DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 15, 2019

Ms.. Laura Ahlf, Administrator
Green Pine Acres Nursing Home
427 Main Street Northeast
Menahga, MN 56464

Re: Reinspection Results - Complaint Number H5563012C

Dear Ms.. Ahlf:

On April 9, 2019 a surveyor from the Minnesota Department of Health, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on February 26, 2019. At this time these correction orders were found corrected.

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

Electronically Submitted
March 18, 2019

Administrator
Green Pine Acres Nursing Home
427 Main Street Northeast
Menahga, MN 56464

RE: Project Number H5563012C

Dear Administrator:

On February 26, 2019, an extended standard survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the February 26, 2019 extended survey the Minnesota Department of Health completed an investigation of complaint number H5563012C.

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

REMOVAL OF IMMEDIATE JEOPARDY

On February 26, 2019, the situation of immediate jeopardy to potential health and safety cited at F-684 was removed. However, continued non-compliance remains at the lower scope and severity of G.

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 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 May 17, 2019.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 17, 2019, 42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 17, 2019, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 26, 2019. 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. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If**

you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Green Pine Acres Nursing Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective February 26, 2019. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 26, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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.

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
	245563	A. BUILDING _____ B. WING _____	C 02/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	**427 MAIN STREET NORTHEAST MENAHGA, MN 56464**

(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 2/25/19, and 2/26/19, an abbreviated survey was completed at your facility. A complaint investigation was also conducted. Your facility was found NOT to be in compliance with requirements of 42 CFR Part 483, Subpart B and requirements for Long Term Care Facilities. Complaint H5563012C was found to be substantiated and resulted in an Immediate Jeopardy (IJ) at F684 due to the facility's failure to thoroughly investigate contributing factors related to the saturation and subsequent decline of a surgical wound for 1 of 1 resident (R1) who had physician orders to keep the surgical site dry and the resident had experienced complications as a result of saturated wound dressings which resulted in macerated skin, wound dehiscence, and required additional surgical intervention. An extended survey was conducted by the Minnesota Department of Health on 2/26/19. 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 684	Quality of Care	F 684		3/26/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/28/2019

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

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F 684 SS=J	Continued From page 1 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate contributing factors related to the saturation and subsequent decline of a surgical wound for 1 of 1 resident (R1) who had physician orders to keep the surgical site dry and the resident experienced complications resulting from saturated wound dressings which resulted in macerated skin, wound dehiscence and required additional surgical intervention. This failure to thoroughly investigate causative factors related to the surgical wound decline, and subsequent failure to develop/modify interventions, resulted in an immediate jeopardy situation for R1. The immediate jeopardy (IJ) began on 2/8/19, when the facility received notification from a medical provider that R1's surgical wound had dehisced as a result of maceration from saturated wound dressings, and the facility failed to thoroughly investigate, and failed to modify or develop policies and procedures for the protection of surgical wounds. The IJ was identified on 2/25/19. The administrator, director of nursing (DON) and licensed social worker (LSW) were notified of the IJ at 6:38 p.m. on	F 684	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance It is the policy of Green Pine Acres to provide quality of care to all our residents, including those with wounds. The policy and procedure have been updated to include bathing status. Orders will be obtained by the provider on admission on residents with wounds that have non-removable dressings, casts, splints, staples and/or sutures, and with orders to keep the wound/dressing dry. Cast covers have been obtained and nursing staff (RNs and LPNs) were	

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F 684	Continued From page 2 2/25/19. The IJ was removed on 2/26/19, but noncompliance remained at the lower scope and severity of G, isolated scope with actual harm. Findings include: R1's Admission Record form printed 2/25/19, indicated R1 was admitted to the facility 1/25/19, with diagnoses which included: orthopedic aftercare following surgical amputation, peripheral vascular disease, diabetes due to underlying condition with diabetic polyneuropathy, nutritional deficiency, hypertensive chronic kidney disease, vascular dementia without behavioral disturbance, arteriosclerosis of native arteries of extremities with gangrene, and acquired absence of other right toes. R1's admission Minimum Data Set (MDS) assessment dated 2/7/19, indicated R1 was admitted from the hospital, had moderate cognitive impairment and demonstrated no behaviors. The MDS also indicated R1 required: extensive assist of one to two staff for bed mobility, transfers, locomotion on and off the unit, toileting, dressing and bathing; and required limited assistance of one staff for hygiene, and assistance of one person to walk in the corridor, which had occurred only once or twice. The MDS also indicated R1 utilized a walker and wheelchair. The MDS also indicated R1 had a foot infection, a surgical wound and received surgical wound care with the application of foot dressings, and physical and occupational therapy (PT and OT) were provided. R1's 5 day Medicare MDS also dated 2/7/19, identified the same information as the admission MDS, however, indicated R1 did not ambulate during the reference period and utilized a walker and a	F 684	educated on the use of them as well as demonstrated competency in the use of them, according to manufacturer's guidelines from 3/6/19-3/15/19. Cast covers will be used to cover wounds on extremities that require moisture barrier where the physician has indicated the resident may shower. If a resident has a wound order which indicates it is to be kept dry on another area of the body then a bed bath will be done, with the wound that is to be kept dry avoided. If a resident requires open or closed wounds, dressings, wraps, braces, splints, or casts to be kept dry, the NAR will not bathe resident until a cast cover has been applied by a competent licensed nurse. The licensed nurse will apply the cover at which time the NAR may then bathe the resident. Once the bathing is complete the licensed nurse is to remove the cast cover and assess for any wetness by both looking and feeling. Any dampness or wetness noted will be reported to the provider immediately, for further instructions. The Wound Care Nurse will assure that care plans, orders, and documentation is up-to-date and notify provider if concerns. This is to be done on weekly wound care rounds, ongoing. Nurse will document any concerns found and report to Director of Nursing and/or provider, if warranted. The Director of Nursing or designee will complete weekly chart audits on care plan completion and orders for bathing, if applicable, for six (6) months, to assure competency; then to continue with monthly audits thereafter.	

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F 684	Continued From page 3 wheelchair. R1's primary medical condition was due to an amputation. R1's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 2/7/19, indicated R1 was aware of his short term memory deficit with a goal of cognitive improvement as he desired to return home. R1's Activities of Daily Living (ADL)/Rehabilitation Potential CAA dated 2/7/19, indicated R1 was admitted from the hospital for short term stay following the surgical amputation of the 2nd and 3rd digits on the right foot. The CAA also indicated R1 was non weight bearing, non-ambulatory, and required physical assistance with ADLs. In addition, the CAA indicated R1 was working with PT (physical therapy) and OT (occupational therapy) and indicated the goal was for R1 to improve ADL abilities and avoid complications. R1's Pressure Ulcer/Injury CAA dated 2/7/19, indicated R1 was admitted following amputation of the right foot 2nd and 3rd digits with stitches in place. According to the CAA, wound treatment consisted of cleansing and dressing as needed. In addition interventions included staff were to monitor pain, monitor and manage diabetes, diabetic foot checks weekly, weekly skin checks x four weeks, appropriate foot and nail care, and PT/OT as ordered. R1's Psychosocial Well-Being CAA dated 2/7/19, indicated R1 was working hard toward his discharge goal of returning home. R1's Fall's CAA dated 2/7/19, indicated R1 was non-weight bearing to the right foot therefore	F 684	The procedure for transcribing orders was changed January 28, 2019 in that all orders are to be double-checked by two (2) nurses or a nurse and TMA. Also added to the policy and procedure on February 26, 2019 was for the nurse/TMA to number orders if there are multiple orders on a page that are difficult to read. Nursing and TMA staff were educated on the policy and procedure update. Training was completed February 26, 2019. Date of compliance when all training was complete was March 15, 2019. Any staff that is currently on a leave will receive training/competency testing prior to taking a shift at the facility. The QA committee was updated on plan of correction on March 22, 2019 and The QA committee will continue to monitor compliance/training audits monthly for 6 months. The Administrator and DON are responsible for oversight and completion of this plan	

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F 684	Continued From page 4	F 684		

required physical assist of two staff for transfers and toileting, had a history of falls prior to admission and one fall occurrence while at the facility with no injury. The CAA also indicated R1 required reminders of non-weight bearing status.

An Interagency Referral Form dated 1/25/19, indicated R1 had been hospitalized with a principal problem of gangrene of right foot, had undergone cystoscopy for foreign body removal from bladder, and had a right transmetatarsal amputation. Discharge orders included but were not limited to:
-Appointments with Podiatry 1 week and 2 weeks from discharge
-Don't change dressing, keep clean dry and intact until clinic visit
-Non weight bearing-right. Medical predictability-predict that weight bearing status will increase and will be reevaluated at next appointment in 2 weeks.
- Will have follow-up in 1 week but sutures will not be removed for at least 2 weeks and he is non weight bearing until the sutures are removed.
-Physical Therapy: evaluate and treat
-Discharge potential: length of stay <30 days, then plan assisted living.

In addition an After Visit Summary (AVS), also dated 1/25/19, included the following instructions for R1's care:
-Weight bearing status: non weight bearing-right
-Medical Predictability - Predict that weight bearing status will increase and will be reevaluated at next appointments in 2 weeks. Will have follow-up in 1 week but sutures will not be removed for at least 2 weeks and he is non weight bearing until the sutures are removed.
-Appointment with Podiatry - Referral Reason:

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F 684	Continued From page 5	F 684		

Injury/Trauma: amputation
-Wound Care Instructions: Don't change dressing, keep clean dry and intact until clinic visit. Additional wound care instructions: per podiatry orders.
-Physical Therapy Referral instructions: evaluate and treat
-Discharge Potential: Length of stay < 30 days. Then plan assisted living.

Although both documents include physician discharge wound care orders with directions to leave the wound dressing intact, R1's facility Skin Check form dated 1/25/19, identified an incision to R1's right foot which was 12 centimeters (cm) long with 18 stitches however the wound would not have been visible had the dressing remained intact.

R1's Medication Administration Records (MAR) dated 1/1 -1/31/19, and 2/1-2/28/19, included the following orders:
-Weekly wound monitoring to right foot transmetatarsal amputation site in the morning every Wednesday. The order start date was 1/30/19 and was documented as completed on 1/30/19, 2/6/18 and 2/13/19.
-Weekly wound monitoring to right foot open incision one time a day every Wednesday. The order start date was 2/13/19 and was documented as completed on 2/13/19.
-Do not change dressings. Elevate leg and keep bunny boot on at all times every shift for right foot. The order start date was 2/1/19. The order was discontinued 2/8/19.

R1's Treatment Administration Record (TAR) dated 1/1 -1/31/19 and 2/1-2/28/19, included the following orders:

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F 684	Continued From page 6 -Check right foot surgical site for any signs/symptoms of infection. Cleanse and dress as needed two times a day. The order start date was 1/25/19. -Infection monitoring note to right foot two times a day. The order start date was 1/25/19. -Do not put plastic bandage over right lower extremity when showering will cause maceration to wound. The order start date was 2/9/19. -Dressing change to right lower extremity, apply betadine, non-adherent gauze, 4 x 4 gauze, ace bandage one time a day for diagnosis. The order start date was 2/9/19. -Strict non weight bearing to right lower extremity three times a day for diagnosis. The order start date was 2/9/19. The podiatrist's Surgical Follow report dated 2/1/19, indicated R1 presented one week status post transmetatarsal amputation secondarily due to peripheral artery disease with gangrenous changes to the distal forefoot. The report indicated instructions after discharge from the hospital were to keep dressings on while at the skilled nursing facility and included: "Unfortunately, his dressings are different, therefore, they were changed but I am unaware whether there was strikethrough noted or any drainage from this area." Further documentation indicated a physical exam had revealed R1 had overall diminished sensation to the lower extremity and pedal pulses were not palpable however, indicated dorsal not plantar aspect of the transmetatarsal amputation site did have a capillary refill time of less then 3 seconds. The report included, "Incision site was well coapted although there was a central portion of mild necrosis which was dry and stable. There was rubor plant flap. Sutures were intact without	F 684		

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loosening, normal postoperative edema near incision site. There was also an ulcerative lesion to the plantar aspect at the central portion of the flap as well, which appeared superficial in nature." The plan indicated R1 would have a follow up appointment in one week for suture removal and included: "Keep leg elevated, do not get operative site wet. Keep Bunny boot on at all times. Continue oral antibiotics previous dispensed by the primary care team. Informed the patient that if he does develop further necrosis or the transmetatarsal amputation site does develop some wound dehiscence we will go forth with having him reassessed by the vascular team next week. Written instructions were provided for skilled nursing facility to not change dressings."

R1's podiatry Surgical Follow up dated 2/8/19, indicated the patient had attended the appointment with his sister and included: "Patient is currently residing in a skilled nursing facility. During today's office visit there is significant malodor associated with the patient's operative extremity and his dressings were saturated. After discussing this with his sister, it does appear that patient has been showering by the nursing staff at the nursing facility. They are attempting to wrap his lower extremity with plastic to prevent water seeping into the dressings. Unfortunately, we do not know how long his dressings have been saturated. Skin was macerated and wound dehiscence was clearly evident to the amputation site. Laterally the flaps had coaptation secondarily due to macerated tissue. Erythema is present medially and laterally to the amputation site. There appears to be no cellulitis or lymphangitic streaking, however we will obtain labs to assess for infections. Discussing with [R1] as well, he states he has been ambulating on the

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operative extremity." The physical exam indicated the dressings were removed and the heel was completely macerated with desquamated hyperkeratotic tissue. The surgical follow up note indicated R1's right lower extremity was colder to touch and, "Pedal pulses were difficult to Doppler. Central area of necrosis was present. Medially and laterally to the transmetatarsal amputation site there was wound dehiscence noted laterally with no acute signs of infections, no coaptation was noted laterally. Medially there is increase in erythema from this area however, no purulent drainage was noted with mechanical compression of the amputation site. No soft tissue emphysema is palpable...concern for worsening PAD (peripheral artery disease) of his right lower extremity. Capillary refill time dorsal lateral flat of the amputation site was delayed between 3 and 5 seconds and sluggish in nature." The plan included: "I informed the patient and his sister I do have some concern about worsening appearance of his amputation site which is likely due to multiple reasons including but not limited to patient's peripheral arterial disease, diabetes, recent saturation of his postoperative dressings and complete noncompliance of ambulating on extremity. I informed him there is a higher risk of below-knee amputation. I informed him of the wound dehiscence as the flap has not adherent. Going forth we can continue with wound care management potential use of a wound VAC, more proximal foot amputation versus below-knee amputation given the appearance of his foot clinically, I do not believe this amputation site will heal. We will await vascular's recommendation, for the time being nursing staff will perform daily dressing changes with the use of Betadine and dry sterile gauze, strict non-weight bearing to the right lower extremity, do not get operative site

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wet. Patient will follow up with me next week to discuss further options going forward." The instructions for the right lower extremity transmetatarsal amputation site included: "Dressings need to be changed every day, apply Betadine, non-adherent gauze, 4 x 4 gauze, Ace bandages. Patient is to be strictly non-weight bearing to the right lower extremity. Do not get the operative site wet, patient presented during today's office visit with macerated tissue due to his gauze and dressings being saturated with water after his recent shower. Please do not attempt to apply a plastic bandage around his lower extremity and shower as this typically leads to some sort of leakage causing noted dressings to become macerated and wet which will lead to wound dehiscence which he currently has. Follow-up with vascular next week, Wednesday likely needs revascularization per vascular versus below-knee amputation to the right lower extremity."

R1's care plan printed on 2/25/19, identified the right foot surgical wound and directed the staff to provide weekly wound monitoring and treatments. However, the care plan failed to include the interventions related to the care of the surgical site/extremity such as to maintain dryness of the surgical limb as well as how to provide appropriate bathing, and protect dressing from getting wet when bathing.

Review of R1's progress notes (PN) revealed the following:

-1/25/19, R1 admitted post transmetatarsal amputation of right foot secondary to gangrene related to diabetes and frost bite. To receive skilled therapy and IV therapy for wound

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management. R1 would be non-weight bearing on the right foot until cleared by the physician. An additional PN dated 1/25/19, indicated R1 was admitted for a short stay of about three weeks to heal surgical site, recover strength and return home. Incision clean and dry on top of right foot with no signs of infection noted.
-1/30/19, weekly wound monitoring: right foot surgical amputation of toes. 1. The surgical incision measured 120 cm with intact sutures. 2. A 20 cm x 45 cm dried blister from amputation site on bottom of foot. 3. A 10 cm x 10 cm dried scab on top of the foot. 4. A 20 cm x 16 cm dried scab on the top of the foot. The observation of the aforementioned indicated wound #1 had a small amount of serosanguineous (contains both blood and serum) drainage on the dressing, no odor, skin was a healthy pink color. Wound #2 indicated skin intact with no drainage skin soft with dark red areas and a couple of lighter areas within. both #3 and #4 wounds were noted as dried res scabs, skin dry. Treatment consisted of cleansing and covering the wounds twice a day and as needed. The wounds were identified as improving. An additional PN dated 1/30/19, indicated pedal pulses were present with no edema noted.
-2/1/19, R1 had a podiatry appointment. New orders to no change R1's dressings, keep leg elevated with bunny boot on at all times, and R1 to "follow up with podiatrist next week for suture removal".
-2/8/18, pedal pulses present bilaterally with no edema present. Right foot dressing intact. A note indicated at 12:19 p.m. R1 left the facility for a podiatry appointment.
-2/8/19, the note indicated R1 returned to the facility at 5:30 p.m.
-2/9/19, at 10:31 a.m. dressing change to right

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foot, sutures removed at 2/8/19, appointment and now incision line is open. Incision measures 12 cm long with open area 1 cm along entire incision line. Skin on the edge of the incision is dusky in color. Incision cleansed, painted with betadine, covered with a non adherent, wrapped with kling dressing followed by an Ace wrap.
-2/11/19, late entry from appointment 2/8/19, included: "Dressing needs to be changed daily with betadine applied, non adherent gauze followed by 4x4 gauze and an Ace bandage. R1 was to be strictly non-wight bearing to the right lower extremity. Do not get the operative site wet, patient presented during today's visit with macerated tissue to his gauze and dressing being saturated with water after recent shower. Please do not attempt to apply plastic bandage around his lower extremity and shower as this typically leads to some sort of leakage causing noted dressing to become macerated and wet which will lead to wound dehiscence which he currently has. Follow up with vascular next week as likely needs revascularization per vascular versus a below the knee amputation to the right lower extremity."

On 2/25/19, at 11:14 a.m. the occupational therapist (OTR) stated she was contracted with the facility and was familiar with R1, who had received skilled PT and OT services. The OTR stated R1 had come in with a metatarsal amputation and had been non weight bearing on the right side. The OTR stated she had done some cognitive testing with R1 and had assessed him to have minimum to moderate cognitive deficits. In addition, she stated R1 had been very weak, had endurance issues, and that she had been working with R1 on self cares/independence, transfers, and standing. The OTR also confirmed R1 had planned to go home.

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The OTR stated when R1 had been admitted, he'd had the impression he could put weight on his heel and the OTR stated everyday they'd stressed with him he could not do that. The OTR also stated R1 had a tough time standing to transfer so they had started using a sliding board for transfers. The OTR stated she could not verify whether R1 had been putting weight on his right leg when nursing provided care however, stated he had it in his mind he could bear weight on his heel. The OTR reiterated staff had stressed with R1 he was strict non-weight bearing and stated after awhile he kind of remembered it, but thought R1's cognitive deficits were a factor in that. Further, the OTR stated she had not seen R1's surgical wound and was not aware whether R1 used the shower.

On 2/25/19, at 11:22 a.m. trained medication aide (TMA)-A confirmed R1 had been admitted with an amputation of the right forefoot and had been non weight bearing. TMA-A stated R1 had graduated to a slide board with assist of 2 for transfers. TMA-A stated R1 had been compliant with cares, had no resistance to cares and exhibited no behaviors. TMA-A indicated R1 had never walked while in the facility, and stated R1's foot had remained wrapped and she had not done any treatments to the foot. TMA-A verified R1 had taken a shower and indicated he had a shower in his room which he had used one to two times per week. TMA-A stated when R1 had showered staff had wrapped his right lower extremity in "Saran wrap." TMA-A stated the last time she had assisted R1 with a shower, she had applied Saran Wrap around the foot as they were not supposed to change the dressing. However, TMA-A stated when she had assisted R1 with a shower, his dressing to the right foot had never

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gotten wet. She also denied having ever noted any drainage on the dressing and stated it never looked or felt wet.

On 2/25/19, at 11:27 a.m. the physical therapist (PT) indicated she was familiar with R1 and stated PT had worked with him, 5 days per week. PT verified R1 had been non weight bearing on the right side and indicated they worked with R1's stand/pivot transfers and also sliding board transfers due to his non weight bearing status. PT indicated they had also worked on safety awareness. PT stated R1 needed help to get up so she couldn't imagine him walking and indicated she didn't feel he was able to ambulate or get up on own. PT indicated she he never seen R1's wound and stated she had never noted if it was wet or if there had been drainage on the dressing. PT stated R1 had worn a bunny boot when up and in bed for the relief of pressure.

On 2/25/19, at 11:31 a.m. TMA-B stated TMA's were allowed to do wound care but not if it involved a sterile wound treatment. TMA-B indicated she had never done any wound treatments for R1 as his orders had been updated to not change the dressing and leave it alone by the time she worked with him in a TMA capacity. TMA-B indicated they would visualize the dressing for drainage and stated she had never noted any drainage. TMA-B stated she thought R1 had a shower three times per week on Monday, Wednesday and Friday and bathed in the shower in his room. TMA-B indicated when she had given R1 a shower, she had wrapped his right lower extremity with a garbage bag, wrapped the top of the bag with plastic wrap and taped it. TMA-B indicated R1's dressing never got wet, to her knowledge. TMA-B indicated prior to the

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order not to touch the dressing, they had been checking the bandage twice daily. TMA-B stated if R1's dressing had gotten wet, it would have been evident as it had been wrapped from foot to mid calf with an Ace bandage. TMA-B indicated if a wound got wet she would have contacted the RN to get order from physician to change the dressing and would not have left it wet. TMA-B stated R1 did not walk, but needed some reminders to maintain non weight bearing. TMA-B stated R1 would sometimes try to use the back of his heel with transfers, but indicated this happened less as he started to use the slide board. TMA-B stated it happened more when he could not use slide board; using the toilet for example and indicated this happened maybe once a shift or couple of days.

On 2/25/19, at 11:46 a.m. the health unit coordinator (HUC) stated she sometimes also provided personal cares for residents and had helped transfer R1 once. The HUC stated she also entered physician orders so she knew R1 had orders to be non weight bearing. The HUC stated R1 had put his weight down when she had assisted him with transferring but they had reminded him not to do so. HUC indicated R1 had exhibited no behaviors and was not resistive to cares. HUC indicated she had never assisted R1 to the shower and had not seen his wound, but had heard about R1's dressing being wet after one of his podiatry appointments. HUC stated he had an order to not change the dressing after his first podiatry appointment and then the dressing had been noted to be wet after his second podiatry appointments. The HUC stated she was not sure how/if the dressing had gotten wet and stated she thought R1 had utilized a slide board for transfers by that time. The HUC stated she

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was not sure if R1 had ever been provided a bed bath or whether his showers had ever been placed on hold.

On 2/25/19, at 11:58 AM registered nurse (RN)-C stated she primarily worked on the transitional care unit (TCU) and was familiar with R1. RN-C stated R1 had a little dementia and needed reminders such as with not bearing weight on his right foot during transfers. RN-C stated she had never assisted with R1's transfers but had been in the room while R1 had been transferred. RN-C stated for the most part he did not bear weight but needed reminders not to do so. RN-C stated upon admission they had done a daily dressing change with telfa, 4x4 and ace wrap for R1. RN-C indicated R1's incision had been intact with sutures. R1 had seen the podiatrist after 1 week and they had received orders after that appointment to no change the dressing so they had not done so. RN-C indicated they had a prompt in computer to assess the dressing, clean dry intact, ace wrap on which she had assessed daily. RN-C stated R1 then had another podiatry appointment and when he came back and the wound was open. She indicated they had received new orders for betadine, non-adherent dressing and wrap it. After this, RN-C stated R1 saw a vascular surgeon and was then transferred to hospital. RN-C stated R1 had showers approximately three times per week and showered in room. RN-C stated the aids had wrapped the wound with plastic bag to prevent it from getting wet. RN-C indicated the aids would have let her know if the dressing was wet so she could change it. RN-C stated she was never notified R1's dressing was wet. RN-C stated she had been at the facility the day R1 had his podiatry appointment and indicated R1's dressing

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had been dry as of noon. RN-C stated she does not know how the dressing could have gotten wet. RN-C indicated R1's appointment had been in the afternoon and he had left the facility at 12:15 p.m. RN-C stated she had tested R1's blood sugar, he had lunch and had then been seated in the common area. RN-C indicated she had felt of R1's dressing and it had not been wet and there had been no indication the wound required further assessment. RN-C indicated R1 had went to the appointment alone. RN-C stated she doesn't think the dressing could have been wet without her knowledge and indicated she had felt the entire area. She stated R1's right lower extremity had been wrapped from foot to mid calf with an Ace bandage. RN-C stated she always looked at the dressing in the morning and at noon.

On 2/25/19, at 1:23 p.m. family member (FM)-A was interviewed by telephone. FM-A stated she had met R1 at his 2/8/19, podiatry appointment and had observed his wound dressing "was wet, very noticeably" however, the Ace bandage did not appear visibly wet. FM-A said when the wet dressing was removed, R1's wound was noted to be gaping open with areas of black in the incision line. FM-A stated the staff had given R1 a shower prior to his appointment and R1 had told her the staff had wrapped the right foot with plastic during the shower. FM-A stated R1's wound dressing was wet when he arrived at the appointment and as a result ended up having a below the knee amputation. FM-A said when R1 returned to the facility from the appointment, she had spoken to the staff and informed them R1's physician was extremely upset about R1's wound dressing having been wet. FM-A said staff had informed her the physician had already contacted the facility about his concerns. FM-A stated R1's

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foot was in horrible shape from day one, was not healing, and getting it wet "did not help." FM-A stated she was aware the facility had been providing R1 showers every 2-3 days however, at the 2/1/19 appointment, the physician had specifically ordered for the wound dressing to not get wet.

On 2/25/19, at 1:50 p.m. nursing assistant (NA)-A confirmed she had provided cares to R1 while he was a resident at the facility. NA-A stated R1 was non-weight bearing, required assist of two staff for transfers and his right foot to mid-calf was wrapped with an Ace wrap but was unsure as to what type of dressings was beneath the Ace wrap. NA-A stated she had assisted R1 with showers and had wrapped the right extremity with saran type plastic/wrap and kept the foot elevated when washed. Following the shower, the saran wrap would be removed. NA-A stated she assisted R1 with a shower the morning of the 2/8/19, appointment and stated during the shower, R1 had stuck his foot out as there was nothing for him to rest it on while showering. NA-A stated she had wrapped the foot well with the saran wrap and if she had noticed if it had gotten wet, she would have reported it to the nurse. NA-A stated she did not recall the wound dressing ever getting wet and and believed she would have noticed the change in the coloring of the Ace wrap, if it had gotten wet.

On 2/25/19, at 2:28 p.m. R1's hospital discharge orders were reviewed with HUC. HUC verified the discharge orders included "Don't change dressing, keep clean, dry and intact until clinic visit". HUC verified the order had been omitted from entry into the facility computer system and stated it looks like it got missed. HUC stated the

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	245563	A. BUILDING _____ B. WING _____	C 02/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	**427 MAIN STREET NORTHEAST MENAHGA, MN 56464**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 18	F 684		

unit manager had entered the order to check the right surgical site for signs/symptoms of infection and cleanse and dress as needed. HUC verified R1 had a podiatry appointment on 2/1/19 and they received orders to not change dressing so that order was added. HUC also verified R1 returned to podiatrist on 2/8/19 after which they had received orders to not place plastic bandage over R1's right lower extremity when showering will cause maceration to occur and also received an order for dressing change with betadine, non adherent gauze 4 x 4 gauze and ace bandage. HUC verified there was no order in the facility computer system to keep R1's dressing dry prior to 2/9/19.

On 2/25/19, at 2:36 p.m. the podiatry clinic manager (CM) stated the concern related to R1's foot care was the fact that on 2/8/19, R1 presented to his appointment with the right foot wound dressings saturated and his wound had dehisced (incision line ruptured/separated). The CM stated the skin on the right foot was macerated which could have occurred within the previous hours of the appointment or could have macerated at any time during the previous week. The CM stated the facility had been showering R1 and putting a bag over the foot in order to try keep it dry which may or may not have been effective. The CM stated the physician's notes indicated it was unknown as to how long the wound had been saturated.

On 2/25/19, at 3:19 p.m. RN-A confirmed the health unit coordinator (HUC) inputted physician orders into the electronic medical record however, the orders remained there until a nurse reviewed and activated the order. R1's AVS and interagency referral form which contained the

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F 684	Continued From page 19	F 684		

admission orders were reviewed. RN-A who confirmed the admission order to leave R1's right foot dressing intact had not been processed and stated it had been missed. When asked about the order to cleanse and dress the right foot wound as needed, RN-A stated this order was a nursing order and not physician ordered. RN-A stated if a surgical wound was on a limb they could put on Saran wrap and protect the area so bathing would be appropriate. RN-A stated she was not aware of a written protocol on how to keep a wound dry or how to wrap a wound for bathing/showering and indicated it would be common sense. RN-A verified there was probably not a way to ensure water wasn't seeping into a dressing for a wound wrapped in plastic wrap. RN-A stated she was unsure of how R1's dressing got wet and indicated she had seen the wound prior to 2/1/19 and had been surprised at how well it looked. RN-A stated if she hadn't missed the order she probably wouldn't have had R1 shower until after the sutures were out. RN-A verified R1's care plan did not address the care and treatment of R1's surgical wound and confirmed R1 was not provided care as directed by the podiatrist/surgeon.

On 2/25/19, at 5:48 p.m. the director of nursing (DON) reviewed R1's admission orders and confirmed the 1/25/19, physician order to keep the right foot wound dressing dry and intact, had been missed. DON indicated if had a resident a surgical wound on an extremity she felt bathing/showering was appropriate. DON confirmed the facility did not have a protocol or standard process for the use of Saran/plastic wrap to cover surgical dressings and any of the aforementioned techniques would be appropriate. DON verified she could not guarantee 100% a

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F 684	Continued From page 20	F 684		

dressing wrapped in this way would remain dry and stated that goes for everything. When asked if R1's dressing could have been wet prior to the 2/8/19 appointment due to seepage during showering, the ace wrap dried, however dressings remained wet, DON agreed this could have occurred. DON stated even if order to maintain the dressing clean, dry and intact had been transcribed upon admission, she still would have expected staff to offer R1 a shower if that were his preference and if concerns arose would have notified the MD rather than offering a bed bath . DON stated the concerns communicated by the podiatrist after the 2/8/19 appointment were discussed at the facility stand up meeting however, determined they felt the dressing had not gotten wet at the facility, therefore, no further investigation or process improvements had been identified or implemented. The DON stated there had been other occasions where a unit manager had determined a shower was not appropriate for a resident and other bathing interventions were recommended and verified going forward, they could potentially obtain a physician bathing order upon admission.

On 2/26/19, at 9:02 a.m. a telephone interview was conducted with the podiatry clinic's nurse who had cared for R1 during the 2/8/19, appointment. The nurse stated strict instructions had been given to the facility to not get the wound wet however, when R1 presented to the 2/8/19 appointment, he was seated in a tilt in space wheelchair with his leg elevated and his Ace wrap and dressings were wet like a sponge. The clinic nurse stated there was no wound drainage or discoloration noted on the wet dressings. The Ace wrap was multi tone and was also wet to the touch. The nurse stated FM-A had accompanied

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F 684	Continued From page 21	F 684		

R1 to the appointment and informed her the facility had been applying plastic over the right foot and giving him showers. The nurse stated she could not speak as to what happened at the facility, rather only to what she had seen and touched at the appointment and unfortunately, due to the wet dressings and wound dehiscence, R1 would now need to have a partial leg amputation. The nurse confirmed R1 had other complicating health factors such as vascular issues, however, the saturated dressings and related skin maceration directly contributed to R1's wound dehiscence and subsequent need for further surgical intervention.

On 2/26/19, 10:34 a.m. RN-B stated she was responsible for staff education and competency testing. RN-B stated the facility did not provide training or complete competency testing for the protection of wounds/dressings during bathing. RN-B confirmed she had received a telephone call from R1's podiatrist related to concerns of R1's wound/dressing becoming saturated. RN-B indicated she had spoken with staff regarding the reported concerns and verified the concerns had been discussed at the stand up meeting. However, they had determined the dressing had not become wet while at the facility therefore, no further investigation or process improvement had been identified or implemented.

On 2/26/19, at 11:43 a.m. an interview with the administrator, DON, and RN-B was conducted. When asked about the 2/1/19 physician orders, with directives to leave the bunny boot on at all times, they stated "all times" was for interpretation and the boot could be taken off during times such as when showering. They stated once RN-B was notified by the physician

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F 684	Continued From page 22	F 684		

regarding the wet dressings and status of the wound, she had asked the staff if the dressing was wet when he had left for the appointment and the staff had stated the dressing was dry. When a policy and procedure related to the provision of showers and the protection of an affected limb during showering was requested, the DON stated the facility did not have policies and procedures which addressed that.

The facility's Medication Orders policy and procedure signed 5/2/17, indicated a current list of orders must be maintained in the clinical record of each resident and orders must be written and maintained in chronological order. The section Recording Orders #6 titled Treatment Orders, indicated when recording order, specify the treatment, frequency and duration of the treatment.

The facility's Baseline Care Plan policy and procured signed 4/6/17, included: "A baseline plan of care to meet the resident's needs shall be developed for each resident within twenty-four hours of admission." The policy indicated the RN Unit Manager was to open the comprehensive care plan and enter the required baseline information for the baseline care plan. Information was to continue to be entered into the care plan with final completion of the comprehensive care plan as indicated in the Comprehensive Care Plan policy. The policy further indicated the interdisciplinary team would review the attending physician's order which included routine treatments, and were to complete a nursing care plan. The baseline care plan was to consist of, at a minimum, the following:

-initial goals based on admission orders

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F 684	Continued From page 23 -physician orders -dietary orders -therapy services -social services -PASARR recommendation, if applicable The facility's Care Plans-Comprehensive policy and procedure dated 11/28/16, indicated the facility's care planning/interdisciplinary team, in coordination with the resident, his/her family or representative, developed and maintained a comprehensive care plan for each resident which identified the highest level of functioning the resident may be expected to attain. The policy indicated the comprehensive care plan was based on a thorough assessment which included but was not limited to the MDS, and each resident's care plan was designed to incorporate identified problem areas. The facility's Policy and Procedure on Skin Assessment and Preventative Skin Care dated 10/10/18, indicated each resident wound have a skin assessment and treatment plan for the maintenance of skin integrity and wound management if required. The immediate jeopardy that began on 2/8/19, was removed on 2/26/219, at 4:02 p.m. when it could be determined by interview and document review, the facility had implemented an acceptable removal plan: -bathing orders would be obtained for all residents admitted with wounds that have non removable dressings, casts, splints, wraps, sutures and/or staples or with orders to keep wound dry. -If a resident had a wound indicated to be kept dry, a bed bath would be provided with the wound	F 684		

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F 684	Continued From page 24	F 684		

that is to remain dry, avoided.
-Cast covers were ordered and to be applied and removed by a licensed nurse after the nurse had completed a competency assessment related to the placement of the covers.
-If a resident required the use of a cast cover, the NA will not bathe the resident until the licensed nurse applied the cover to the affected limb. Following the shower, the NA would notify the nurse to remove the cover and assess the area for wetness by looking and feeling. Any dampness notes would be reported to the provider immediately for further instructions. The wound care nurse would assure the care plans, orders, and documentation was up to date and notify the provider of any concerns.
-The donning and doffing of cast covers as well as the assessment of the covered site for wetness will be prompted in the ETAR for the cart nurse and would be care planned on applicable residents. The DON will complete weekly chart audits on care plan completion and orders for bathing, if applicable, for six months to assure competency then will continue monthly. The wound care nurse would continue weekly chart audits with wound care day to assure care plan and ETAR accuracy.
-The provider updated their Admission policy, Policy and Procedure on Skin Assessment and Preventative Skin Care, and Return from Hospital and Admission check lists to reflect the established new procedure.
-A Procedure that had been modified on 1/28/19, after a quality assurance (QA) meeting to double check all orders entered into the computer, was reviewed. A new procedure was effective 2/26/19, to numerate orders when there are multiple orders on a page that are difficult to read, indicating they would be numbered by the nurse

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F 684	Continued From page 25 or the HUC during transcription. Staff will be educated via text message and a confirmation will be received that they have received the message. Staff will be reminded via the home page to remember to clarify any orders that are unclear.	F 684		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 18, 2019

Administrator
Green Pine Acres Nursing Home
427 Main Street Northeast
Menahga, MN 56464

Re: State Nursing Home Licensing Orders - Complaint Number H5563012C

Dear Administrator:

A complaint investigation was completed on February 26, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations 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 of the Minnesota Department of Health.

To assist in complying with the licensing 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 violation. 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 violation within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing 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 after the statement, "This Rule is not met as evidenced by." Following investigator's 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.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request 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.

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
	00678	A. BUILDING: _____ B. WING _____	C 02/26/2019

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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 2/25/19, and 2/26/19, an abbreviated survey was conducted to determine compliance for state licensure. The following correction orders are issued. 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	*****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has	

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2 000	Continued From page 1 The following complaint was found to be substantiated: H5563012C: Correction order issued at 0830 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. 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 which are in violation of the state statute after the statement, "This Rule 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.	2 000	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:	

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2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate contributing factors related to the saturation and subsequent decline of a surgical wound for 1 of 1 resident (R1) who had physician orders to keep the surgical site dry and the resident experienced complications resulting from saturated wound dressings which resulted in macerated skin, wound dehiscence and required additional surgical intervention. This failure to thoroughly investigate causative factors related to the surgical wound decline, and subsequent failure to develop/modify interventions, resulted in an immediate jeopardy situation for R1 The immediate jeopardy (IJ) began on 2/8/19, when the facility received notification from a medical provider that R1's surgical wound had dehisced as a result of maceration from saturated wound dressings, and the facility failed to	2 830	Corrected	3/26/19

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thoroughly investigate, modify or develop policies and procedures for the protection of surgical wounds. The IJ was identified on 2/25/19. The administrator, director of nursing (DON) and licensed social worker (LSW) were notified of the IJ at 6:38 p.m. on 2/25/19. The IJ was removed on 2/26/19, but noncompliance remained at the lower scope and severity of G, isolated scope with actual harm.

Findings include:

R1's Admission Record form printed 2/25/19, indicated R1 was admitted to the facility 1/25/19, with diagnoses which included: orthopedic aftercare following surgical amputation, peripheral vascular disease, diabetes due to underlying condition with diabetic polyneuropathy, nutritional deficiency, hypertensive chronic kidney disease, vascular dementia without behavioral disturbance, arteriosclerosis of native arteries of extremities with gangrene, and acquired absence of other right toes.

R1's admission Minimum Data Set (MDS) assessment dated 2/7/19, indicated R1 was admitted from the hospital, had moderate cognitive impairment and demonstrated no behaviors. The MDS also indicated R1 required: extensive assist of one to two staff for bed mobility, transfers, locomotion on and off the unit, toileting, dressing and bathing; and required limited assistance of one staff for hygiene, and assistance of one person to walk in the corridor, which had occurred only once or twice. The MDS also indicated R1 utilized a walker and wheelchair. The MDS also indicated R1 had a foot infection, a surgical wound and received surgical wound care with the application of foot dressings, and physical and occupational therapy

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2 830	Continued From page 4 (PT and OT) were provided. R1's 5 day Medicare MDS also dated 2/7/19, idenfied the same information as the admission MDS, however, indicated R1 did not ambulate during the reference period and utilized a walker and a wheelchair. R1's primary medical condition was due to an amputation. R1's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 2/7/19, indicated R1 was aware of his short term memory deficit with a goal of cognitive improvement as he desired to return home. R1's Activities of Daily Living (ADL)/Rehabilitation Potential CAA dated 2/7/19, indicated R1 was admitted from the hospital for short term stay following the surgical amputation of the 2nd and 3rd digits on the right foot. The CAA also indicated R1 was non weight bearing, non-ambulatory, and required physical assistance with ADLs. In addition, the CAA indicated R1 was working with PT (physical therapy) and OT (occupational therapy) and indicated the goal was for R1 to improve ADL abilities and avoid complications. R1's Pressure Ulcer/Injury CAA dated 2/7/19, indicated R1 was admitted following amputation of the right foot 2nd and 3rd digits with stitches in place. According to the CAA, wound treatment consisted of cleansing and dressing as needed. In addition interventions included staff were to monitor pain, monitor and manage diabetes, diabetic foot checks weekly, weekly skin checks x four weeks, appropriate foot and nail care, and PT/OT as ordered. R1's Psychosocial Well-Being CAA dated 2/7/19, indicated R1 was working hard toward his	2 830		

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2 830	Continued From page 5 discharge goal of returning home. R1's Fall's CAA dated 2/7/19, indicated R1 was non-weight bearing to the right foot therefore required physical assist of two staff for transfers and toileting, had a history of falls prior to admission and one fall occurrence while at the facility with no injury. The CAA also indicated R1 required reminders of non-weight bearing status. An Interagency Referral Form dated 1/25/19, indicated R1 had been hospitalized with a principal problem of gangrene of right foot, had undergone cystoscopy for foreign body removal from bladder, and had a right transmetatarsal amputation. Discharge orders included but were not limited to: -Appointments with Podiatry 1 week and 2 weeks from discharge -Don't change dressing, keep clean dry and intact until clinic visit -Non weight bearing-right. Medical predictability-predict that weight bearing status will increase and will be reevaluated at next appointment in 2 weeks. - Will have follow-up in 1 week but sutures will not be removed for at least 2 weeks and he is non weight bearing until the sutures are removed. -Physical Therapy: evaluate and treat -Discharge potential: length of stay <30 days, then plan assisted living. In addition, an After Visit Summary (AVS, also dated 1/25/19, included the following intructions for R1's care: -Weight bearing status: non weight bearing-right -Medical Predictability - Predict that weight bearing status will increase and will be reevaluated at next appointments in 2 weeks. Will have follow-up in 1 week but sutures will not	2 830		

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be removed for at least 2 weeks and he is non weight bearing until the sutures are removed.
-Appointment with Podiatry - Referral Reason: Injury/Trauma: amputation
-Wound Care Intructions: Don't change dressing, keep clean dry and intact until clinic visit. Additional wound care instructions: per podiatry orders.
-Physical Therapy Referral instructions: evaluate and treat
-Discharge Potential: Length of stay < 30 days. Then plan assisted living.

Although both documents include physician discharge wound care orders with directions to leave the wound dressing intact, R1's facility Skin Check form dated 1/25/19, identified an incision to R1's right foot which was 12 centimeters (cm) long with 18 stitches however the wound would not have been visible had the dressing remained intact.

R1's Medication Administration Records (MAR) dated 1/1 -1/31/19, and 2/1-2/28/19, included the following orders:
-Weekly wound monitoring to right foot transmetatarsal amputation site in the morning every Wednesday. The order start date was 1/30/19 and was documented as completed on 1/30/19, 2/6/18 and 2/13/19.
-Weekly wound monitoring to right foot open incision one time a day every Wednesday. The order start date was 2/13/19 and was documented as completed on 2/13/19.
-Do not change dressings. Elevate leg and keep bunny boot on at all times every shift for right foot. The order start date was 2/1/19. The order was discontinued 2/8/19.

R1's Treatment Administration Record (TAR)

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2 830	Continued From page 7 dated 1/1 -1/31/19 and 2/1-2/28/19, included the following orders: -Check right foot surgical site for any signs/symptoms of infection. Cleanse and dress as needed two times a day. The order start date was 1/25/19. -Infection monitoring note to right foot two times a day. The order start date was 1/25/19. -Do not put plastic bandage over right lower extremity when showering will cause maceration to wound. The order start date was 2/9/19. -Dressing change to right lower extremity, apply betadine, non-adherent gauze, 4 x 4 gauze, ace bandage one time a day for diagnosis. The order start date was 2/9/19. -Strict non weight bearing to right lower extremity three times a day for diagnosis. The order start date was 2/9/19. The podiatrist's Surgical Follow report dated 2/1/19, indicated R1 presented one week status post transmetatarsal amputation secondarily due to peripheral artery disease with gangrenous changes to the distal forefoot. The report indicated instructions after discharge from the hospital were to keep dressings on while at the skilled nursing facility and included: "Unfortunately, his dressings are different, therefore, they were changed but I am unaware whether there was strikethrough noted or any drainage from this area." Further documentation indicated a physical exam had revealed R1 had overall diminished sensation to the lower extremity and pedal pulses were not palpable however, indicated dorsal not plantar aspect of the transmetatarsal amputation site did have a capillary refill time of less then 3 seconds. The report included, "Incision site was well coapted although there was a central portion of mild necrosis which was dry and stable. There was	2 830		

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2 830	Continued From page 8 rubor plant flap. Sutures were intact without loosening, normal postoperative edema near incision site. There was also an ulcerative lesion to the plantar aspect at the central portion of the flap as well, which appeared superficial in nature." The plan indicated R1 would have a follow up appointment in one week for suture removal and included: "Keep leg elevated, do not get operative site wet. Keep Bunny boot on at all times. Continue oral antibiotics previous dispensed by the primary care team. Informed the patient that if he does develop further necrosis or the transmetatarsal amputation site does develop some wound dehiscence we will go forth with having him reassessed by the vascular team next week. Written instructions were provided for skilled nursing facility to not change dressings." R1's podiatry Surgical Follow-up dated 2/8/19, indicated the patient had attended the appointment with his sister and included: "Patient is currently residing in a skilled nursing facilty. During today's office visit there is significant malodor associated with the patient's operative extremity and his dressings were saturated. After discussing this with his sister, it does appear that patient has been showering by the nursing staff at the nursing facility. They are attempting to wrap his lower extremity with plastic to prevent water seeping into the dressings. Unfortunately, we do not know how long his dressings have been saturated. Skin was macerated and wound dehiscence was clearly evident to the amputation site. Laterally the flaps had coaptation secondarily due to macerated tissue. Erythema is present medially and laterally to the amputation site. There appears to be no cellulitis or lymphangitic streaking, however we will obtain labs to assess for infections. Discussing with [R1] as well, he states he has been ambulating on the	2 830		

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operative extremity." The physical exam indicated the dressings were removed and the heel was completely macerated with desquamated hyperkeratotic tissue. The surgical follow up note indicated R1's right lower extremity was colder to touch and, "Pedal pulses were difficult to Doppler. Central area of necrosis was present. Medially and laterally to the transmetatarsal amputation site there was wound dehiscence noted laterally with no acute signs of infections, no coaptation was noted laterally. Medially there is increase in erythema from this area however, no purulent drainage was noted with mechanical compression of the amputation site. No soft tissue emphysema is palpable...concern for worsening PAD (peripheral artery disease) of his right lower extremity. Capillary refill time dorsal lateral flat of the amputation site was delayed between 3 and 5 seconds and sluggish in nature." The plan included: "I informed the patient and his sister I do have some concern about worsening appearance of his amputation site which is likely due to multiple reasons including but not limited to patient's peripheral arterial disease, diabetes, recent saturation of his postoperative dressings and complete noncompliance of ambulating on extremity. I informed him there is a higher risk of below-knee amputation. I informed him of the wound dehiscence as the flap has not adherent. Going forth we can continue with wound care management potential use of a wound VAC, more proximal foot amputation versus below-knee amputation given the appearance of his foot clinically, I do not believe this amputation site will heal. We will await vascular's recommendation, for the time being nursing staff will perform daily dressing changes with the use of Betadine and dry sterile gauze, strict non-weightbearing to the right lower extremity, do not get operative site wet. Patient will follow up with me next week to

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discuss further options going forward." The instructions for the right lower extremity transmetatarsal amputation site included: "Dressings need to be changed every day, apply Betadine, non-adherent gauze, 4 x 4 gauze, Ace bandages. Patient is to be strictly non-weightbearing to the right lower extremity. Do not get the operative site wet, patient presented during today's office visit with macerated tissue due to his gauze and dressings being saturated with water after his recent shower. Please do not attempt to apply a plastic bandage around his lower extremity and shower as this typically leads to some sort of leakage causing noted dressings to become macerated and wet which will lead to wound dehiscence which he currently has. Follow-up with vascular next week, Wednesday likely needs revascularization per vascular versus below-knee amputation to the right lower extremity."

R1's care plan printed on 2/25/19, identified the right foot surgical wound and directed the staff to provide weekly wound monitoring and treatments. However, the care plan failed to include the interventions related to the care of the surgical site/extremity such as to maintain dryness of the surgical limb as well as how to provide appropriate bathing, and protect dressing from getting wet when bathing.

Review of R1's progress notes (PN) revealed the following:

-1/25/19, R1 admitted post transmetatarsal amputation of right foot secondary to gangrene related to diabetes and frost bite. To receive skilled therapy and IV therapy for wound management. R1 would be non-weight bearing on the right foot until cleared by the physician. An

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2 830	Continued From page 11 additional PN dated 1/25/19, indicated R1 was admitted for a short stay, about three weeks to heal surgical site, recover strength and return home. Incision clean and dry on top of right foot with no signs of infection noted. -1/30/19, weekly wound monitoring: right foot surgical amputation of toes. 1. The surgical incision measured 120 cm with intact sutures. 2. A 20cm x 45cm dried blister from amputation site on bottom of foot. 3. A 10cm x 10cm dried scab on top of the foot. 4. A 20cm x 16cm dried scab on the top of the foot. The observation of the aforementioned indicated wound #1 had a small amount of serosanguineous (contains both blood and serum) drainage on the dressing, no odor, skin was a healthy pink color. Wound #2 indicated skin intact with no drainage skin soft with dark red areas and a couple of lighter areas within. both #3 and #4 wounds were noted as dried res scabs, skin dry. Treatment consisted of cleansing and covering the wounds twice a day and as needed. The wounds were identified as improving. A second PN dated 1/30/19, indicated pedal pulses were present with no edema noted. -2/1/19, R1 had a podiatry appointment. New orders to no change R1's dressings, keep leg elevated with bunny boot on at all times, and R1 to follow up with podiatrist next week for suture removal. -2/8/18, pedal pulses present bilaterally with no edema present. Right foot dressing intact. A 12:19 p.m. PN indicated R1 left the facility for a podiatry appointment. -2/8/19, R1 returned to the facility at 5:30 p.m. -2/9/19, at 10:31 a.m. dressing change to right foot, sutures removed at 2/8/19, appointment and now incision line is open. Incision measures 12cm long with open area 1cm along entire incision line. Skin on the edge of the incision is dusky in color. Incision cleansed, painted with	2 830		

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2 830	Continued From page 12 betadine, covered with a non adherent, wrapped with kling dressing followed by an Ace wrap. -2/11/19, late entry from appointment 2/8/19, included: "Dressing needs to be changed daily with betadine applied, non adherent gauze followed by 4x4 gauze and an Ace bandage. R1 was to be strictly non-wight bearing to the right lower extremity. Do not get the operative site wet, patient presented during today's visit with macerated tissue to his gauze and dressing being saturated with water after recent shower. Please do not attempt to apply plastic bandage around his lower extremity and shower as this typically leads to some sort of leakage causing noted dressing to become macerated and wet which will lead to wound dehiscence which he currently has. Follow up with vascular next week as likely needs revascularization per vascular versus a below the knee amputation to the right lower extremity." On 2/25/19, at 11:14 a.m. the occupational therapist (OTR) stated she was contracted with the facility and was familiar with R1, who had received skilled PT and OT services. The OTR stated R1 had come in with a metatarsal amputation and had been non weight bearing on the right side. The OTR stated she had done some cognitive testing with R1 and had assessed him to have minimum to moderate cognitive deficits. In addition, she stated R1 had been very weak, had endurance issues, and that she had been working with R1 on self cares/independence, transfers, and standing. The OTR also confirmed R1 had planned to go home. The OTR stated when R1 had been admitted, he'd had the impression he could put weight on his heel and the OTR stated everyday they'd stressed with him he could not do that. The OTR also stated R1 had a tough time standing to transfer so they had started using a sliding board	2 830		

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for transfers. The OTR stated she could not verify whether R1 had been putting weight on his right leg when nursing provided care however, stated he had it in his mind he could bear weight on his heel. The OTR reiterated staff had stressed with R1 he was strict non-weight bearing and stated after awhile he kind of remembered it, but thought R1's cognitive deficits were a factor in that. Further, the OTR stated she had not seen R1's surgical wound and was not aware whether R1 used the shower.

On 2/25/19, at 11:22 a.m. trained medication aide (TMA)-A confirmed R1 had been admitted with an amputation of the right forefoot and had been non weight bearing. TMA-A stated R1 had graduated to a slide board with assist of 2 for transfers. TMA-A stated R1 had been compliant with cares, had no resistance to cares and exhibited no behaviors. TMA-A indicated R1 had never walked while in the facility, and stated R1's foot had remained wrapped and she had not done any treatments to the foot. TMA-A verified R1 had taken a shower and indicated he had a shower in his room which he had used one to two times per week. TMA-A stated when R1 had showered staff had wrapped his right lower extremity in "Saran wrap." TMA-A stated the last time she had assisted R1 with a shower, she had applied Saran Wrap around the foot as they were not supposed to change the dressing. However, TMA-A stated when she had assisted R1 with a shower, his dressing to the right foot had never gotten wet. She also denied having ever noted any drainage on the dressing and stated it never looked or felt wet.

On 2/25/19, at 11:27 a.m. the physical therapist (PT) indicated she was familiar with R1 and stated PT had worked with him, 5 days per week.

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2 830	Continued From page 14 PT verified R1 had been non weight bearing on the right side and indicated they worked with R1's stand/pivot transfers and also sliding board transfers due to his non weight bearing status. PT indicated they had also worked on safety awareness. PT stated R1 needed help to get up so she couldn't imagine him walking and indicated she didn't feel he was able to ambulate or get up on own. PT indicated she he never seen R1's wound and stated she had never noted if it was wet or if there had been drainage on the dressing. PT stated R1 had worn a bunny boot when up and in bed for the relief of pressure. On 2/25/19, at 11:31 a.m. TMA-B stated TMA's were allowed to do wound care but not if it involved a sterile wound treatment. TMA-B indicated she had never done any wound treatments for R1 as his orders had been updated to not change the dressing and leave it alone by the time she worked with him in a TMA capacity. TMA-B indicated they would visualize the dressing for drainage and stated she had never noted any drainage. TMA-B stated she thought R1 had a shower three times per week on Monday, Wednesday and Friday and bathed in the shower in his room. TMA-B indicated when she had given R1 a shower, she had wrapped his right lower extremity with a garbage bag, wrapped the top of the bag with plastic wrap and taped it. TMA-B indicated R1's dressing never got wet, to her knowledge. TMA-B indicated prior to the order not to touch the dressing, they had been checking the bandage twice daily. TMA-B stated if R1's dressing had gotten wet, it would have been evident as it had been wrapped from foot to mid calf with an Ace bandage. TMA-B indicated if a wound got wet she would have contacted the RN to get order from physician to change the dressing and would not have left it wet. TMA-B	2 830		

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2 830	Continued From page 15 stated R1 did not walk, but needed some reminders to maintain non weight bearing. TMA-B stated R1 would sometimes try to use the back of his heel with transfers, but indicated this happened less as he started to use the slide board. TMA-B stated it happened more when he could not use slide board; using the toilet for example and indicated this happened maybe once a shift or couple of days. On 2/25/19, at 11:46 a.m. the health unit coordinator (HUC) indicated she sometimes also provided personal cares for residents and had helped transfer R1 once. HUC stated she also entered physician orders so she knew R1 had been non weight bearing. HUC indicated R1 had put his weight down when she had assisted him with transferring but they had reminded him not to do so. HUC indicated R1 had exhibited no behaviors and was not resistive to cares. HUC indicated she had never assisted R1 to the shower and had not seen his wound. HUC stated she had heard about R1's dressing being wet after one of his podiatry appointments. HUC stated he had an order to not change the dressing after his first podiatry appointment and then the dressing had been noted to be wet after his second podiatry appointments. HUC stated she was not sure how/if the dressing had gotten wet and stated she thought R1 had utilized a slide board for transfers by that time. HUC stated she was not sure if R1 had ever been provided a bed bath or if his showers had ever been placed on hold. On 2/25/19, at 11:58 AM registered nurse (RN)-C stated she primarily worked on the transitional care unit (TCU) and was familiar with R1. RN-C stated R1 had a little dementia and needed reminders such as with not bearing weight on his	2 830		

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2 830	Continued From page 16	2 830		

right foot during transfers. RN-C stated she had never assisted with R1's transfers but had been in the room while R1 had been transferred. RN-C stated for the most part he did not bear weight but needed reminders not to do so. RN-C stated upon admission they had done a daily dressing change with telfa, 4x4 and ace wrap for R1. RN-C indicated R1's incision had been intact with sutures. R1 had seen the podiatrist after 1 week and they had received orders after that appointment to no change the dressing so they had not done so. RN-C indicated they had a prompt in computer to assess the dressing, clean dry intact, ace wrap on which she had assessed daily. RN-C stated R1 then had another podiatry appointment and when he came back and the wound was open. She indicated they had received new orders for betadine, non-adherent dressing and wrap it. After this, RN-C stated R1 saw a vascular surgeon and was then transferred to hospital. RN-C stated R1 had showers approximately three times per week and showered in room. RN-C stated the aids had wrapped the wound with plastic bag to prevent it from getting wet. RN-C indicated the aids would have let her know if the dressing was wet so she could change it. RN-C stated she was never notified R1's dressing was wet. RN-C stated she had been at the facility the day R1 had his podiatry appointment and indicated R1's dressing had been dry as of noon. RN-C stated she does not know how the dressing could have gotten wet. RN-C indicated R1's appointment had been in the afternoon and he had left the facility at 12:15 p.m. RN-C stated she had tested R1's blood sugar, he had lunch and had then been seated in the common area. RN-C indicated she had felt of R1's dressing and it had not been wet and there had been no indication the wound required further assessment. RN-C indicated R1 had went to the

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appointment alone. RN-C stated she doesn't think the dressing could have been wet without her knowledge and indicated she had felt the entire area. She stated R1's right lower extremity had been wrapped from foot to mid calf with an Ace bandage. RN-C stated she always looked at the dressing in the morning and at noon.

On 2/25/19, at 1:23 p.m. family member (FM)-A was interviewed by telephone. FM-A stated she had met R1 at his 2/8/19, podiatry appointment and had observed his wound dressing "was wet, very noticeably" however, the Ace bandage did not appear visibly wet. FM-A said when the wet dressing was removed, R1's wound was noted to be gaping open with areas of black in the incision line. FM-A stated the staff had given R1 a shower prior to his appointment and R1 had told her the staff had wrapped the right foot with plastic during the shower. FM-A stated R1's wound dressing was wet when he arrived at the appointment and as a result ended up having a below the knee amputation. FM-A said when R8 returned to the facility from the appointment, she had spoken to the staff and informed them R1's physician was extremely upset about R1's wound dressing having been wet. FM-A said had informed her the physician had already contacted the facility about his concerns. FM-A stated R1's foot was in horrible shape from day one, was not healing, and getting it wet "did not help." FM-A stated she was aware of the facilty providing R1 showers every 2-3 days however, at the 2/1/19 appointment, the physician had specifically ordered for the wound dressing to not get wet.

On 2/25/19, at 1:50 p.m. nursing assistant (NA)-A confirmed she had provided cares to R1 while he was a resident at the facility. NA-A stated R1 was non-weight bearing, required assist of two staff

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2 830	Continued From page 18	2 830		

for transfers and his right foot to mid-calf was wrapped with an Ace wrap but was unsure as to what type of dressings was beneath the Ace wrap. NA-A stated she had assisted R1 with showers and had wrapped the right extremity with saran type plastic/wrap and kept the foot elevated when washed. Following the shower, the saran wrap would be removed. NA-A stated she assisted R1 with a shower the morning of the 2/8/19, appointment and stated during the shower, R1 had stuck his foot out as there was nothing for him to rest it on while showering. NA-A stated she had wrapped the foot well with the saran wrap and if she had noticed if it had gotten wet, she would have reported it to the nurse. NA-A stated she did not recall the wound dressing ever getting wet and and believed she would have noticed the change in the coloring of the Ace wrap, if it had gotten wet.

On 2/25/19, at 2:28 p.m. R1's hospital discharge orders were reviewed with HUC. HUC verified the discharge orders included "Don't change dressing, keep clean, dry and intact until clinic visit". HUC verified the order had been omitted from entry into the facility computer system and stated it looks like it got missed. HUC stated the unit manager had entered the order to check the right surgical site for signs/symptoms of infection and cleanse and dress as needed. HUC verified R1 had a podiatry appointment on 2/1/19 and they received orders to not change dressing so that order was added. HUC also verified R1 returned to podiatrist on 2/8/19 after which they had received orders to not place plastic bandage over R1's right lower extremity when showering will cause maceration to occur and also received an order for dressing change with betadine, non adherent gauze 4x4 gauze and ace bandage. HUC verified there was no order in the facility

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2 830	Continued From page 19 computer system to keep R1's dressing dry prior to 2/9/19. On 2/25/19, at 2:36 p.m. the podiatry clinic manager (CM) stated the concern related to R1's foot care was the fact that on 2/8/19, R1 presented to his appointment with the right foot wound dressings saturated and his wound had dehisced (incision line ruptured/separated). The CM stated the skin on the right foot was macerated which could have occurred within the previous hours of the appointment or could have macerated at any time during the previous week. The CM stated the facility had been showering R1 and putting a bag over the foot in order to try keep it dry which may or may not have been effective. The CM stated the physician's notes indicated it was unknown as to how long the wound had been saturated. On 2/25/19, at 3:19 p.m. RN-A confirmed the health unit coordinator (HUC) inputted physician orders into the electronic medical record however, the orders remained there until a nurse reviewed and activated the order. R1's AVS and interagency referral form which contained the admission orders were reviewed. RN-A who confirmed the admission order to leave R1's right foot dressing intact had not been processed and stated it had been missed. When asked about the order to cleanse and dress the right foot wound as needed, RN-A stated this order was a nursing order and not physician ordered. RN-A stated if a surgical wound was on a limb they could put on Saran wrap and protect the area so bathing would be appropriate. RN-A stated she was not aware of a written protocol on how to keep a wound dry or how to wrap a wound for bathing/showering and indicated it would be common sense. RN-A verified there was probably not a way to ensure	2 830		

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water wasn't seeping into a dressing for a wound wrapped in plastic wrap. RN-A stated she was unsure of how R1's dressing got wet and indicated she had seen the wound prior to 2/1/19 and had been surprised at how well it looked. RN-A stated if she hadn't missed the order she probably wouldn't have had R1 shower until after the sutures were out. RN-A verified R1's care plan did not address the care and treatment of R1's surgical wound and confirmed R1 was not provided care as directed by the podiatrist/surgeon.

On 2/25/19, at 5:48 p.m. the director of nursing (DON) reviewed R1's admission orders and confirmed the 1/25/19, physican order to keep the right foot wound dressing dry and intact, was missed. DON indicated if had a resident a surgical wound on an extremity she felt bathing/showering was appropriate. DON confirmed the facility did not have a protocol or standard process for the use of Saran/plastic wrap to cover surgical dressings and any of the aforementioned techniques would be appropriate. DON verified she could not guarantee 100% a dressing wrapped in this way would remain dry and stated that goes for everything. When asked if R1's dressing could have been wet prior to the 2/8/19 appointment due to seepage during showering, the ace wrap dried, however dressings remained wet, DON agreed this could have occurred. DON stated even if order to maintain the dressing clean, dry and intact had been transcribed upon admission, she still would have expected staff to offer R1 a shower if that were his preference and if concerns arose would have notified the MD rather than offering a bed bath . DON stated the concerns communicated by the podiatrist after the 2/8/19 appointment were discussed at the facility stand up meeting

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2 830	Continued From page 21 however, determined they felt the dressing had not gotten wet at the facility, therefore, no further investigation or process improvements had been identified or implemented. DON indicated there had been other occasions where a unit manager had determined a shower was not appropriate for a resident and other bathing interventions were recommended and verified going forward, they could potentially obtain a physican bathing order upon admission. On 2/26/19, at 9:02 a.m. a telephone interview was conducted with the podiatry clinic's nurse who had cared for R1 during the 2/8/19, appointment. The nurse stated strict instructions had been given to the facility to not get the wound wet, however, when R1 presented to the 2/8/19, appointment, he was seated in a tilt in space wheelchair with his leg elevated and his Ace wrap and dressings were wet like a sponge. There was no wound drainage or discoloration noted on the wet dressings. The Ace wrap was multi tone and also wet to the touch. The nurse stated FM-A had accompanied R1 to the appointment and informed her the facility had been applying plastic over the right foot and giving him showers. The nurse stated she could not speak as to what happened at the facility, rather only to what she had seen and touched at the appointment and unfortunately, due to the wet dressings and wound dehiscence, R1 would now need to have a partial leg amputation. The nurse confirmed R1 had other complicating health factors such as vascular issues, however, the saturated dressings and related skin maceration directly contributed to R1's wound dehiscence and subsequent need for further surgical intervention. On 2/26/19, 10:34 a.m. RN-B indicated she was responsible for staff education and competency	2 830		

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testing. RN-B indicated the facility did not provide training or complete competency testing for the protection of wounds/dressings during bathing. RN-B indicated she had received a telephone call from R1's podiatrist related to concerns of R1's wound/dressing becoming saturated. RN-B indicated she had spoken with staff regarding the reported concerns and verified the concerns had been discussed at the stand up meeting. RN-B stated they had determined the dressing had not become wet while at the facility, therefore, no further investigation or process improvement had been identified or implemented.

On 2/26/19, at 11:43 a.m. an interview with the administrator, DON, and RN-B was conducted. When asked about the 2/1/19, physician orders and the directive to leave the bunny boot on at all times, they stated "all times" was for interpretation and the boot could be taken off during times such as when showering. They stated once RN-B was notified by the physician regarding the wet dressings and status of the wound, she had asked the staff if the dressing was wet when he had left for the appointment and the staff indicated the dressing was dry. When a policy and procedure related to the provision of showers and the protection of an affected limb during showering was requested, the DON stated the facility did not have policies and procedures which addressed those care areas.

The facility's Medication Orders policy signed 5/2/17, and procedure indicated a current list of orders must be maintained in the clinical record of each resident and orders must be written and maintained in chronological order. The Recording Orders #6 titled Treatment Orders indicated when recording order, specify the treatment, frequency and duration of the treatment.

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2 830	Continued From page 23 The facility's Baseline Care Plans policy and procured signed 4/6/17, indicated a baseline plan of care to meet the resident's needs shall be developed for each resident within twenty-four hours of admission. The RN Unit Manager was to open the comprehensive care plan and enter the required baseline information for the baseline care plan. Information was to continue to be entered into the care plan with final completion of the comprehensive care plan as indicated in the Comprehensive Care Plan policy. The interdisciplinary team would review the attending physician's order which included routine treatments and complete a nursing care plan. The baseline care plan would to consist of, at a minimum, the following: -initial goals based on admission orders -physician orders -dietary orders -therapy services -social services -PASARR recommendation, if applicable The facility's Care Plans-Comprehensive policy and procedure dated 11/28/16, indicated the facility's care planning/interdisciplinary team, in coordination with the resident, his/her family or representative, developed and maintained a comprehensive care plan for each resident which identified the highest level of functioning the resident may be expected to attain. The comprehensive care plan was based on a thorough assessment which included but was not limited to the MDS. Each resident's care plan was designed to incorporate identified problem areas The facility's Policy and Procedure on Skin	2 830		

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2 830	Continued From page 24 Assessment and Preventative Skin Care dated 10/10/18, indicated each resident wound have a skin assessment and treatment plan for the maintenance of skin integrity and wound management if required. The immediate jeopardy that began on 2/8/19, was removed on 2/26/219, at 4:02 p.m. when the facility had implemented an acceptable removal plan: -bathing orders would be obtained for all residents admitted with wounds that have non removable dressings, casts, splints, wraps, sutures and/or staples or with orders to keep wound dry. -Cast covers were ordered and to be applied and removed by a licensed nurse after the nurse had completed a competency assessment related to the placement of the covers. -If a res had a wound indicated to be kept dry, a bed bath would be provided with the wound that is to remain dry, avoided. -If a resident required the use of a cast cover, the NA will not bathe the resident until the licensed nurse applied the cover to the affected limb. Following the shower, the NA would notify the nurse to remove the cover and assess the area for wetness by looking and feeling. Any dampness notes would be reported to the provider immediately for further instructions. The wound care nurse would assure the care plans, orders, and documentation was up to date and notify the provider of any concerns. -Updated the Admission policy, Policy and Procedure on Skin Assessment and Preventative Skin Care, and Return from Hospital and Admission check lists to reflect the established new procedure. -The donning and doffing of cast covers as well as the assessment of the covered site for	2 830		

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2 830	Continued From page 25 wetness will be prompted in the ETAR for the cart nurse and would be care planned on applicable residents. The DON will complete weekly chart audits on care plan completion and orders for bathing, if applicable, for six months to assure competency then will continue monthly. The wound care nurse would continue weekly chart audits with wound care day to assure care plan and ETAR accuracy. -Procedure was changed on 1/28/19, after a QA meeting to double check all orders entered into the computer. New procedure was effective 2/26/19, to numerate orders if there are multiple orders on a page that are difficult to read and will be numbered by the nurse or the HUC during transcription. Staff will be educated via text message and a confirmation will be received that they have received the message. Staff will be reminded via the home page to remember to clarify any orders that are unclear. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and revise as necessary the policies and procedures regarding the care of surgical wounds. The DON or designee could provide training for all appropriate staff on these policies and procedures. The quality assessment and assurance committee could do random audits of surgical wounds and physician orders to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		