff and felt like they knew what they were doing and was seeing the physician via telehealth since her admission. R2 stated she had not seen the wound physician but indicated the facility had been in contact with him. R2 stated she did not get out of bed during the day and indicated she wouldn't until the pressure ulcers were healed up. R2 stated she has an air mattress on her bed. R2 was able to turn side to side however, did not keep track of how often she moved to relieve pressure from her buttocks.

R2's Skin Condition/Wound Progression documentation from 8/19/20 through 11/3/20, included the following pressure ulcer monitoring/assessments:

Sacrum:
On 8/21/20, the initial pressure ulcer assessment was completed and indicated a stage 4 pressure ulcer present upon admission with tunneling along top of right gluteal, 5.5 cm deep. Open pressure ulcer along left gluteal. Tunneling along bottom right gluteal into upper thigh, about 4.5 cm. Tunneling into right gluteal, about 5 cm. The assessment lacked further measurements of the pressure ulcers. The pressure ulcer was assessed again on 8/24/20 and measured 4 cm x 3 cm x 2 cm. The pressure ulcer was assessed weekly until 9/28/20, and then not assessed again until 10/26/20, 4 weeks later. All assessments after the initial assessment lacked measurement of any pressure ulcer tunneling.

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Bottom Thigh/Gluteal Fold:
On 8/21/20, the initial pressure ulcer assessment was completed and indicated a stage 4 pressure ulcer present upon admission with tunneling along bottom right gluteal into upper thigh, about 4.5 cm. The assessment lacked further measurement of the pressure ulcer. The pressure ulcer was assessed again on 8/24/20, and measured 4 cm x 20 cm x 5 cm. The pressure ulcer was assessed weekly until 9/28/20, and then not assessed again until 10/26/20, 4 weeks later. All assessments after the initial assessment lacked measurement of any pressure ulcer tunneling.

Right Gluteal:
On 8/21/20, the initial pressure ulcer assessment was completed and indicated a stage 4 pressure ulcer present upon admission with tunneling along top of right gluteal, 5.5 cm deep. Tunneling into right gluteal, about 5 cm. The assessment lacked further measurements of the pressure ulcers. The pressure ulcer was assessed again on 8/24/20, and measured 7 cm x 3 cm x .01 cm. The pressure ulcer was assessed weekly until 9/28/20, and then not assessed again until 10/26/20, 4 weeks later. All assessments after the initial assessment lacked measurement of any pressure ulcer tunneling.

Left Gluteal(s):
On 8/21/20, the initial pressure ulcer assessment was completed and indicated an open pressure ulcer along left gluteal. The assessment lacked measurement of the pressure ulcers. The pressure ulcer was assessed again on 8/24/20 and measured 8 cm x 2 cm x 0.1 cm. The pressure ulcer was assessed weekly and on 9/8/20, documentation identified and upper

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gluteal pressure ulcer which measured 4/5 cm x 1 cm and a lower gluteal pressure ulcer which measured 9 cm x 2 cm. The pressure ulcers were assessed weekly until 9/28/20, and then not assessed again until 10/26/20, 4 weeks later. All assessments after the initial assessment lacked measurement of any pressure ulcer tunneling. In addition, R2's medical record lacked a comprehensive assessment: to include the potential causative/contributing factors when the pressure ulcer developed, to ensure appropriate interventions were identified and implemented to promote pressure ulcer healing.

Left Heel
On 8/21/20, a pressure ulcer ulcer to the left heel was identified as a scabbed over area on the inside of the left heel. The assessment lacked measurement of the area. The pressure ulcer was not assessed again until 9/21/20, four weeks later. On 9/21/20, the pressure ulcer measured 1 cm x 1 cm. No further assessments of the pressure ulcer were available. In addition, R2's medical record lacked a comprehensive assessment: to include the potential causative/contributing factors when the pressure ulcer developed, to ensure appropriate interventions were identified and implemented to promote pressure ulcer healing.

R1's progress notes from 9/28/20, throguh 11/3/20, were reviewed and the notes failed to inlcude weekly pressure ulcer monitoring assessments.

R2's Telehealth Report dated 9/4/20, identified R2 was admitted to the facility after having extensive stage IV sacral decubitus ulcers. She had dealing with chronic obesity. As a result of

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sitting, developed significant ischemia and ulceration. She was in the hospital in Duluth for several months. She was discharged for continued care of these pressure ulcers. Via camera, nursing was able to show me her sacral area with regards to pressure ulcers. Plan: 1) Continue with treatment of the pressure ulcers. Nursing reported these are improved. Obviously, the gravity of the situation is such that these pressure ulcers could be life-threatening.

On 11/5/20, at 9:12 a.m. NA-A stated R2 did not like to be repositioned and it was very hard to get her comfortable. NA-A confirmed R2 had a lot of open areas, "basically everywhere, her entire bottom." NA-A stated R2 would refuse repositioning as well and when she refused they were to report it to the nurse so her refusals could be charted. NA-A indicated R2 was to be repositioned every two hours.

On 11/5/20, at 9:32 AM NA-B stated R2 had "quite a few nasty sores." NA-B stated R2 could assist to boost up in the bed and roll but indicated she was to the point where she was refusing cares such as repositioning. NA-B stated once they get her comfortable she was "done" and doesn't like to reposition. NA-B stated they position her with pillows to offload the best they can and what R2 would allow. NA-B also indicated they floated her right heel on a pillow so it didn't rest on the bed. NA-B stated they were to chart and notify the nurse when R2 refused repositioning.

On 11/5/20, at 9:51 a.m. RN-B stated she had completed a dressing change for R2 but had not completed measurements of R2's pressure ulcers. RN-B stated RN-C was responsible for

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wound measurements. Residents were seen on routine rounds by a physician or nurse practitioner and stated she was not sure if NP-A had seen R2's pressure ulcers however, stated MD-A had seen them.

On 11/6/20 at 3:07 p.m. the DON reviewed the documentation of R2's pressure ulcer care and stated she would have expected the pressure ulcer assessments to include measurements of the pressure ulcers as well as measurements of any tunneling of the pressure ulcer. DON stated she had looked at R2's pressure ulcer on 10/2/20, and had been concerned that an MD had not looked at it so she had tracked down the wound specialist. The DON stated residents with a pressure ulcer should have at least weekly documentation of an assessment and confirmed pressure ulcer monitoring would include measurements and a description of the wound appearance and any drainage. The DON stated when she came on board in June (2020), their wound nurse at the time, RN-D had been looking to change jobs. RN-C had started working with the facility in July (2020) and had been willing to work with RN-D on wounds, however, she only wanted to work two days per week. RN-D had agreed to train RN-C however, things got busy for her and she thought RN-D had only spent a few Mondays working with RN-C. Further, she discovered the LPN's did not assist with pressure ulcer measurements and stated the plan was to have the facility quality consultant put together some training for their staff and to have RN-A obtain wound care certification.

The Skin Ulcer Protocol updated 7/1/20, directed assessment and monitoring of skin concerns included daily documentation to address the

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F 686	Continued From page 29 following: an evaluation of the ulcer, if no dressing was present; an evaluation of the status of the dressing, if present (intact, drainage, etc.); the status of the tissue/area surrounding the ulcer, the presence of possible complications, such as increasing size or infection (redness/drainage); and presence of pain and if controlled, how, etc. The protocol also directed wound round documentation should be completed weekly at minimum and should include: type of wound, location and staging, size (including length, width and depth and the presence of any undermining or tunneling/sinus tract), exudate including color, odor and approximate amount, presence of pain, wound bed to include color and type of tissue/character, evidence of healing or necrosis, description of the wound edges and surrounding tissue, wound type specific charting, interventions in place, and current treatment and response to treatment. The protocol indicated if a wound was not showing improvement in the last 2-4 weeks, the MD should be contacted for new treatment orders. Further, the wound status would be tracked on the Skin Tracking Form	F 686		

Electronically delivered
December 3, 2020

Administrator
Littlefork Medical Center
912 Main Street
Littlefork, MN 56653

Re: State Nursing Home Licensing Orders
Event ID: N3XY11

Dear Administrator:

The above facility was surveyed on November 2, 2020 through November 6, 2020 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:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
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You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK MEDICAL CENTER	912 MAIN STREET LITTLEFORK, MN 56653

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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 11/2/20 through 11/6/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be not in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5542024C with a licensing order issued at MN Rule 4658.0525 Subp 3. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm 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. PLEASE DISREGARD THE HEADING OF THE	2 000		

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2 000	Continued From page 2 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.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess facility acquired pressure ulcers and provide consistent weekly pressure ulcer monitoring for 2 of 3 residents (R1, R2) reviewed for pressure ulcers. In addition, the facility failed to identify and implement new and timely interventions to promote the healing of pressure	2 900	Completed.	12/16/20

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ulcer(s) for R1. This caused actual harm to R1 whose stage 2 left buttock pressure ulcer worsened to an unstageable pressure ulcer and acquired a second pressure ulcer.

Findings include:

R1's quarterly Minimum Data Set (MDS) dated 9/1/20, identified R1 was cognitively intact and required limited assistance with bed mobility and transfers. The MDS included diagnoses of cancer, generalized muscle weakness, and chronic pain. R1 had no symptoms of psychosis or behavioral symptoms and exhibited no rejection of care. Further, the MDS identified R1 had two, unhealed stage 2 pressure ulcers (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister) which were not present upon admission. R1 required a pressure relieving device for the chair, a turning and repositioning program and pressure ulcer care. A subsequent MDS tracking record identified R1 died in the facility on 10/24/20.

R1's Pressure Ulcer Care Area Assessment (CAA) dated 6/2/20, indicated R1 was independent with bed mobility and R1's Tissue Tolerance (TT) (the ability of the skin to withstand the effects of unrelieved pressure) was 4 hours sitting. R1 transferred surface to surface with assist of one and utilized CPAP [continuous positive airway pressure] throughout the night. R1 had history of skin breakdown. Currently, R1 had a stage 2 pressure ulcer on coccyx, covered with Mepilex (absorbent foam dressing), 1 centimeter (cm) X 1 cm, wound bed 100% white, drainage moderate, tan in color; presented on admission with stage 2 pressure ulcer on coccyx which

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2 900	Continued From page 4 healed; pressure ulcer on left heel, 1 cm X 1 cm-skin will not blanche; left lower buttocks macular denudation-blanches, no odor, moderate thin drainage. R1 was at risk for skin breakdown, related to decreased mobility. A goal was identified for R1 to remain independent in all toileting tasks; pressure ulcer(s) would heal without signs & symptoms of infection; would be free of clinical signs/symptoms of breakdown. Approaches included: observe skin daily with cares; inspect skin weekly; moisturizing lotions with cares; monitor pressure ulcer-report any changes; occupational therapy evaluation & treatment for positioning & as indicated per order; physical therapy & evaluation as indicated & per orders. Further, R1 had a pressure reducing mattress on bed R1's Care Plan History (Entire) provided 11/6/20, identified R1 had a pressure ulcer, stage 2 to coccyx. Interventions implemented on 4/7/20 included: inspect skin weekly, observe skin daily with cares, encourage and assist resident to turn and reposition self at least every two hours and as needed for comfort, monitor for clinical signs and symptoms of wound infection and report, Occupational therapy (OT) evaluation and treatment for positioning and other as indicated and per orders, Physical therapy (PT) evaluation and treatment as indicated and per orders, pressure reducing cushion on wheelchair, pressure reducing mattress on bed, treatments as ordered/monitor effectiveness and report, treatments per physician (MD) order. An additional intervention dated 4/15/20, directed staff to encourage to turn/reposition every two hours due to pressure sore to coccyx (TT dated 4/13/20 indicated every 4 hours). R1's care plan lacked identification of further	2 900		

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2 900	Continued From page 5	2 900		

pressure related injuries and lacked any further interventions related to the care of R1's pressure ulcer or to minimize the risk of additional pressure ulcer development until R1's admission to Hospice services on 10/20/20. At that time the care plan identified alteration in skin integrity actual or potential related to terminal illness and indicated Hospice would provide a specialty mattress and Hospice would assess pain during each visit. R1's care plan did not include wedge pillows, keep heels off bed, boots or any further intervention.

On 11/3/20, at 7:28 a.m. family member (FM)-A stated the pressure ulcer care R1 had received at the facility had been inadequate. FM-A indicated she was not exactly sure when R1's pressure ulcer had started; however, had been able to physically see R1 on 10/12/20. When FM-A entered R1's room, FM-A stated the smell from his pressure ulcer was horrible; "It smelled like necrotic (dead) flesh and could be smelled all the way down the hallway." FM-A stated she had previously contacted a facility RN about R1's pressure ulcer and wound care on 10/13/20, but was not given any answers at that time. FM-A stated she did not believe a medical provider had been contacted about R1's pressure ulcer and stated she had contacted nurse practitioner (NP) -A regarding R1's pressure ulcer and the odor she had noticed during her 10/12/20, visit. FM-A stated to her understanding NP-A looked at the pressure ulcer, a culture had been done due to concern about bacteria and NP-A had ordered some treatment for the pressure ulcer. FM-A stated she did not believe anything would have been done if she had not called the provider herself. FM-A stated R1 had acquired the pressure ulcer while in the facility's care, the facility had not provided the proper care to

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2 900	Continued From page 6	2 900		

prevent this from occurring and had not provided the proper care for the pressure ulcer after it had been acquired.

R1's Skin Condition/Wound Progression documentation from 2/26/20 to 11/3/20, included the following pressure ulcer monitoring/assessments:

Coccyx
On 5/25/20, a recurrence of a pressure ulcer to R1's coccyx was identified as a stage 1 pressure ulcer (intact skin with non-blanchable redness of a localized area usually over a bony prominence) measuring 1 cm x 0.5 cm. On 6/1/20, the staging of the coccyx pressure ulcer was identified as stage 2 and the pressure ulcer measured 1 cm x 1 cm. Wound monitoring/assessments were completed weekly through 9/28/20. On 9/28/20, the pressure ulcer measured 1 cm x 0.5 cm x 0.2 cm. The record lacked further monitoring or assessment of the coccyx pressure ulcer. In addition, R1's medical record lacked a comprehensive assessment: to include the potential causative/contributing factors when the pressure ulcer developed, to ensure appropriate interventions were identified and implemented to promote pressure ulcer healing.

Left Heel
On 6/1/20, a new pressure ulcer was identified on R1's left heel as a stage 1 pressure ulcer measuring 1 cm x 1 cm. The pressure ulcer was described as a red area on the heel with a light purple spot in the middle measuring 0.25 cm x 0.25 cm. The pressure ulcer was assessed the next two weeks with changes to the size of the purple area noted. R1's left heel ulcer was assessed/monitored 4 of next 11 weeks (7/2/20, 7/23/20, 7/27/20, and 8/3/20) with measurements

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2 900	Continued From page 7 identified at 0.5 cm x 0.5 cm x <0.1 cm at each assessment. The record lacked assessments for 7 of 11 weeks. The record included two additional assessments of R1's left heel pressure ulcer . On 9/8/20, the pressure ulcer had increased in size to 1.5 cm x 1.5 cm x 0.1 cm. On 9/28/20, the pressure ulcer was now identified as a partial thickness, open area measuring 1.1 cm x 1.3 cm x 0.1 cm, with a white wound base, a scant amount of drainage and some complaints of pain while applying pressure to the area. The record lacked further monitoring or assessment of the left heel pressure ulcer . In addition, R1's medical record lacked a comprehensive assessment: to include the potential causative/contributing factors when the pressure ulcer developed, to ensure appropriate interventions were identified and implemented to promote pressure ulcer healing. Left Lower Buttocks On 8/3/20, a recurrence of a pressure ulcer to R1's left lower buttocks was identified which measured 1 cm x 0.5 cm x 0.1 cm. With a partial thickness pressure ulcer on the fatty part of buttocks. The pressure ulcer was assessed again on 8/10/20, and then no assessment or monitoring was completed until 9/18/20, over 5 weeks later. On 9/18/20, the pressure ulcer had increased in size and measured 2.5 cm x 3.5 cm with eschar tissue (dead tissue found in a full-thickness wound) present, covering the majority of the pressure ulcer , 90%. The depth of the pressure ulcer was unable to be determined due to the presence of eschar tissue. R1 reported pain while applying pressure to the area. The pressure ulcer was assessed 9/21/20 and again measured 2.5 cm x 3.5 cm. Slough (necrotic tissue that needs to be removed from	2 900		

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2 900	Continued From page 8 the pressure ulcer for healing to take place)/eschar tissue present, covering about 85% of pressure ulcer. The depth was unable to be determined due to cover. A scant amount of sanguineous drainage was present. On 9/28/20, the pressure ulcer had again increased in size and measured 3 cm x 4 cm x 0.2 cm with slough covering 85% of the wound bed. The record lacked further monitoring or assessment of the left buttock pressure ulcer . In addition, R1's medical record lacked a comprehensive assessment: to include the potential causative/contributing factors when the pressure ulcer developed, to ensure appropriate interventions were identified and implemented to promote pressure ulcer healing. Right Heel: On 9/28/20, a new pressure ulcer was identified on R1's right heel described as a closed, blister-like area, reddish-purple with brown around the edge, located on outside of right heel measuring 3 cm x 4 cm. The record lacked further monitoring or assessment of the right heel pressure ulcer . In addition, R1's medical record lacked a comprehensive assessment: to include the potential causative/contributing factors when the pressure ulcer developed, to ensure appropriate interventions were identified and implemented to promote pressure ulcer healing. After 9/28/20, R1's Skin Condition/Wound Progression documentation lacked further monitoring or assessments of R1's skin integrity regarding the left buttock, coccyx and left and right heel pressure ulcers. R1's progress notes from 9/28/20 to 10/24/20, identified the following:	2 900		

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2 900	Continued From page 9 -10/9/20: Resident had no dressing to his bottom, removed soiled clothing and bedding and assisted with a dressing change. The pressure ulcer had an odor and continued to deteriorate. The pressure ulcer was cleansed well and a fresh dressing was placed, this time a larger Allevyn (moist wound environment dressings designed specifically for the management of chronic and exuding wounds) was used as the smaller size did not seem to be working well. Barrier Wipe was applied to the intact skin to help with dressing staying intact as ordered. The note lacked identification of the location of the pressure ulcer. -10/9/20: Resident's wound culture had not come back yet. Did ask we check back again on 10/12/2020. The note lacked identification of the wound culture location. -10/13/20: The pressure ulcer on R1's left gluteus (buttocks) was very hard and red around the entire thing. He had a lot of pain with it. -10/16/20: Dressing was changed to the left gluteal. No dressing present at this time, as R1 had just received a bath. There was a slight amount of purulent drainage on R1's bed protector. The wound base was covered with eschar/sloughing. Area was cleansed with warm water. Mupirocin (generic form of Bactroban a topical antibiotic) was applied to the site. Cut Silvercel (non-adherent antimicrobial alginate dressing) to fit, and placed on pressure ulcer. Covered with Allevyn dressing. -10/17/20: There was a small amount of drainage from his dressing on R1's buttocks. There is a red area on the top of the left outer	2 900		

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2 900	Continued From page 10 buttock. Heel boots and heels up are in place. -10/18/20: Dressing on his bottom had some drainage and was changed. The note lacked identification of the location or description of the pressure ulcer . -10/21/20: Resident had several black spots throughout his scrotum, some do feel "soft" to the touch as though they may break open soon. -10/21/20: Inter-dry (moisture-wicking fabric with antimicrobial silver) was cut into a strip and applied to resident's scrotum to make a sling to help keep the scrotum dry and elevated. -10/21/20; Resident's daughter requested that resident's pressure ulcer to his left buttock be inspected by a physician or resident's PCP [primary care provider]. 10/21/20: Resident's son called today to report that he was disappointed in the care his father had received, in particular the pressure ulcer care. Daughter was here and also complained no one had addressed the residents buttocks PU. NP-A agreed on 10/14/20, to have PT look at the PU and debride the pressure ulcer , if that was appropriate. Hospice admitted this resident on Monday. Hospice required different training for PT so the decision was made that our resident PT would not observe the pressure ulcer. After the daughter and son expressed their frustrations and anger in regards to the pressure ulcer [the writer] proceeded to research steps taken in regards to residents integument system. Resident was admitted with a stage two ulcer in February [2020]. The pressure ulcer was documented as healed at one point, so the pressure ulcer did close. The resident always had a pin hole type of	2 900		

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wound on his coccyx, threatening to open up from the inside out. An RN followed his skin weekly. About 2 weeks ago it was reported the resident had a pressure ulcer that opened up and was progressing rapidly. This RN spoke with NP-A who agreed to have therapy evaluate the pressure ulcer. The repositioning documentation was reviewed and there was an evening shift on the 16th of October and R1 was not repositioned as scheduled. Education and guidance would be provided to the NA's [nursing assistants] and the LPN [licensed practical nurse] on duty was educated as well. NP-B was contacted and planned to do a visit with the resident to assess the pressure ulcer. Hospice would be involved going forward. The note did not identify which pressure ulcer.

-10/21/20: Received a call from [NP-B's nurse] stating to discontinue wound debridement and R1 would be seen by NP-B via Telehealth visit. Measurements would be needed prior to this appointment. Measurements were L-2.6 [cm], W-2.2 [cm], D-2.9 [cm]. The pressure ulcer was cleansed and re-dressed as per orders at 4:45 p.m. The note did not identify which pressure ulcer.

-10/22/20: Resident was seen for pressure ulcer inspection per NP-B. She inspected scrotum ulcerations, wound to left buttock, back (reddened skin) and both heals. NP-B asked that [the writer] re-dress the pressure ulcer to R1's heels with foam dressing with the surrounding skin covered with foam and eschar tissue left open to air and secured with a Kerlix (woven gauze bandage) dressing and be kept on until dressing falls off and then re-placed with the foam only on intact skin. NP-B ordered pressure ulcer care to left buttock - flush wound with 25%

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2 900	Continued From page 12 peroxide/0.9 normal saline (NS) solution using a 30-60 cubic centimeter (cc) syringe then pack with Iodoform gauze (cotton gauze strip impregnated with formulated Iodoform solution primarily used for sterile drainage of open and/or infected wounds) and cover with Kerlix fluff. Change the dressing twice daily and as needed if saturated. Pressure ulcer care to left heel is - surround the pressure ulcer with padding and apply Bactroban 2% to ulcer twice a day then cover with gauze. Right heel pressure ulcer would be dressed with a padded dressing and covered with gauze. Petroleum Jelly for a skin barrier to scrotum 3 times daily and as needed. -10/23/20: Late entry for 10/21/20, Heels were dressed as order on the evening shift. Left inside had a callus that was open but dry. Tissue around callus was hard and starting to peel. Outside of right heel was black with no drainage. -10/23/20: Dressing change completed at 10:30 a.m. Left buttock pressure ulcer had mucous drainage but less odor then last evening. Did flush pressure ulcer well as per MD orders and re-packed pressure ulcer with packing, covered with a loose gauze pad. Right heel dressing continued to be intact on surrounding skin - area cut out as per verbally instructed from NP to pad area surrounding callous. Left heel dressing was intact to skin surrounding wound - area still cut out as per NP orders, did apply Bactroban to callous. Resident did grimace with touch of left heel ulcer. - 10/24/20: Resident passed away at 1:42 p.m. that afternoon. R1's Resident Concerns form (to communicate changes to medical provider) dated 10/4/20,	2 900		

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2 900	Continued From page 13 included a note to the provider which identified R1's pressure ulcer to left gluteal fold had increased pain and redness. "Could we please obtain a culture?" The provider responded on 10/5/20, with an order to culture pressure ulcer on left gluteal fold. The note did not provide any further information related to the deterioration of R1's pressure ulcer (s). R1's Visit Note dated 10/14/20, completed by NP-A identified the reason for visit as an evaluation of pressure ulcer on the left buttock and the right heel. Staff and family reported malodor. R1 was lying in bed with a wedge cushion under the calves to prevent R1's heels from touching the bed; however, R1 had adjusted the wedge under his legs so his heels were actually touching the bed. Skin Exam Common Findings: there is a stage IV pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the pressure ulcer bed. Often includes undermining and tunneling.) on the left buttock which was approximately 5.5 cm in diameter. The entire pressure ulcer was covered in green/black slough and eschar. Undermining on the edges of the pressure ulcer. Pressure ulcer was 0.75 to 1 cm in depth. Pressure ulcer was extremely malodorous. Right heel had a a red/purple closed pressure pressure ulcer on the lateral side which was covered in hard calloused tissue. The left heel had a small pink area approximately 1.5 cm in diameter. Impression: 1. Stage IV pressure ulcer-left buttock. 2. Stage unknown pressure ulcer-right heel. 3. Stage 1 pressure ulcer - left heel. 4. Metastatic cancer. Plan: Pressure ulcer culture of the buttock was done and positive for Enterococcus faecalis. Order written temporarily for Bactroban topically until PCP [primary care physician] returns to the	2 900		

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office. Given his condition, oral antibiotics would likely cause more harm than good. Any attempts to try to heal these areas will likely fail due to terminal condition. Order for PT debridement to remove loose slough on the left buttock. Heel protectors ordered while patient is in bed. I did discuss this with the patient who has agreed at this time to keep them in place. Will also keep wedge in place for added protection. Will discuss with PCP next week.

R1's Telehealth Visit Report dated 10/22/20, completed by NP-B, identified R1 was seen related to concerns of skin integrity. NP-B's physical exam observations were completed with the assistance of nursing. NP-B was able to visualize, in fairly good detail, the pressure ulcers. The left buttock pressure ulcer was a little better than 3 cm in diameter and was 3 cm deep. It had some thick areas of eschar that had partially softened. There also was some pseudomembranous mucoid appearing discharge. Most of the tissue and discharge was gray in appearance. The undersurface of R1's scrotum was red and irritated in appearance and had several areas of stage 2-3 ulcerations that spanned nearly the entire undersurface. Wherever the scrotum was in contact with the bed, essentially. There were so many different ulcerations that were confluent they essentially become one very large pressure ulcer. This area expanded greater than 10 cm in length and greater than 5 cm in width. On the left heel he had a stage 2-3 ulceration on the medial aspect. The pressure ulcer base was pink. On the right heel the lateral area had a 3 cm diameter area that was red with one area in particular that was a bit soft and mushy making this a 1-2 stage pressure ulcer. Assessment 1) Stage IV pressure ulcer left buttock 2) Stage 2-3 pressure

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ulcers on scrotum, and left heel. 3) Stage 1-2 pressure ulcer on right heel. 4) low urinary output. Plan 1) In an effort to ensure improved skin integrity and to keep moisture off the scrotum, apply petroleum jelly up to three times daily and will straight cath patient, if greater than 100 milliliters (ml) of urine, leave the catheter in place, remove if less than 100 ml. 2) For the stage IV pressure ulcer will flush with a diluted peroxide/saline flush and pack with Iodoform 2 inch gauze changing twice daily and as needed. Cover with large Kerlix fluff. This should help with both bacteria as well as debridement of the eschar. 3) For his heels, surround both pressure ulcers with a Mepilex foam cutting out the area of ulcerations to take the pressure off those. On the left heel apply Bactroban to the ulceration and cover with gauze; for the right heel simply cover with gauze and place padded boots over both heels. 4) Use wedged pillows and other padding to ensure the patient is not laying on his back and is turn side to side every 2 hours to relieve pressure and keep pressure off the scrotum as well as the left buttock. Nursing staff was instructed to be liberal with R1's pain medications especially prior to any of his dressing changes.

During interview on 11/5/20, at 9:14 a.m. NA-A stated R1 had a pressure ulcer on his left hip and for awhile also had one on his coccyx; however, indicated "that one kind of healed up". NA-A indicated R1 preferred to stay in his recliner most of the time with his feet down and indicated staff did not do anything with R1 regarding repositioning. R1 was capable of letting them know if he needed the restroom or anything. NA-A stated toward the end, approximately the last month, R1 would lay down on his bed between breakfast and lunch, otherwise his care didn't change much. NA-A denied R1 ever being

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2 900	Continued From page 16 on a turning/repositioning program. When interviewed on 11/5/20, at 9:35 a.m. NA-B stated R1 was pretty mobile in bed and until the end and then staff had used a sit to stand lift for transfers. NA-B indicated R1 sat in a recliner about 95% of the time. NA-B verified R1 had sores on his bottom and stated he had a lot more pain with them toward the end as they got bigger. NA-B also indicated R1 used a wedge under his feet and booties as he got open sores on his heels. NA-B stated until the very end R1 could reposition himself in bed but once in his chair, he didn't like to move. On 11/5/20, at 9:51 a.m. RN-B stated RN-C was the one responsible for doing the pressure ulcer care as RN-C had been trained by their previous wound nurse, RN-D. RN-B indicated RN-D had left employment with the facility in June 2020, and since then RN-C had been managing resident pressure ulcer care. RN-B indicated other nurses had assisted by performing dressing changes and assessments, however RN-C was the only one who measured the pressure ulcer. RN-B indicated RN-C documented his assessments in the Wound/Skin documentation section of the electronic record but when other nurses completed resident dressing changes, they signed off on the eTAR [electronic treatment administration record] and some nurses would also do a progress note. RN-B stated to her knowledge, pressure ulcers should be measured every week and assessed for signs of infection or pressure ulcer worsening. RN-B verified R1 was admitted with a pressure ulcer on his coccyx and also developed a pressure ulcer on the left buttock that healed and then came back. RN-B also verified R1's left heel ulcer started in June 2020, and a right heel ulcer developed in	2 900		

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September 2020. RN-B stated in September 2020, over the course of a few days, the buttock pressure ulcer "really blew up" and indicated she hadn't laid eyes on it until it really opened up a couple weeks before he passed. RN-B indicated they were putting dressings on it but it kept opening up. RN-B stated the pressure ulcer was painful for R1 toward the end. RN-B indicated NP-A had seen the pressure ulcer in the beginning of October 2020, and had ordered to have PT see the pressure ulcer for debridement but then R1 had been admitted to Hospice and the therapist did not work with Hospice so there was "a bit of a mess over that". RN-B indicated NP-A had come in person to see R1's pressure ulcer but she was not sure if any provider had seen the pressure ulcer prior to that.

When interviewed on11/5/20, at 11:02 a.m. the quality consultant (QC) stated resident pressure ulcers should be monitored and assessed weekly. Following review of R1's record, QC stated R1's medical record lacked evidence of weekly pressure ulcer monitoring and assessments. She had addressed this concern with RN-C and had provided education on the importance of weekly documentation. QC thought R1 had been seen by NP-A and indicated she would request the documentation of the visit from the clinic. QC was not able to speak to the deterioration of R1's pressure ulcers as she had never assessed the pressure ulcers.

During interview on 11/5/20, at 2:35 p.m. NP-B identified she was R1's primary care provider prior to R1's admission to the nursing home. However, when COVID-19 hit, the facility "wouldn't let them [providers] in there". NP-B identified she saw R1 for a preoperative exam in May [2020] and at that time R1 had a small

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pressure ulcer on his heel and stage 2 pressure ulcer on his coccyx, in the gluteal crease. NP-B indicated the pressure ulcer was being taken care of and was getting better and also indicated R1 had no pressure ulcers on his buttocks at that time. NP-B stated she had seen R1 via telehealth on 10/22/20, after being contacted by R1's family.

- At the time of the pressure ulcer assessment, NP-B indicated she had been completely overwhelmed by condition of R1's skin and stated "I almost started to cry. It was impressive." NP-B indicated her examination was limited by the technology (the telehealth exam was conducted via video); however, stated the buttock pressure ulcer had eschar that was several inches thick and the pressure ulcer was quite deep. NP-B indicated she had not been contacted by the facility regarding R1's pressure ulcers prior to the telehealth visit and stated she would have expected they contact either her or the local providers regarding the condition of R1's pressure ulcers. NP-B indicated she was also contacted by the Hospice registered nurse (HRN) prior to the telehealth visit who had enquired if NP-B had been aware of the condition of R1's skin. NP-B identified HRN had contacted her as soon as she (HRN) had evaluated R1 with concerns related to the care of R1's pressure ulcers.

When interviewed on 11/5/20, at 2:57 p.m. NP-A stated she saw and evaluated R1's pressure ulcers on 10/14/20. NP-A stated she recalled the visit as she had not physically been at the nursing home except for that visit. NP-A stated neither she, nor the physician had seen R1's pressure ulcers prior to the 10/14/20, appointment. The pressure ulcer was "not good" and described it

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as "pretty deep and very odorous, almost gagging". The pressure ulcer edges had undermining and the pressure ulcer bed was pea green/black in color. R1 was rolled on his side and she lifted up his left foot and noted a stage 1 pressure ulcer on the left heel. She then looked at his right heel, which also had a pressure ulcer and noted it was worse than the left. NP-A stated R1 sis not like wearing heel protectors and stated she "had to talk him into that." NP-A stated if a resident pressure ulcer was worsening the facility usually let her know and stated she should have been contacted sooner regarding R1's pressure ulcers. NP-A stated they could have put interventions in place; she was not sure if intervention would have helped heal the pressure ulcer but could have potentially made R1 more comfortable.

On 11/5/20, at 3:08 p.m. HRN identified she had completed an initial evaluation of R1 for admission to Hospice services on 10/19/20, and stated she was concerned as R1's buttocks pressure ulcer was open, had "stringy stuff coming out if it" and a "horrible, horrible odor." HRN stated when she evaluated R1 on the 10/19/20, and again on 10/21/20. R1's pressure ulcer had smelled like stool. HRN indicated the area had "no wound care to it" and stated the last order was to apply Bactroban twice daily. HRN stated Bactroban wasn't usually applied to pressure ulcers with that depth and she had concerns regarding the adequacy of the pressure ulcer care for the condition of R1's pressure ulcer. HRN stated she did not know what pressure ulcer care the facility had been providing prior to hospice but identified on 10/19/20, there had been nothing/no dressing on the pressure ulcer and also nothing on the pressure ulcer when she returned on the 10/21/20. Further, she could not

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get any direction for the care of R1's pressure ulcer from the nursing home, as there were no pressure ulcer care orders, so she had contacted NP-B as she needed direction on what to do with R1's pressure ulcer. HRN stated NP-B had given the order to do wet to dry dressing changes twice daily and had faxed an order to HRN which she had faxed to the nursing home. HRN stated she "absolutely felt this should have been evaluated by physician."

During interview on 11/5/20, at 3:26 p.m. RN-A stated it was planned for her to have training in wound care, however she had not been trained yet. RN-A indicated RN-C was doing all of the pressure ulcer measurements and she had assisted with dressing changes. RN-A could not explain the gaps in R1's pressure ulcer documentation. R1's pressure ulcer to his buttocks "came on quickly"; within a matter of days. However, identified a progress note dated 9/20/20, which identified R1 had an open area on the left buttocks "the size of a quarter". RN-A also stated a progress note dated 10/9/20, identified R1's pressure ulcer had odor and "continued to deteriorate. RN-A stated R1 had complained of "terrible pain" in the pressure ulcer at the end. After review of R1's medical record RN-A stated R1's left buttock pressure ulcer had first been visualized on 10/14/20, by NP-A. RN-A stated a physician should be notified for new pressure ulcers, foul odor, fever, or other signs or symptoms of infection pressure ulcer, including deterioration or pain.

On 11/5/20 at 3:56 p.m. RN-C stated he was responsible for wound care in the facility until the middle of September 2020, when he had taken another job, at another facility, for a period of time. RN-C stated it was his understanding RN-A

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took over, the pressure ulcer monitoring; however, it appeared that had not happened. RN-C stated he had only completed pressure ulcer care monitoring from August 2020 to mid-September 2020. He worked with RN-D, the previous wound nurse, who had left at the end of August 2020 or beginning of September 2020. RN-C stated when he was doing pressure ulcer care for R1, the only pressure ulcer requiring a dressing change was on on his coccyx. There was only a small ulcer on R1's coccys at that time. Further, one of the LPN's later noticed a spot further down on R1's buttocks and had described it as a round, purple spot. RN-C stated he spoke with RN-D about it, who had indicated R1 had developed spots like that previously which cleared up after a while. RN-C stated RN-A would have taken over so he did not recall seeing the pressure ulcer again after that. However, RN-C stated he did not think the pressure ulcer had healed and redeveloped. RN-C identified his documentation and what had been documented by RN-D sounded like the same area. RN-C stated he had received direction from RN-D on what to use on R1's left buttock pressure ulcer when it had reappeared in August 2020. RN-C stated a medical provider had not assessed R1's pressure ulcers until NP-A had done so on 10/14/20.

During interview on 11/6/20, at 1:37 p.m. NA-C stated R1 had been pretty independent at first, however about two months before passing away, R1 required more assistance. R1 required help with transfers using a sit to stand lift, due to weakness. NA-C stated they were monitoring an open area on R1's coccyx but stated she didn't think he had other skin issues at first. NA-C indicated quite a few months ago they had a cushion they wanted R1 to try in his recliner, but

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he didn't like it and then within the last couple of months he was provided an air mattress as he was laying in bed more. NA-C stated R1 sat in his chair during they day but they encouraged him to lay down in the afternoon. NA-C indicated they tried to get him to move around during the day and confirmed he did sleep in the bed. NA-C also indicated when R1 ended up being in bed more often than not, he needed more attention at that time and they had to reposition him every two hours.

On 11/6/20 at 3:07 p.m. the director of nursing (DON) stated, following a review of R1's pressure ulcer documentation, it was not the kind of monitoring she would expect to have been provided. They had tried many different solutions for the care of R1's pressure ulcer including different cushions, pads, and encouraging him to lay down. The DON stated they probably should have provided risk versus benefit education to R1 regarding his refusal to implement the interventions. When R1's son had called her about pressure ulcer care concerns she started reviewing the care he had received, she had questioned if the care R1 received was neglect of care. Further, she probably should have been more involved in the facility's management of pressure ulcers and verified her staff needed training. The DON stated R1's care "fell through the cracks" and stated R1's pressure ulcer should have been assessed by a provider prior to 10/14/20. The DON stated "The most surprising thing is nobody came to me and asked me to look at this."

R2's admission MDS dated 8/26/20, identified R2 was cognitively intact and required extensive assistance of two for bed mobility, dressing, toilet

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2 900	Continued From page 23 use and personal hygiene and was totally dependent on two plus staff for transfers. The MDS included diagnoses of a stage 4 sacral pressure ulcer, morbid obesity, reduced mobility, weakness and depression. R2 had no symptoms of psychosis or behavioral symptoms and exhibited no rejection of care. The MDS further identified R2 had one stage 4 pressure ulcer, present on admission, and 1 venous/arterial ulcer. The MDS indicated R2 required pressure relieving devices for bed and chair, a turning and repositioning program and pressure ulcer care. R2's Pressure Ulcer CAA dated 8/31/20, indicated R2 was overweight, fed self independently and required a wheelchair for ambulation. R2 needed encouragement to get out of bed and required assist of 1-2 for bed mobility. R2 transferred surface to surface with assist of 1-2. Present on admission, R2 had redness under both breasts; pressure ulcer of sacral region/coccyx, 4 cm x 3 cm x 2 cm - bottom thigh gluteal fold is 4 cm x 20 cm x 5 cm, right gluteal pressure ulcer in 7 cm x 3 cm x 0.1 cm, left gluteal 8 cm x 2 cm x 0.1 cm; left lower shin has two picked/scratched areas 1 inch x 0.5 inches and 1 inch x 0.5 inch (covered to prevent scratching/picking; bruising on right and left outer shoulders, left elbow, right and left back of hands; and venous ulcer on right heel 0.3 cm deep, left heel pressure ulcer inside heel - open to air. R2 had impaired skin integrity/pressure ulcer to coccyx, gluteal folds and right heel. Goal: open areas would heal without signs and symptoms of infection, as evidenced by no purulent drainage and intact skin. R2's care plan dated 8/26/20, indicated R2 had impaired skin integrity with pressure ulcers to coccyx, gluteal fold and right heel and required a	2 900		

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pressure reducing mattress on bed and pressure reducing cushion in wheelchair. Interventions included: staff to encourage and assist R2 to turn and reposition self at least every two hours and as needed for comfort, get out of bed daily as tolerated, and float heels at all times when in bed, observe skin daily with cares, monitor pressure ulcer daily for changes and sign/symptoms of infection, inspect skin weekly, provide treatment per MD orders and monitor/report effectiveness of treatment. Additionally, the Care Plan indicated R2 refused to get out of bed at this time was working with PT/OT and directed staff to inform R2 of possible complications with healing of ulcers, blood clots, and contractures and to continue to encourage R2 to get out of bed daily.

During observation on 11/2/20, at 2:58 p.m. R2 was resting in bed on her back with the head of the bed elevated approximately 30 degrees. R2's lower body was covered with a blanket and was unable to visualize R2's lower extremities.

During observation on 11/3/20, at 8:16 a.m. R2 was resting in bed on her back with the head of the bed elevated approximately 30 degrees. R2's lower body was covered with a blanket and was unable to visualize R2's lower extremities.

On 11/3/20, at 8:38 a.m. R2 remained in bed and stated she preferred to not have her dressing change observed.

During interview on 11/3/20, at 9:04 a.m. after completion of the dressing change, R2 stated she had been at the facility for approximately one month and was admitted for pressure ulcer care and PT after a hospitalization with the hope to discharge back to home. R2 indicated PT had not started as her pressure ulcers were still too

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deep. R2 stated she had pressure ulcer treatments twice daily after admission but it had recently changed to once daily. R2 indicated she has three pressure ulcers on her bottom and after she was admitted to the facility she acquired two more and she thought she now had a total of 5 pressure ulcers. R2 stated her pressure ulcers on her bottom were getting better. R2 stated she was confident in the staff and felt like they knew what they were doing and was seeing the physician via telehealth since her admission. R2 stated she had not seen the wound physician but indicated the facility had been in contact with him. R2 stated she did not get out of bed during the day and indicated she wouldn't until the pressure ulcers were healed up. R2 stated she has an air mattress on her bed. R2 was able to turn side to side however, did not keep track of how often she moved to relieve pressure from her buttocks.

R2's Skin Condition/Wound Progression documentation from 8/19/20 through 11/3/20, included the following pressure ulcer monitoring/assessments:

Sacrum:
On 8/21/20, the initial pressure ulcer assessment was completed and indicated a stage 4 pressure ulcer present upon admission with tunneling along top of right gluteal, 5.5 cm deep. Open pressure ulcer along left gluteal. Tunneling along bottom right gluteal into upper thigh, about 4.5 cm. Tunneling into right gluteal, about 5 cm. The assessment lacked further measurements of the pressure ulcers. The pressure ulcer was assessed again on 8/24/20 and measured 4 cm x 3 cm x 2 cm. The pressure ulcer was assessed weekly until 9/28/20, and then not assessed again until 10/26/20, 4 weeks later. All assessments after the initial assessment lacked measurement

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2 900	Continued From page 26 of any pressure ulcer tunneling. Bottom Thigh/Gluteal Fold: On 8/21/20, the initial pressure ulcer assessment was completed and indicated a stage 4 pressure ulcer present upon admission with tunneling along bottom right gluteal into upper thigh, about 4.5 cm. The assessment lacked further measurement of the pressure ulcer. The pressure ulcer was assessed again on 8/24/20, and measured 4 cm x 20 cm x 5 cm. The pressure ulcer was assessed weekly until 9/28/20, and then not assessed again until 10/26/20, 4 weeks later. All assessments after the initial assessment lacked measurement of any pressure ulcer tunneling. Right Gluteal: On 8/21/20, the initial pressure ulcer assessment was completed and indicated a stage 4 pressure ulcer present upon admission with tunneling along top of right gluteal, 5.5 cm deep. Tunneling into right gluteal, about 5 cm. The assessment lacked further measurements of the pressure ulcers. The pressure ulcer was assessed again on 8/24/20, and measured 7 cm x 3 cm x .01 cm. The pressure ulcer was assessed weekly until 9/28/20, and then not assessed again until 10/26/20, 4 weeks later. All assessments after the initial assessment lacked measurement of any pressure ulcer tunneling. Left Gluteal(s): On 8/21/20, the initial pressure ulcer assessment was completed and indicated an open pressure ulcer along left gluteal. The assessment lacked measurement of the pressure ulcers. The pressure ulcer was assessed again on 8/24/20 and measured 8 cm x 2 cm x 0.1 cm. The pressure ulcer was assessed weekly and on	2 900		

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2 900	Continued From page 27 9/8/20, documentation identified and upper gluteal pressure ulcer which measured 4/5 cm x 1 cm and a lower gluteal pressure ulcer which measured 9 cm x 2 cm. The pressure ulcers were assessed weekly until 9/28/20, and then not assessed again until 10/26/20, 4 weeks later. All assessments after the initial assessment lacked measurement of any pressure ulcer tunneling. In addition, R2's medical record lacked a comprehensive assessment: to include the potential causative/contributing factors when the pressure ulcer developed, to ensure appropriate interventions were identified and implemented to promote pressure ulcer healing. Left Heel On 8/21/20, a pressure ulcer ulcer to the left heel was identified as a scabbed over area on the inside of the left heel. The assessment lacked measurement of the area. The pressure ulcer was not assessed again until 9/21/20, four weeks later. On 9/21/20, the pressure ulcer measured 1 cm x 1 cm. No further assessments of the pressure ulcer were available. In addition, R2's medical record lacked a comprehensive assessment: to include the potential causative/contributing factors when the pressure ulcer developed, to ensure appropriate interventions were identified and implemented to promote pressure ulcer healing. R1's progress notes from 9/28/20, throguh 11/3/20, were reviewed and the notes failed to inlcude weekly pressure ulcer monitoring assessments. R2's Telehealth Report dated 9/4/20, identified R2 was admitted to the facility after having extensive stage IV sacral decubitus ulcers. She had dealing with chronic obesity. As a result of	2 900		

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sitting, developed significant ischemia and ulceration. She was in the hospital in Duluth for several months. She was discharged for continued care of these pressure ulcers. Via camera, nursing was able to show me her sacral area with regards to pressure ulcers. Plan: 1) Continue with treatment of the pressure ulcers. Nursing reported these are improved. Obviously, the gravity of the situation is such that these pressure ulcers could be life-threatening.

On 11/5/20, at 9:12 a.m. NA-A stated R2 did not like to be repositioned and it was very hard to get her comfortable. NA-A confirmed R2 had a lot of open areas, "basically everywhere, her entire bottom." NA-A stated R2 would refuse repositioning as well and when she refused they were to report it to the nurse so her refusals could be charted. NA-A indicated R2 was to be repositioned every two hours.

On 11/5/20, at 9:32 AM NA-B stated R2 had "quite a few nasty sores." NA-B stated R2 could assist to boost up in the bed and roll but indicated she was to the point where she was refusing cares such as repositioning. NA-B stated once they get her comfortable she was "done" and doesn't like to reposition. NA-B stated they position her with pillows to offload the best they can and what R2 would allow. NA-B also indicated they floated her right heel on a pillow so it didn't rest on the bed. NA-B stated they were to chart and notify the nurse when R2 refused repositioning.

On 11/5/20, at 9:51 a.m. RN-B stated she had completed a dressing change for R2 but had not completed measurements of R2's pressure ulcers. RN-B stated RN-C was responsible for wound measurements. Residents were seen on

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routine rounds by a physician or nurse practitioner and stated she was not sure if NP-A had seen R2's pressure ulcers however, stated MD-A had seen them.

On 11/6/20 at 3:07 p.m. the DON reviewed the documentation of R2's pressure ulcer care and stated she would have expected the pressure ulcer assessments to include measurements of the pressure ulcers as well as measurements of any tunneling of the pressure ulcer. DON stated she had looked at R2's pressure ulcer on 10/2/20, and had been concerned that an MD had not looked at it so she had tracked down the wound specialist. The DON stated residents with a pressure ulcer should have at least weekly documentation of an assessment and confirmed pressure ulcer monitoring would include measurements and a description of the wound appearance and any drainage. The DON stated when she came on board in June (2020), their wound nurse at the time, RN-D had been looking to change jobs. RN-C had started working with the facility in July (2020) and had been willing to work with RN-D on wounds, however, she only wanted to work two days per week. RN-D had agreed to train RN-C however, things got busy for her and she thought RN-D had only spent a few Mondays working with RN-C. Further, she discovered the LPN's did not assist with pressure ulcer measurements and stated the plan was to have the facility quality consultant put together some training for their staff and to have RN-A obtain wound care certification.

The Skin Ulcer Protocol updated 7/1/20, directed assessment and monitoring of skin concerns included daily documentation to address the following: an evaluation of the ulcer, if no dressing was present; an evaluation of the status

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2 900	Continued From page 30 of the dressing, if present (intact, drainage, etc.); the status of the tissue/area surrounding the ulcer, the presence of possible complications, such as increasing size or infection (redness/drainage); and presence of pain and if controlled, how, etc. The protocol also directed wound round documentation should be completed weekly at minimum and should include: type of wound, location and staging, size (including length, width and depth and the presence of any undermining or tunneling/sinus tract), exudate including color, odor and approximate amount, presence of pain, wound bed to include color and type of tissue/character, evidence of healing or necrosis, description of the wound edges and surrounding tissue, wound type specific charting, interventions in place, and current treatment and response to treatment. The protocol indicated if a wound was not showing improvement in the last 2-4 weeks, the MD should be contacted for new treatment orders. Further, the wound status would be tracked on the Skin Tracking Form SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policy and procedures related to pressure ulcer prevention, care and services in order to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The DON or designee could educate all staff and conduct random audits of the delivery of care to ensure appropriate care and services are implemented. The quality assurance committee could monitor the effectiveness of the plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		