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

Electronically delivered
January 12, 2023

Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN  56081

RE: CCN: 245593
Cycle Start Date: October 20, 2022

Dear Administrator:

On November 28, 2023, we notified you a remedy was imposed. On December 7, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 18, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 20, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 7, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 20, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 18, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

*An equal opportunity employer.*

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Electronically delivered

January 12, 2023

Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN  56081

Re: Reinspection Results
Event ID:  NT0112 and DMEQ12

Dear Administrator:

On December 7, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on October 20, 2022 and November 9, 2022.  At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

DEPARTMENT OF HEALTH

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

Electronically delivered

November 28, 2022

Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN  56081

RE: CCN: 245593
Cycle Start Date: October 20, 2022

Dear Administrator:

On November 7, 2022, we informed you that we may impose enforcement remedies.

On November 9, 2022, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

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

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 20, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 20, 2023.  They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 20, 2023.

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.

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)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 20, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - St James will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 20, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being

corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 20, 2023 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42

CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Electronically delivered
November 28, 2022

Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN  56081

Re: State Nursing Home Licensing Orders
Event ID: DMEQ11

Dear Administrator:

The above facility was surveyed on November 9, 2022 through November 9, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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

Please feel free to call me with any questions.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245593 | A. BUILDING _____ B. WING _____ | C 11/09/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - ST JAMES | 1000 SOUTH SECOND STREET ST JAMES, MN 56081 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>On 11/9/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed:<br><br>H55935586C (MN88117) and H55935726C (MN88374) with a deficiency cited at (F686).<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F 000 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent | F 686 | | 11/18/22 |

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

Electronically Signed — 12/04/2022

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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| GOOD SAMARITAN SOCIETY - ST JAMES | 1000 SOUTH SECOND STREET ST JAMES, MN 56081 |

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| F 686 | Continued From page 1<br>with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure adequate treatment of pressure ulcers was completed and recorded for 1 of 1 resident (R1) reviewed for pressure ulcer care and services.<br><br>Findings include:<br><br>Pressure Ulcer stages defined by the Minimum Data Set (MDS) per Center Medicare/Medicaid Services:<br><br>Stage I pressure ulcer (An observable, pressure-related alteration of intact skin, whose indicators as compared to adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.)<br><br>Stage II pressure ulcers (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ ruptured blister.)<br><br>Stage III pressure ulcers (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.) | F 686 | Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.<br><br>F686 Treatment/Services to Prevent/Heal Pressure Ulcer<br>1. Daily wound data collections and weekly wound RN assessments are being completed for R3 until wounds are healed.<br>2. All residents with pressure ulcers were reviewed by the DON on 11/8/22. Daily wound data collections and weekly RN assessments have been scheduled to be completed for these residents until they are healed.<br>3. Education on GSS Policy "Pressure Ulcer Prevention and Documentation Requirements" was provided by the CLDS on 11/18/22 with all nurses.<br>4. Audits will continue to be conducted for R3 and 3 other random residents with | |

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| F 686 | Continued From page 2<br><br>Stage IV pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.)<br><br>Unstageable pressure ulcer: (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar)<br><br>R1's face sheet printed on 11/9/22, included diagnoses of cerebral infarction (stroke) with hemiplegia (paralysis on one side of the body), dementia, diabetes, chronic kidney disease, protein-calorie malnutrition, anemia, contracture of multiple muscles, pressure ulcer of sacral region (located below the lumbar spine and above the tailbone, which is known as the coccyx) - stage 4, pressure ulcer of right heel - unstageable, pressure ulcer of left hip - unstageable.<br><br>R1's admission Minimum Data Set (MDS) assessment dated 9/6/22, indicated R1 had severely impaired cognition. R1 did not speak, hearing was highly impaired, vision was severely impaired and he was rarely/never understood nor did he understand. R1 did not walk and required extensive assistance of two staff for bed mobility and toileting. R1 was totally dependent upon two staff and a mechanical lift for transfers.<br><br>R1's care plan revised on 11/9/22, indicated R1 had impairment to skin integrity related to malnourishment brought on by CVA (cardiovascular accident, or stroke) and would have no complications related to skin integrity | F 686 | pressure ulcers by the Quality Assurance Coordinator or designee five times weekly x 2 weeks, three times weekly x 2 weeks, twice weekly x 2 weeks, and 1x weekly x 2 months to ensure wound data collections are being completed daily and wound RN assessments weekly for residents with pressure ulcers. Audit results will be brought to the QAPI committee for further recommendations. | |

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| F 686 | Continued From page 3<br>concerns identified upon admission. R1's pressure ulcers would show signs of healing and remain free from infection. Interventions included monitor location, size and treatment of skin injury, report abnormalities, failure to heal, s/s of infection, maceration, etc. to health care provider; high risk for skin injury: use extra caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface; avoid scratching and keep hands and body parts from excessive moisture: keep fingernails short, keep skin clean and dry, use lotion on dry skin, do not apply on site of injury, weekly skin observation by licensed nurse, provide pressure relieving/reducing mattress and heel protectors on feet to protect heels, heel protectors to be on at all times.<br><br>Braden scale for predicting pressure sore risk indicated R1 had been a high risk and a very high risk for PU development when assessed on 8/31/22, and 10/18/22, respectively.<br><br>R1's record review revealed multiple wound care treatment orders and the treatment administration record (TAR) indicated an order dated 10/18/22, sacral dressing acetic acid 0.25% put 30 ml (milliliters) in blunted syringe to flush wound, pat dry then apply iodoform ribbon 1/2 or 1/4 inch ribbon loosely into wound bed, skin prep to wound edges and cover with foam, change BID (two times a day), related to pressure ulcer of sacral region, stage 4, and an enteral feed order dated 10/20/22, indicated 500mL flush of free water every 6 hours.<br><br>R1's TAR dated 10/1/22, through 10/31/22, indicated:<br>- 10/28/22, and 10/31/22, documentation failed | F 686 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 686 | Continued From page 4<br>to indicate the 8:00 a.m. sacral dressing<br>- 10/28/22, 10/29/22, 10/30/22, documentation failed to indicate one out of the four orders for the 500 ml flush of free water daily.<br><br>Facility investigation notes dated 10/31/22, were reviewed and licensed practical nurse (LPN)-A written statement indicated LPN-A started shift on 10/31/22, at 6:00 a.m. and checked on R1, and R1's sheets were observed with bowel movement, the bowel movement covered right heel, right legs, and coming out the side of the front of R1's brief. LPN-A written statement further indicated, R1's right gluteal fold sacral wound had dressing LPN-A applied on 10/28/22. Social service (SS)-A was asked to check the facility cameras for R1's room and was reported to LPN-A nobody had entered R1's room since 10/30/22, at 8:37 p.m. The statement further indicated, LPN-A completed a documentation audit for the evening and overnight shift for R1, and the evening wound care had been signed off, but not physically completed, and found the overnight shift for 500ml water was signed off, and due to the camera observance was clear the nurse who was responsible for R1's cares signed the orders, but never completed.<br><br>SS-A written statement dated 10/31/22, indicated SS-A reviewed the cameras for cares of R1 and the footage of cameras indicated:<br>10/30/22:<br>o 6:26 p.m. registered nurse (RN)-A entered R1's room<br>o 6:27 p.m. RN-A exited R1's room<br>o 8:20 p.m. former director of nursing (DON) entered R1's room.<br>o 8:23 p.m. former DON exited R1's room<br>o 8:37 p.m. former DON entered and exited | F 686 | | |

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| F 686 | Continued From page 5<br>R1's room<br>10/31/22:<br>o 3:21 a.m. unidentified nursing assistant (NA) entered R1's room<br>o 3:23 a.m. unidentified NA exited R1's room<br>o 3:29 a.m. unidentified NA entered and exited R1's room<br><br>On 11/9/22, at 8:45 a.m. during an interview the administrator indicated on 10/30/22, the former DON worked on 10/30/22, from 6:00 p.m. until 6:00 a.m. and was responsible for R1's care and included wound care and enteral orders. The administrator indicated on 10/31/222, LPN-A brought concerns related to R1's wound care not completed on 10/30/22, the administrator further indicated the facility started an investigation into the concern R1's wound care. The administrator indicated the former DON documented on 10/30/22, completion of R1's wound care and cameras and facility investigation determined she falsely documented the treatment orders for wound care and enteral orders. The administrator indicated when the former DON was questioned about R1's wound care initially denied the accusations, and then later the former DON indicated she forgot to complete R1's wound care on 10/30/22. The administrator further indicated R1's wounds treatments were not completed by RN-A and RN-B on different occasions. The administrator indicated the interim DON is working on the plan of correction, and the facility initiated an audit on R1's wound care and enteral orders to back up the MAR. The administrator stated staff missed R1's wound care treatment and the former DON documented she completed the treatments she had not done. The administrator indicated the facility interventions were to terminate the DON, provided education to | F 686 | | |

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| F 686 | Continued From page 6<br>all nurse staff on wound treatments, data collection, and dressing changes, and initiation of an audit on R1's treatments. The administrator further indicated R1's wounds have not worsened.<br><br>On 11/9/22, at 10:15 a.m. during an interview RN-A indicated she worked on 10/30/22, from 6:00 a.m. to 6:00 p.m. and completed R1's wound care, however failed to complete the sacral wound care and sacral dressing change. RN-A further indicated two staff members were needed for positioning during R1's sacral dressing change and RN-A indicated facility staff were not available to assist during R1's dressing change. RN-A further indicated on 10/30/22 documentation of R1's sacral dressing change, however confirmed she had not completed the treatment of R1's sacral dressing or wound care. RN-A indicated on 10/30/22, during shift change report communication to DON that R1 did not have sacral wound care or dressing change. RN-A indicated she did not document a progress note to indicate she charted incorrectly, and/or change or edit the documentation. RN-A further indicated she should not have documented the wound care until she complete R1's wound treatments as that was general nursing knowledge . RN-A indicated she was hired as the MDS nurse, and last week became responsible for facility wound assessments and tracking. RN-A indicated the facility did not a have a defined wound care nurse.<br><br>On 11/9/22, at 10:46 a.m. during a follow up interview the administrator indicated he was not aware RN-A documented R1's wound care treatments, without actual completion of the treatment. The administrator further indicated if | F 686 | | |

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| F 686 | Continued From page 7<br>he was aware of RN-A documenting on a treatment which was not completed education would have been provided, along with corrective action. The administrator further indicated the facility had not investigated R1's wound care not completed on 10/29/22, as the former DON was responsible for corrective action of the nursing staff.<br><br>On 11/9/22, at 11:00 a.m. during a phone interview LPN-A indicated on 10/31/22, shift started at 6:00 a.m. and rounded on residents, and R1 had an odor coming from his room of bowel movement and LPN-A indicated discovered R1's wound care had not been done since 10/28/22. LPN-A and further indicated the date on R1's sacral dressing was dated 10/28/22. LPN-A further indicated the former DON was working the night shift and provided him report, and LPN-A indicated he did not receive report about R1's wound care treatments not completed. LPN-A indicated he made the administrator aware R1's wound care dressing still intact from 10/28/22, and concerns with R1 failed wound care treatments on 10/29/22, and 10/30/22. LPN-A indicated SS-A was asked to review camera footage about the concerns with R1's wound care. LPN-A indicated SS-A reviewed the camera footage for 10/30/22, and indicated the last time was observed nursing staff entered R1's room was on 10/30/22, at 8:37 p.m. LPN-A indicated was the facility's infection prevention nurse. LPN-A indicated risk R1's wound treatments not changed or completed placed R1 at risk for multiple organism infection. LPN-A indicated the facility provided education to nursing staff and audits were initiated on R1's treatments and wound orders. | F 686 | | |

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| F 686 | Continued From page 8<br>During an interview and observation on 11/9/22, at 11:51 a.m., with licensed practical nurse RN-B and NA-A observed dressing changes to R1. RN-B indicated other than the sacrum, R1 had no other open wounds. R1 was on a pressure relieving mattress. RN-B indicated worked at the facility for one week and R1's wounds had not worsened<br><br>On 11/9/22, at 12:45 p.m. during a phone interview RN-C indicated she worked on 10/29/22, and completed R1's wound care. When asked about R1's dressing dated 10/28/22, when found on 10/30/22, RN-B indicated she had completed R1's dressing change on 10/29/22, and may have wrote the wrong date on the dressing. RN-B indicated the facility had not provided education regarding dressing changes and wound care, and further indicated she worked on 11/8/22.<br><br>On 11/9/22, at 4:39 p.m. during a phone interview the former DON indicated she worked on 10/30/22, from 6:00 p.m. until 6:00 a.m. and verified documentation of R1's wound care and treatments. The former DON indicated R1's wound care treatments were inadvertently documented as it was a busy night with lots of orders and treatments throughout the facility. The former DON indicated documentation without completion of the treatment was not something done before. The former DON indicated R1's 500 ml water flush was administered at 8:00 p.m., which was earlier then ordered, and gave the flush when administered R1's Tylenol. The DON validated R1 was not receiving wound care and treatment as ordered by facility nursing staff, and the former DON stated in the past she had provided general statements to nursing staff on | F 686 | | |

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| F 686 | Continued From page 9<br>the importance of completion of wound treatments. The former DON indicated staff had not received any formal education or corrective action from her. The former DON confirmed she was no longer employed at the facility as of 11/1/22<br><br>Facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation dated 4/26/22, indicated the purpose was to accurately document observations and assessments of residents. If a pressure ulcer was identified the registered nurse should record the type of wound and the degree of tissue damage on the Wound RN Assessment UDA (i.e., for a PU, record the stage). The licensed nurse recorded the location of the area, the measurements and the ulcer/wound characteristics. Document the information on the Wound Data Collection UDA. Skin tears, abrasions and bruises were not intended to be recorded on this form. Interdisciplinary team should determine any modifications that were necessary to the residents plan of care. When a PU was present, daily monitoring should occur. The PU should be assessed/evaluated at least weekly and documented on the Wound RN Assessment UDA. Observations should include: measurements - length, width, depth, characteristics - including wound bed, undermining, tunneling, exudate, surrounding skin, presence of pain, current treatments. Progress toward healing and modifications to the plan of care/treatments should be assessed and evaluated by the RN. In-services for nursing and other disciplines would be held as necessary and would include: pressure ulcer protocols and guidelines, skin observation and assessments, instruction of accurate documentation. | F 686 | | |

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.<br><br>INITIAL COMMENTS:<br>On 11/9/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. | 2 000 | | |

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| 2 000 | Continued From page 1<br><br>The following complaints were reviewed:<br><br>H55935586C (MN88117) and H55935726C (MN88374) with a licensing order issued at 0900.<br><br>The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.<br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html><br>The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at | 2 000 | | |

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| 2 000 | Continued From page 2<br>the bottom of the first page of state form.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. | 2 000 | | |
| 2 900 | MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers<br><br>Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:<br><br>A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and<br><br>B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure adequate treatment of pressure ulcers was completed and recorded for 1 of 1 resident (R1) reviewed for pressure ulcer care and services.<br><br>Findings include: | 2 900 | Corrected | 11/18/22 |

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| 2 900 | Continued From page 3<br><br>Pressure Ulcer stages defined by the Minimum Data Set (MDS) per Center Medicare/Medicaid Services:<br><br>Stage I pressure ulcer (An observable, pressure-related alteration of intact skin, whose indicators as compared to adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.)<br><br>Stage II pressure ulcers (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ ruptured blister.)<br><br>Stage III pressure ulcers (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.)<br><br>Stage IV pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.)<br><br>Unstageable pressure ulcer: (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar)<br><br>R1's face sheet printed on 11/9/22, included diagnoses of cerebral infarction (stroke) with | 2 900 | | |

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| 2 900 | Continued From page 4<br><br>hemiplegia (paralysis on one side of the body), dementia, diabetes, chronic kidney disease, protein-calorie malnutrition, anemia, contracture of multiple muscles, pressure ulcer of sacral region (located below the lumbar spine and above the tailbone, which is known as the coccyx) - stage 4, pressure ulcer of right heel - unstageable, pressure ulcer of left hip - unstageable.<br><br>R1's admission Minimum Data Set (MDS) assessment dated 9/6/22, indicated R1 had severely impaired cognition. R1 did not speak, hearing was highly impaired, vision was severely impaired and he was rarely/never understood nor did he understand. R1 did not walk and required extensive assistance of two staff for bed mobility and toileting. R1 was totally dependent upon two staff and a mechanical lift for transfers.<br><br>R1's care plan revised on 11/9/22, indicated R1 had impairment to skin integrity related to malnourishment brought on by CVA (cardiovascular accident, or stroke) and would have no complications related to skin integrity concerns identified upon admission. R1's pressure ulcers would show signs of healing and remain free from infection. Interventions included monitor location, size and treatment of skin injury, report abnormalities, failure to heal, s/s of infection, maceration, etc. to health care provider; high risk for skin injury: use extra caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface; avoid scratching and keep hands and body parts from excessive moisture: keep fingernails short, keep skin clean and dry, use lotion on dry skin, do not apply on site of injury, weekly skin observation by licensed nurse, provide pressure relieving/reducing mattress and | 2 900 | | |

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| 2 900 | Continued From page 5<br><br>heel protectors on feet to protect heels, heel protectors to be on at all times.<br><br>Braden scale for predicting pressure sore risk indicated R1 had been a high risk and a very high risk for PU development when assessed on 8/31/22, and 10/18/22, respectively.<br><br>R1's record review revealed multiple wound care treatment orders and the treatment administration record (TAR) indicated an order dated 10/18/22, sacral dressing acetic acid 0.25% put 30 ml (milliliters) in blunted syringe to flush wound, pat dry then apply iodoform ribbon 1/2 or 1/4 inch ribbon loosely into wound bed, skin prep to wound edges and cover with foam, change BID (two times a day), related to pressure ulcer of sacral region, stage 4, and an enteral feed order dated 10/20/22, indicated 500mL flush of free water every 6 hours.<br><br>R1's TAR dated 10/1/22, through 10/31/22, indicated:<br>- 10/28/22, and 10/31/22, documentation failed to indicate the 8:00 a.m. sacral dressing<br>- 10/28/22, 10/29/22, 10/30/22, documentation failed to indicate one out of the four orders for the 500 ml flush of free water daily.<br><br>Facility investigation notes dated 10/31/22, were reviewed and licensed practical nurse (LPN)-A written statement indicated LPN-A started shift on 10/31/22, at 6:00 a.m. and checked on R1, and R1's sheets were observed with bowel movement, the bowel movement covered right heel, right legs, and coming out the side of the front of R1's brief. LPN-A written statement further indicated, R1's right gluteal fold sacral wound had dressing LPN-A applied on 10/28/22. Social service (SS)-A was asked to check the | 2 900 | | |

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| 2 900 | Continued From page 6<br><br>facility cameras for R1's room and was reported to LPN-A nobody had entered R1's room since 10/30/22, at 8:37 p.m. The statement further indicated, LPN-A completed a documentation audit for the evening and overnight shift for R1, and the evening wound care had been signed off, but not physically completed, and found the overnight shift for 500ml water was signed off, and due to the camera observance was clear the nurse who was responsible for R1's cares signed the orders, but never completed.<br><br>SS-A written statement dated 10/31/22, indicated SS-A reviewed the cameras for cares of R1 and the footage of cameras indicated:<br>10/30/22:<br>o 6:26 p.m. registered nurse (RN)-A entered R1's room<br>o 6:27 p.m. RN-A exited R1's room<br>o 8:20 p.m. former director of nursing (DON) entered R1's room.<br>o 8:23 p.m. former DON exited R1's room<br>o 8:37 p.m. former DON entered and exited R1's room<br>10/31/22:<br>o 3:21 a.m. unidentified nursing assistant (NA) entered R1's room<br>o 3:23 a.m. unidentified NA exited R1's room<br>o 3:29 a.m. unidentified NA entered and exited R1's room<br><br>On 11/9/22, at 8:45 a.m. during an interview the administrator indicated on 10/30/22, the former DON worked on 10/30/22, from 6:00 p.m. until 6:00 a.m. and was responsible for R1's care and included wound care and enteral orders. The administrator indicated on 10/31/222, LPN-A brought concerns related to R1's wound care not completed on 10/30/22, the administrator further indicated the facility started an investigation into | 2 900 | | |

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| 2 900 | Continued From page 7<br><br>the concern R1's wound care. The administrator indicated the former DON documented on 10/30/22, completion of R1's wound care and cameras and facility investigation determined she falsely documented the treatment orders for wound care and enteral orders. The administrator indicated when the former DON was questioned about R1's wound care initially denied the accusations, and then later the former DON indicated she forgot to complete R1's wound care on 10/30/22. The administrator further indicated R1's wounds treatments were not completed by RN-A and RN-B on different occasions. The administrator indicated the interim DON is working on the plan of correction, and the facility initiated an audit on R1's wound care and enteral orders to back up the MAR. The administrator stated staff missed R1's wound care treatment and the former DON documented she completed the treatments she had not done. The administrator indicated the facility interventions were to terminate the DON, provided education to all nurse staff on wound treatments, data collection, and dressing changes, and initiation of an audit on R1's treatments. The administrator further indicated R1's wounds have not worsened.<br><br>On 11/9/22, at 10:15 a.m. during an interview RN-A indicated she worked on 10/30/22, from 6:00 a.m. to 6:00 p.m. and completed R1's wound care, however failed to complete the sacral wound care and sacral dressing change. RN-A further indicated two staff members were needed for positioning during R1's sacral dressing change and RN-A indicated facility staff were not available to assist during R1's dressing change. RN-A further indicated on 10/30/22 documentation of R1's sacral dressing change, however confirmed she had not completed the | 2 900 | | |

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| 2 900 | Continued From page 8<br><br>treatment of R1's sacral dressing or wound care. RN-A indicated on 10/30/22, during shift change report communication to DON that R1 did not have sacral wound care or dressing change. RN-A indicated she did not document a progress note to indicate she charted incorrectly, and/or change or edit the documentation. RN-A further indicated she should not have documented the wound care until she complete R1's wound treatments as that was general nursing knowledge . RN-A indicated she was hired as the MDS nurse, and last week became responsible for facility wound assessments and tracking. RN-A indicated the facility did not a have a defined wound care nurse.<br><br>On 11/9/22, at 10:46 a.m. during a follow up interview the administrator indicated he was not aware RN-A documented R1's wound care treatments, without actual completion of the treatment. The administrator further indicated if he was aware of RN-A documenting on a treatment which was not completed education would have been provided, along with corrective action. The administrator further indicated the facility had not investigated R1's wound care not completed on 10/29/22, as the former DON was responsible for corrective action of the nursing staff.<br><br>On 11/9/22, at 11:00 a.m. during a phone interview LPN-A indicated on 10/31/22, shift started at 6:00 a.m. and rounded on residents, and R1 had an odor coming from his room of bowel movement and LPN-A indicated discovered R1's wound care had not been done since 10/28/22. LPN-A and further indicated the date on R1's sacral dressing was dated 10/28/22. LPN-A further indicated the former DON was working the night shift and provided him report, | 2 900 | | |

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| 2 900 | Continued From page 9<br><br>and LPN-A indicated he did not receive report about R1's wound care treatments not completed. LPN-A indicated he made the administrator aware R1's wound care dressing still intact from 10/28/22, and concerns with R1 failed wound care treatments on 10/29/22, and 10/30/22. LPN-A indicated SS-A was asked to review camera footage about the concerns with R1's wound care. LPN-A indicated SS-A reviewed the camera footage for 10/30/22, and indicated the last time was observed nursing staff entered R1's room was on 10/30/22, at 8:37 p.m. LPN-A indicated was the facility's infection prevention nurse. LPN-A indicated risk R1's wound treatments not changed or completed placed R1 at risk for multiple organism infection. LPN-A indicated the facility provided education to nursing staff and audits were initiated on R1's treatments and wound orders.<br><br>During an interview and observation on 11/9/22, at 11:51 a.m., with licensed practical nurse RN-B and NA-A observed dressing changes to R1. RN-B indicated other than the sacrum, R1 had no other open wounds. R1 was on a pressure relieving mattress. RN-B indicated worked at the facility for one week and R1's wounds had not worsened<br><br>On 11/9/22, at 12:45 p.m. during a phone interview RN-C indicated she worked on 10/29/22, and completed R1's wound care. When asked about R1's dressing dated 10/28/22, when found on 10/30/22, RN-B indicated she had completed R1's dressing change on 10/29/22, and may have wrote the wrong date on the dressing. RN-B indicated the facility had not provided education regarding dressing changes and wound care, and further indicated she worked on 11/8/22. | 2 900 | | |

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| 2 900 | Continued From page 10<br><br>On 11/9/22, at 4:39 p.m. during a phone interview the former DON indicated she worked on 10/30/22, from 6:00 p.m. until 6:00 a.m. and verified documentation of R1's wound care and treatments. The former DON indicated R1's wound care treatments were inadvertently documented as it was a busy night with lots of orders and treatments throughout the facility. The former DON indicated documentation without completion of the treatment was not something done before. The former DON indicated R1's 500 ml water flush was administered at 8:00 p.m., which was earlier then ordered, and gave the flush when administered R1's Tylenol. The DON validated R1 was not receiving wound care and treatment as ordered by facility nursing staff, and the former DON stated in the past she had provided general statements to nursing staff on the importance of completion of wound treatments. The former DON indicated staff had not received any formal education or corrective action from her. The former DON confirmed she was no longer employed at the facility as of 11/1/22<br><br>Facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation dated 4/26/22, indicated the purpose was to accurately document observations and assessments of residents. If a pressure ulcer was identified the registered nurse should record the type of wound and the degree of tissue damage on the Wound RN Assessment UDA (i.e., for a PU, record the stage). The licensed nurse recorded the location of the area, the measurements and the ulcer/wound characteristics. Document the information on the Wound Data Collection UDA. Skin tears, abrasions and bruises were not intended to be recorded on this form. | 2 900 | | |

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| 2 900 | Continued From page 11<br><br>Interdisciplinary team should determine any modifications that were necessary to the residents plan of care. When a PU was present, daily monitoring should occur. The PU should be assessed/evaluated at least weekly and documented on the Wound RN Assessment UDA. Observations should include: measurements - length, width, depth, characteristics - including wound bed, undermining, tunneling, exudate, surrounding skin, presence of pain, current treatments. Progress toward healing and modifications to the plan of care/treatments should be assessed and evaluated by the RN. In-services for nursing and other disciplines would be held as necessary and would include: pressure ulcer protocols and guidelines, skin observation and assessments, instruction of accurate documentation.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures related to pressure ulcer assessment, care and treatment and ensure facility staff are educated. The director of nursing (DON) or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee could conduct random audits of the delivery of care to ensure appropriate care and services are implemented and documented. The DON or designee could bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 900 | | |

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