Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 26, 2024

Administrator
South Shore Care Center
1307 South Shore Drive
Worthington, MN 56187

RE: CCN: 245596
Cycle Start Date: December 12, 2024

Dear Administrator:

On December 12, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 10, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 10, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 10, 2025.

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

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; 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 10, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, South Shore Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 10, 2025. 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)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester MN, 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - 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

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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 12, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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December 26, 2024

Administrator
South Shore Care Center
1307 South Shore Drive
Worthington, MN 56187

Re: State Nursing Home Licensing Orders
Event ID: NPC311

Dear Administrator:

The above facility was surveyed on December 6, 2024 through December 12, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester MN, 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. BUILDING _____ B. WING _____	C 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE CARE CENTER	1307 SOUTH SHORE DRIVE WORTHINGTON, MN 56187

(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 12/6/24, 12/10/24, 12/11/24, and 12/12/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H55962180C (MN00108788), H55962181C (MN00108791), H55961820C (MN00108621), H55961393C (MN00108316) and H55962362C (MN00108936) with a deficiency cited at F609, F686, F689, F728. F849 and F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609		1/6/25

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

Electronically Signed | 01/02/2025

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 609	Continued From page 1 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure alleged violations involving abuse/neglect were reported to the State Agency (SA) timely for 2 of 2 resident (R5, R7) reviewed for abuse/neglect. Findings include: R5's quarterly Minimum Data Set (MDS) dated 11/18/2024 identified severe cognitive impairment and dependent for dressing, grooming and hygiene. R5's care plan focus dated 12/5/24, identified R5 was at end of life and utilizing hospice. Interventions included coordinate care with hospice and other end of life services.	F 609	Resident R 5 expired at the facility on 12/8/2024. R 7 will have a risk management incident created and thoroughly reviewed for root cause. R 7 vulnerable adult care plan will be reviewed and updated as needed. Incidents from survey exit until present will be thoroughly reviewed and any allegation of abuse or injury of unknown origin will be reported to the State Agency per facility policy. Future allegations of abuse will be reported within 2 hours of the allegation or serious bodily injury. Facility staff were in-serviced on the Abuse, Neglect, Exploitation Reporting and Investigating that all allegations of abuse must be reported within 2 hours of the allegation and on item #7 that all	

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F 609	Continued From page 2 During an interview on 12/12/24 at 8:43 a.m., hospice registered nurse (HRN)-D stated R5 was recently certified for hospice care. HRN-D visited R5 in the facility on 12/8/24 at 11:30 a.m. HRN-D reported when she entered R5's room, R5 was in bed and unresponsive, both eyes were matted shut and dark brown material on both corners of her mouth. HRN-D stated R5 appeared to be in same position she had placed her the day prior, R5's bed linens were soiled and incontinent pad on and was heavily "saturated" with urine. HRN-D did not inform the nurse on duty of her concerns due to being "upset". During an interview on 12/12/24 at 3:04 p.m., HRN-D indicated she was not an employee of the facility rather employed by the hospice agency in which the facility had a contract with; she would be considered a contracted staff. HRN-D stated in the event of potential abuse/neglect she normally would report this to the nurse in charge, social service, or the director of nursing (DON). HRN-D stated the concerns she had for R5's cares on 12/8/24 were not reported to facility staff, social services, or director of nursing. During an interview on 12/12/24 at 1:35 p.m., the DON stated hospice was to report abuse/neglect concerns to the nurse on duty. During an interview on 12/12/24 at 2:50 p.m., Administrator stated his expectations for any hospice visit to report to the nurse on duty and if there were concerns, hospice staff would report this to the DON, who would share the concerns to the Administrator. R7's face sheet dated 12/12/24, identified diagnoses that included amputation of right leg	F 609	evidence, interviews, and all events leading up to the incident are thoroughly reviewed. Facility DON will also provide education in-service to the Hospice organization on that all allegations of abuse and neglect must be reported to the DON, staff nurse and/or Executive Director immediately. The Executive Director and/or designee is responsible for compliance. Audits on reporting timely to the state agency and thoroughly investigating allegations of abuse will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take the audit results to QAPI for review and recommendations. Compliance: 01/06/2025	

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F 609	Continued From page 3 (removal of limb). R7's quarterly MDS dated 11/20/24, identified severe cognitive impairment and dependent for dressing, toileting, and transfers. R7's fall care plan dated 11/15/24 identified R7 was at risk for falls. Interventions to evaluate for fall risk on admission and as needed and if fall occurs, alert provider. Review of R7's incident report dated 11/30/24, indicated R7 had an unwitnessed fall on 11/30/24 at 2:00 p.m., R7 was sitting on the floor next to her bed and did not have fall mat and bed at waist high position. R7 stated she had pain in her left leg. R7's progress notes dated 11/30/24 R7 was sent to emergency room (ER) for evaluation of left leg pain, x-rays were negative, and returned to the facility. Review of R7's incident report dated 12/1/24, indicated R7 had an unwitnessed fall on 12/1/24 at 4:35 a.m., R7 was found sitting on a mat near her bed and left leg bent in front of her. R7 was assessed and denied pain. However, progress notes on 12/2/24 identified R7 was sent to the ER due to left lower extremity became swollen, red, and painful. The ER called the facility to notify R7 was being sent to another hospital for broken leg and possible surgery. R7's progress note dated 12/3/24 at 11:36 a.m., identified hospital case manager called facility and stated R7 had a left tibia fracture, cellulitis, and abscess to left lower leg. R7 will be having surgery on 12/3/24.	F 609		

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F 609	Continued From page 4 During an interview on 12/11/24 at 3:47 p.m., DON stated R7's fracture of left tibia was a serious injury and with having uncertainty of how it occurred, it should have been reported. Review of the facility Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy undated, identified if resident abuse, neglect, or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator, director of nursing and the other officials according to state law. "Immediately" is defined as: within two hours of an allegation involving abuse or result in serious bodily injury or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Review of the facility Hospice and Nursing Facility Services Agreement dated 10/1/21 indicated hospice shall report to the facility all alleged violations involving mistreatment, neglect or verbal, mental, sexual, and physical abuse within 24 hours of hospice becoming aware which was inconsistent with the facility policy and federal requirements for reporting allegations of abuse and neglect. This polilcy was not consistent with the federal requirements for reporting allegations of abuse/neglect.	F 609		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		1/6/25

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F 686	Continued From page 5 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to accurately comprehensively assess pressure ulcers in order to determine, develop, and implement individualized interventions to reduce the risk and/or prevent new pressure ulcers and/or deterioration of existing pressure ulcers for 2 of 3 residents (R3, R4) reviewed for pressure ulcers. Findings include Definitions: Pressure ulcer/Injury (PU/PI): localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury occurs because of intense and/or prolonged pressure or pressure in combination with shear. Deep tissue pressure injury: Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve	F 686	R 3 was seen by the wound clinic on 12/13/2024 and wounds were assessed and staged. R4 was discharged on 12/19/2024. R 3 and R 4 MDSs will also be reviewed and modified as needed to reflect the correct staging of resident wounds. R 3 had a risk management incident completed and root cause identified, a visual skin assessment was completed on 12/13/2024 and will continue weekly and as needed. A new Braden Assessment and completion of the pressure injury care plan was reviewed and updated as needed. Current residents who have wounds, their staging was reviewed and updated as needed. All current and future residents admitted with pressure injuries will have a skin assessment completed weekly along with care plan focus created and interventions initiated per facility policy. Facility Nursing Staff will be in-serviced on the Pressure Risk Injury Risk Assessment Policy with emphasis on item 4c that if a new pressure injury is noted, complete a new skin assessment and on item #5 to develop a care plan with interventions and to update the care plan intervention if the	

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F 686	Continued From page 6 rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. Stage 2 pressure ulcer: partial thickness loss of skin presenting as a shallow open area with a red or pink wound bed, without slough (a soft, stringy, white or yellow substance can appear in wounds and is made up of dead cells and other materials). May also present as an intact blister or open/ruptured serum filled blister. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Stage 3 pressure ulcer: full thickness skin loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough maybe present but does not block the depth of tissue loss. Stage 4 pressure ulcer: full thickness tissue loss with exposed bone, tendon or muscle. Slough and eschar (a hardened, dead tissue It can appear black, brown, red, tan and may be fluid filled or crusty.) Unstageable pressure ulcer: slough and/or eschar present and covers the wound bed making it impossible to stage the wound. R3's admission Minimum Data Set (MDS) dated 8/27/24, indicated R3 did not have cognitive impairment with diagnoses of diabetes, arthritis, and dementia. R3 was dependent on staff for activities of daily living (ADLs) except for eating and used a manual wheelchair for mobility. R3	F 686	resident condition changes and/or if care plan interventions are deemed inadequate and following the care plan. Director of Nursing and/or designee is responsible for compliance. Audits on completion of the weekly skin and wound assessment, visual audit of wounds and pressure injury care plan completion will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 01/06/2025	

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	245596	A. BUILDING _____ B. WING _____	C 12/12/2024

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F 686	Continued From page 7 was at risk for pressure ulcers and had four stage 3 pressure ulcers present on admission with interventions of pressure reducing device for chair and bed, nutrition/hydration, pressure ulcer care, applications of non-surgical dressings and applications of ointment/medications other than to her feet. R3's care plan history identified care focuses, goals, and revisions since admission, however implementation dates were not identified. The care plan identified R3 had a documented pressure ulcer (did not specify location). Interventions included encourage resident to shift weight frequently, low air loss mattress, wheelchair cushion, reposition resident as allows, monitor ulcer for signs of progression or decline and provide wound treatment. R3's physician orders included wound treatments, however, also included heal protectors while in bed every night shift for offloading heels for wound prevention with a start date of 8/21/24. R3's wound records were reviewed between 10/8/24 through 12/6/24. The records included weekly wound assessments for multiple pressure ulcers varying in stages that were not consistently accurate nor comprehensive; one of which was a wound(s) on the right heel. The records indicated on 10/8/24 a large blister that ruptured on R3's heel was identified; the area deteriorated to two different pressure ulcers a stage 3 and an unstageable ulcer. Additionally, it was not evident the care plan was consistently evaluated and revised to include pressure relieving interventions to prevent or mitigate the risk of deterioration, prevention, or mitigation of risk there of.	F 686		

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F 686	Continued From page 8 R3's progress note dated 10/8/24 at 1:31 p.m., identified during wound rounds on 10/3/24 two new darkened areas to R3's right outer foot, and a new area to R3's right inner foot. R3's heel is macerated, and heel is open and fragile. R3's Skin and Wound Evaluation dated 10/8/24, identified wound type as a ruptured blister that had started on 10/6/24, however, R3's record does not identify the presence of an intact blister and could not be determined when the blister ruptured. Further, the record did not address cause of the blister so appropriate pressure reducing interventions could be developed and implemented to prevent re-current blisters. Description included, no drainage, edges attached and macerated; the wound was healable. Intervention was suspension/protection device; it was not evident R3's care plan was revised. R3's corresponding photo of right heel dated 10/8/24, was not consistent with the evaluation. The photo identified a ruptured blister covering the bottom of the heel; the skin was macerated, "crack" or open area of the maceration from 12:00'oclock to 3:00 o'clock. Additionally, from 9:00 o'clock to 3:00 o'clock the underlying tissue was light purple which was not identified in the wound evaluation. R3's Skin and Wound Evaluation dated 10/11/24, identified shearing on right heel that started on 10/6/24 was described as shearing that measured 0.9 cm x 1.7 cm. Edges attached, fragile surrounding tissue, and improving. Interventions identified as heel suspension/protective device. It was not evident the care plan was revised.	F 686		

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F 686	Continued From page 9 R3's corresponding photo was inconsistent with the evaluation dated 10/11/24. The photo identified sloughing skin from maceration and at the 10:00 o'clock to 12:00 o'clock position there was a dark red area. This area was not identified on the evaluation. During an interview on 12/18/24 at 9:31 a.m., director of nursing (DON) stated the wound type was not shearing. R3's Skin and Wound Evaluation dated 10/20/24, identified wound on right heel was identified as a stage 2 pressure ulcer that measured 4.21 cm x 3.99 cm with no depth identified. No drainage, edges attached, calloused surrounding tissue, stable and healable. Interventions of cushion (was not specified), heel suspension/protection device (was not specified) and turning/repositioning program (was not specified). It was not evident the care plan was revised with the aforementioned interventions. R3's corresponding photo of right heel, was inconsistent with the evaluation dated 10/20/24. The photo identified multiple dark purple areas that varied in size consistent with deep tissue injuries. These areas were not addressed in the evaluation. R3's physician progress note dated 10/22/24, indicated the wounds have extended in size, not improving, and now has maceration of the heel of the right lower extremity. R3's Skin and Wound Evaluation dated 10/25/24, identified wound on right heel was a stage 2 pressure ulcer with measurements of 0.64 cm x 0.69 cm. with no depth identified. Edges attached, surrounding tissue calloused, fragile,	F 686		

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F 686	Continued From page 10 and improving. Goal of care was healable. Education: resident refused alternating pressure mattress. Interventions: suspension/protection device (was not specified) and turning/repositioning program (was not specified). It was not evident the care plan was revised. R3's corresponding photo of right heel was inconsistent with evaluation dated 10/25/24. Photo identified 5 purple areas consistent with deep tissue injuries; one area had a whitish/yellow center. These areas were not identified in the evaluation. During an interview on 12/18/24 at 9:31 a.m., DON stated R3's wound on 10/25/24 should have been marked as a deep tissue injury and not a stage 2. R3's Skin and Wound Evaluation dated 11/2/24, identified wound on right heel was a stage 2 pressure ulcer that measured 1.5 cm x 1.13 cm. with no depth identified. 80% slough, 10% eschar, moderate serosanguineous drainage, edges attached, surrounding tissue calloused. Progress is stalled. Goal of care was healable. R3 refusing air mattress and prevalon boots. Interventions none. It was not evident the care plan was revised. R3's corresponding photo for 11/2/24 did not reflect the documentation. The photo identified the back of the heel had a reddened area and two purplish/red areas noted at the bottom of the heel that was not identified in the evaluation. R3's significant change Minimum Data Set (MDS) dated 11/06/24, indicated R3 had an increase in the number of pressure ulcers since admission	F 686		

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F 686	Continued From page 11 MDS. R3 had one stage 2, and three stage 3, and one unstageable. R3's Skin and Wound Evaluation dated 11/8/24, identified the wound on right heel was stage 2. Wound measurements 1.27 cm x 3.45 cm with no depth identified. 100% eschar, moderate serosanguineous drainage. Progress is deteriorating. Goal of care was healable. Interventions of heel suspension/protection device (was not specified). It was not evident the care plan was revised. R3's corresponding photo for the 11/8/24 evaluation did not reflect the documentation. The photo identified two open wounds: one on each side of the heel. It could not be ascertained which wound the documentation was entered for. The pressure ulcer on the right side of the heel was larger than the left side. Right: had an open area with a yellowish base/center, surrounding tissue was whitish with purple border. Left: had depth, whitish center, surrounding tissue either black or bluish (could not be further described because of the angle of the picture). R3's wound care nurse practitioner note dated 11/11/24, identified R3 was seen for an outpatient wound center follow up on 11/11/24 for right foot ulcer. Wound to right heel described as a Stage 3 with measurements of 1.5 cm x 1.2 cm x 0.2 cm. Ulcer base is 100% slough and near probe to bone. R3's Skin and Wound Evaluation dated 11/13/24, identified wound on right heel was a stage 2 pressure ulcer that measured 3.47 cm x 0.73 cm, no depth with 100% eschar, no drainage, edges attached, surrounding tissue calloused and	F 686		

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F 686	Continued From page 12 stable. Interventions of cushion (was not specified) heel suspension/protection device (was not specified), moisture barrier, nutrition/dietary supplementation. It was not evident the care plan was revised. R3's corresponding photo for the 11/13/24 evaluation did not reflect the documentation. The photo identified two separate wounds both consistent with unstageable pressure ulcer. The evaluation did not identify which wound the description/measurements were for. During an interview on 12/18/24 at 9:31 a.m., DON stated after viewing image for 11/13/24, this should have been marked as an unstageable pressure ulcer. R3's Skin and Wound Evaluation dated 11/22/24, identified wound on left side of the right heel as a stage 2 that measured 2.0 cm x 1.85 cm x 0.4 cm. with 10% slough, 10% eschar, rolled edges, surrounding tissue fragile. Progress was deteriorating. Goal of care was healable. Note: both areas increased in size, unable to capture both areas in 1 picture, obtained separate pictures. Noted resident has increased pain while lying in bed do to contracture of right lower leg, appears to increase pressure to right heel. Area cleansed with normal saline Used Kerlix to secure gauze in place, whole roll used to offer some padding and is willing to wear prevalon boots. Interventions cushion, heel suspension/protection device, moisture barrier, moisture control. It was not evident the care plan was revised. The right pressure wound was described as an unstageable ulcer that measured 2.46 cm x 1.88 cm x 0.2 cm (even though the wound was unstageable) 20% slough and 20% eschar.	F 686		

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F 686	Continued From page 13 R3's corresponding photo for the 11/22/24 evaluation for the right heel wound (left side) did not reflect the documentation. The photo identified two wounds right wound larger than the left. Left wound: open with macerated edges with dark purple area that was consistent with a deep tissue injury that surrounded almost ½ the wound; this area was not identified on the evaluation. R3's Skin and Wound Evaluation dated 12/1/24, identified wound on right heel was a deep tissue injury that measured 2.7 cm x 1.9 cm, 10% slough, 80% eschar, attached edges, dry/flaky and fragile. Wound was deteriorating. Interventions: cushion (was not specified), nutrition, and positioning wedge. It was not evident the care plan was revised. The corresponding photo was consistent with the wound description, however, was not consistent with a deep tissue injury rather an unstageable ulcer according to the definition. R3's Skin and Wound Evaluation dated 12/5/24, identified wound on right heel was deep tissue injury that measured 1.8 cm x 1.0 cm x 0.2 cm with 100% eschar, rolled edges, calloused, dry/flaky and fragile. The wound was stable and healable. Interventions included incontinence management and heel suspension/protection. The wound in the corresponding photo was not consistent with a deep tissue injury rather an unstageable ulcer according to the definition. It was not evident R3's care plan was revised however, physician order dated 12/5/24 directed prevelon boots to both feet. R3's Wound Care Clinic notes dated 12/6/24 identified Stage 4 pressure ulcer on right	F 686		

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F 686	Continued From page 14 posterior heel acquired on 1/1/20 (conflicting information per previous facility wound assessments of start date of 10/6/24). Wound measurements are 2.2 cm x 2.0 cm, with no measurable depth with eschar. Right lateral heel identified as a chronic stage 2 pressure ulcer, acquired on 1/1/20 (conflicting information per previous facility wound assessments of start 10/6/24). Measurements 2.0 cm x 2.0 cm x 0.2 cm. Adipose tissue (body fat) exposed with slough and eschar. Wounds were debrided by provider. New orders for specialty bed/mattress for pressure reduction-keep pressure off right heel. R3's Wound Evaluation dated 12/12/24, identified wound on right heel was a stage 3 pressure ulcer that measured 0.45cm x 0.72 cm. no drainage, fragile surrounding skin, stable and healable. Interventions of heel suspension/protection device and nutritional supplement. During an interview on 12/18/24, DON stated the assistant director of nursing was monitoring the wounds and she noted there was inconsistency of the images and assessments of R3's wounds. DON indicated R3 developed the wounds from propelling herself in her wheelchair with her feet and she refused the blue boots. R3's interventions did not make it in her care plan. DON stated her expectation for any wound that are deteriorating was to have a new intervention place in the care plan. DON stated R3 was refusing dressing changes at times and the dressing changes done at different intervals. R4 R4's quarterly MDS dated 10/31/24, indicated R4 did not have cognitive impairment with diagnoses	F 686		

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F 686	Continued From page 15 that included diabetes, coronary artery disease, renal insufficiency, and dementia. R4 had range of motion impairment to one side of her body and required partial to substantial assist with dressing upper body and dependent on staff for lower body dressing. R4 did not have a toileting program and was always incontinent of bladder and frequently incontinent of bowel. R4 was at risk for pressure ulcers but had none. R4 did have a diabetic foot ulcer she received application of dressing to feet with or without topical medication. R4 had pressure relieving devices in bed and on her electric wheelchair. R4's skin integrity care plan dated 6/12/24 indicated R4 had actual skin impairment related to incontinence and history of vulvar cancer. R4 had areas of MASD to right upper thigh, left gluteal cleft, coccyx, and left buttocks. R4's Skin and Wound evaluation dated 11/27/24, identified MASD/IAD to coccyx that measured 1.1 cm x by 0.3 cm and no depth documented. The area was in house acquired and new as of 11/26/24. The area was 100% granulation filled, no evidence of infection. Light amount of serous drainage without odor. The surrounding skin is dry and flaky, fragile skin at risk for breakdown. Notation of resident is on repositioning program, spends quite a bit of time lying in bed and up to recliner and power chair for short bits of time. Reminded resident to continue with repositioning. Staff educated on following resident care plan, repositioning every 2 hours and check and change. R4's corresponding photo dated 11/27/24, identified an open slit on R4's coccyx. The base was yellow in color and the surrounding tissue	F 686		

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F 686	Continued From page 16 was pink. This wound is not consistent with MASD and by definition is consistent with a stage 2 pressure ulcer. R4's Skin and Wound evaluation dated 12/5/24, identified MASD/IAD to coccyx measured 1.3 cm x 0.3 cm and no depth documented. There was 90% granulation and slough were present over 10% of the wound. There was no evidence of infection. The edges appeared flushed with the wound bed or as sloping edge. The surrounding skin looked fragile, at risk for breakdown. Treatment was to cleanse with soap and water and apply barrier cream. Area was noted to be improving. R4's corresponding photo dated 12/5/24 was not consistent with the evaluation. Photo identified an open slit in the coccyx with visible depth that was not assessed/documented on the evaluation. During an interview on 12/12/24 at 2:11 p.m., registered nurse (RN)-D stated assistant director of nursing (ADON), was responsible to review the quarterly care plans when she does the care conferences and was to make updates. RN-D was responsible for the annual care plan updates when she completed the annual and significant change MDS. RN-D further stated they had switched over to a different program and it did not allow them to make the care plans individualized. They had to use what was in the drop-down box. During an interview on 12/11/24 at 3:45 p.m., DON stated therapy decided the type of pressure relieving device or the wound care provider. All residents have a pressure relieving mattress throughout the facility. DON further stated her expectation was the residents care plan were	F 686		

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F 686	Continued From page 17 updated with current interventions, so the staff knew what they were. Facility policy Pressure Injuries Overview 9/29/21, identified the purpos of the procedure was not provide information regarding definitions and clinical features of pressure injuries. The policy included the descriptions of pressure ulcers and associated terms used to desribe features of the pressure ulcer. This policy did not address components of a comprehensive assessment nor pressure relieving interventions. Facility policy Wound Care dated 9/29/21, indicated to 1) verify the physician's order for the procedure, 2) review resident's care plan for special needs, example: pain medication. Documentation included: 1) The type of wound care given. 2) The date and time the wound care was given. 3) The position in which the resident was placed. 4) The name and title of the individual performing the wound care. 5) Any change in the resident ' s condition. 6) All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 7) How the resident tolerated the procedure. 8) Any problems or complaints made by the resident related to the procedure. 10) If the resident refused the treatment and the reason(s) why. Under Reporting 1) Notify supervisor if the resident refuses the wound care, 2) report other information in accordance with facility policy and professional standards of practice.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		1/6/25

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F 689	Continued From page 18 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete comprehensive fall analysis and implement individualized interventions to prevent re-current falls and/or mitigate the risk for falls with major injury for 2 of 3 residents (R7, R5) reviewed for falls. The facility's failures resulted in actual harm for R7 when she sustained left tibial fracture that required surgical repair. Finding include: R7's face sheet dated 12/12/24 identified R7 had diagnoses that included acquired absence of right leg above knee and type 2 diabetes. R7's admission Minimum Data Set (MDS) dated 9/10/24, identified R7 was admitted to the facility on 9/4/24 and had severe cognitive impairment with no signs or symptoms of delirium, behaviors or history of falls within six (6) months of admission. R7 had functional limitations in range of motion of one lower extremity, used a wheelchair, and was dependent on staff for hygiene needs, lower body dressing and chair to bed transfers. R7's ability to sit to stand and walk was not attempted due to medical condition. R7 was always incontinent of bowel and bladder, and administered insulin in addition to psychotropic, anticoagulant, and opioid medications.	F 689	Resident R 5 expired at the facility on 12/8/2024. R 7 will have risk management incidents thoroughly reviewed and root cause identified. R 7 care plan will be reviewed and updated as needed. Current residents fall assessments and care plans will be reviewed and interventions will be updated as needed. Fall incidents from survey exit until present will be thoroughly reviewed, root cause identified, and care plan interventions initiated. Future residents who fall will have a risk management incident created and thoroughly investigated for root cause and new intervention added to the care plan per the facility policy. Licensed Nurses will be in-serviced on the Falls and Fall Risk Management Policy with emphasis on identifying possible interventions and adding these interventions to the resident care plan so that the care team is knowledgeable of implemented interventions. Director of Nursing and/or designee will be responsible for compliance. Audits on risk management completion and indication of identified intervention and fall care plan intervention initiation will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the	

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F 689	Continued From page 19 R7's undated fall Care Area Assessment (CAA) included, resident currently has falls related to cognitive deficits and amputation of "LRL" (sic). Resident will have less than 2 falls per month through the review date. The CAA indicated and identified R1 was at risk for falls related to cognitive impairment, diagnoses of cardiac dysrhythmias, incontinence, loss of limb, anxiety disorder, schizophrenia, and the medications as identified in the admission MDS. The CAA indicated falls would be addressed in the care plan with the overall objective to avoid complications and minimize risks. R7's fall risk evaluation dated 9/4/24, indicated R7 was at risk for falls with a history of three or more falls in the past three months. R7 was disoriented, chair bound/incontinent and was not able to perform gait/balance evaluation. The interventions listed were to evaluate for falls and if falls occur alert the provider. Although R7's fall risk evaluation and the MDS identified R7 was at risk for falls, R7's care plan dated 9/4/24 did not include and/or address a plan of care for falls. R7's care plan dated 9/4/24 identified the following focuses and interventions: -Current Functional Performance informed staff R7 required one person physical assist for toileting, for transfers R7 required total assist of two person with a full body mechanical lift using amputee sling. -Impaired physical mobility related to amputation leading to phantom limb included but was not limited the direction of for staff to allow R7 adequate time for response and ensure call light available. -Documented Safety -Concerns directed staff to perform safety risk evaluations on admission, as	F 689	Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 01/06/2025	

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F 689	Continued From page 20 needed, and upon change of condition and Safety Measures- including strategies to reduce the risk of infection, falls, injury initiated as appropriate. In review of R7's fall record between 9/5/24 through 12/1/24 identified R7 had 11 total falls. R7's falls incident reports identified the following: R7's fall incident report dated 9/5/24, at 5:25 a.m. indicated R7 had an unwitnessed fall in her room with no injury. R7 had been found on the floor next to her bed with blankets under her bottom, she appeared to have slid from the bed. R7 stated she needed to get up and use the bathroom so she wouldn't be late for school. The incident report identified predisposing factors as R7 was admitted within 72-hours and confused, but did not indicate/identify R7 had needed to use the bathroom as a factor. The report did not include comprehensive fall analysis nor identify immediate fall prevention interventions and not evident R7's care plan was revised. R7's fall incident report dated 9/7/24 at 4:51 a.m. indicated R7 who was wheelchair bound had an unwitnessed fall in her room with no injury. A nursing assistant (NA) had been completing the 30-minute checks and found R7 on the floor drinking water in good spirits with stool smeared on her floor mat. R7 had reported she wanted to get up and get her water. In response to staff asking how she got on the floor, R7 gestured her hand in a gliding motion towards the floor. Predisposing factors included R7 was admitted within 72-hours, but did not/indicate identify R7's bowel incontinence nor R7's location of water and/or need for water. The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions.	F 689		

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F 689	Continued From page 21 Furthermore not evident the care plan was revised to reflect the implementation of when/duration of 30-minute checks or usage of floor mat. R7's fall incident report dated 9/13/24 at 7:30 a.m. indicated R7 who was wheelchair bound normally does not ambulate at all had an unwitnessed fall. R7 was found sitting on the floor next to her bed and could not clearly inform staff if she hit her head or if her bottom hurt or not. Education provided to resident not get out of bed by herself but due to confusion instructions may not be understood. Predisposing factors identified included: confused, impaired memory, and incontinent. The report did not specify if R7 was incontinent when she was found. The report did not include a comprehensive fall analysis nor identify other fall interventions other than the immediate education that may not have been understood by R7. Further not evident of an assessment/evaluation to identify effectiveness of the education provided nor evident the care plan was revised to include resident education. R7's fall incident report dated 9/22/24 at 8:58 a.m. p.m. indicated at 5:25 p.m. R7 was in her room when an NA saw her pulling on the mattress, causing R7 to slide out of her wheelchair onto floor. R7 reported she had wanted to go to bed. Predisposing factors identified as confusion. The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. Further not evident R7's care plan was revised. R7's fall incident report dated 10/19/24, indicated R7 had a witnessed fall with no injuries at 9:30 a.m. when she appeared to be repositioning	F 689		

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F 689	Continued From page 22 herself in her wheelchair and slid out of her chair landing on her bottom. Prior to the fall during breakfast, R1 had been agitated/behavioral and very confused. R7 Unable to give description. Predisposing factors checked were none, but noted mental status as alert and confused. The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. Further not evident R7's care plan was revised. R7's fall incident report dated 11/3/24, indicated R7 had unwitnessed fall around 3:15 p.m. with no injuries. R1 was found by housekeeping staff sitting on floor, on her blue mat, leaning against her bed around 3:15 p.m. Prior to fall NA had just been in room, and found R7 sitting at the edge of the bed. NA assisted R7 back to bed and bed was in the lowest position. R7 was at her night stand and going through her stuff when she lowered herself to the floor. R7 unable to say what she was doing when she lowered herself to the floor but told family she was trying to get into bed. R1 was alert and confused. Predisposing factors included, confused and impaired memory. The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. Further not evident the care plan was revised to include appropriate bed height and usage of the floor mat. R7's care plan was revised to include a fall focus on 11/15/24, that identified R7 was at risk for falls however did not have individualized interventions that would prevent and/or mitigate R7's risk for falls including the usage of the fall mat, 30-minute checks, resident education, and bed height that was identified in the fall incident reports. The fall care plan only directed staff to evaluate for falls	F 689		

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F 689	Continued From page 23 on admission and as needed and if a fall occurs, notify the provider. R7's fall incident report dated 11/26/24 at 1:40 p.m. indicated R7 had an unwitnessed fall with no injuries. R7's physician found R7 sitting on her floor mat. R7 reported she purposely put herself on the floor to get up. R7 was alert and confused. No predisposing factors were identified. Additionally, the report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. R7's fall incident report dated 11/27/24 at 6:45 a.m. indicated R7 had an unwitnessed fall in her room, she was found sitting on her floor mat next to her bed. R7 appeared calm but was not able to state what happened. The fall resulted in a skin tear to left lower leg with minor bleeding. Predisposing factors identified as confused. The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. R7's fall incident report dated 11/29/24 at 7:00 a.m., indicated R7 had an unwitnessed fall and had an open area to her left shin. NA found R7 sitting on the floor mat next to her bed. The report included when asked why she was on the floor resident pointed to room mate. Then resident stated that she wanted to get up. The predisposing factor was identified as "Resident is concerned about recent new room mate". The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. R7's fall incident report dated 11/30/24 at 2:00 p.m., indicated R7 had an unwitnessed fall. NA	F 689		

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F 689	Continued From page 24 found resident sitting on the floor next to the bed. R7 was alert and confused. The bed was in waist high position with no fall mat next to bed. R7 reported her whole leg hurt when the nurse did range of motion (ROM). R7 was sent to the emergency room for further evaluation and the aide was provided with education on following the care plan. Predisposing factors included, confused. The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. R7's fall incident report 12/1/24 at 4:53 a.m. indicated R7 had an unwitnessed fall with no injuries. NA found R7 sitting on her floor mat next to her bed with her leg bent in front of her and incontinent of bowel, call light was in place and bed was in the lowest position. R7 was alert to person and place. Nurse had just been in her room at 4:35 a.m. to check on R7 since she was self-transferring from bed to the floor frequently. Predisposing factors identified as incontinent and R7 "is very curious about roommate-wants to know what she is doing all the times." The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. R7's progress notes dated 12/2/24 at 7:02 a.m., R7 was sent to ER due to left lower extremity became swollen, red, and painful. At 11:54 a.m. the ER called the facility informing R7 was being sent to another hospital for broken leg and possible surgery. R7's emergency department note dated 12/2/24, identified a hematoma (collection of blood) to the proximal (near) the tibia/fibula are of left lower leg and a fracture of the left proximal end of left tibia and was sent to another hospital for surgery.	F 689		

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F 689	Continued From page 25 R7's hospital discharge summary dated 12/10/24, identified R7 was admitted on 12/2/24 for a closed fracture of left proximal tibia that required surgery on 12/3/24, cellulitis and abscess of left lower extremity. R7 was discharged back to the facility on 12/10/24 on IV antibiotics. The records did not include and was not evident the facility completed a comprehensive fall analysis that identified potential causal factors and/or root cause(s) so that appropriate determinations for individualized fall interventions could be developed and implemented to remove R7's fall risk associated with the potential causal factors/root cause. R5 R5's face sheet dated 12/16/24, identified diagnoses of malnutrition (condition where body does not get enough nutrients), chronic kidney disease (condition where kidneys have been damaged), osteoarthritis (condition with joint pain and stiffness), and weakness. R5's quarterly Minimum Data Set (MDS) dated 11/18/2024 identified R5 had severe cognitive impairment. R5 was dependent on staff for dressing, grooming and hygiene and required maximum assistance for all transfer. R5 had two or more falls with no injury and one fall with minor injury. R5's fall care plan dated 8/17/24, indicated R5 was high risk for falls related to weakness, history of falls with the following: "Call don't fall" signs posted in room, anticipate needs, call light within reach, physical therapy (PT) to evaluate and treat	F 689		

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F 689	Continued From page 26 or as needed. R5's fall incident report dated 10/12/24, indicated R5 had an unwitnessed fall at 7:40 p.m. R5 was found in her room laying on her back next to walker. Predisposing risk factors included confusion and ambulating without assistance. Immediate action taken: R5 assessed with no injuries noted. Walker removed and call light placed within reach. R5's record did not include a comprehensive analysis of the fall and R5's care plan was not revised. R5's fall incident report dated 10/13/24, indicated at 11:30 p.m. an NA witnessed R5 attempting to self-transfer in her room and was going to fall so NA assisted R5 to the floor. R5 stated I have to go I want to walk, can I go but she don't state where she want to go. No injuries were noted. Predisposing factors included confused, gait imbalance, using a walker, and alert but confused. Immediate actions taken: Walker removed and call light placed within reach. R5's record did not include a comprehensive analysis of the fall and R5's care plan was not revised. R5's fall incident report dated 10/15/24, indicated R5 had an unwitnessed fall at 6:00 a.m. R5 was yelling and when NA entered R5's room, R5 was found sitting upright behind a closed door. R5 was confused and unable to give any detail of what happened but kept asking staff to lock the door. Resident has delusions of men coming into her room and keeps trying to shut the door. No injuries noted. Predisposing factors included alert and confused, gait imbalance, impaired memory incontinent using a walker, and wanderer. Immediate action taken: R5 assessed for injuries and placed in wheelchair and took to dining area	F 689		

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F 689	Continued From page 27 for close observation. R5's record did not include a comprehensive analysis of the fall and R5's care plan was not revised. R5's fall incident report dated 10/29/24, indicated R5 had an unwitnessed fall at 9:45 p.m., R5 had been in her bed and was found sitting on floor in front of wheelchair close to the bathroom, with gripper socks on, call light at bedside, and had been toileted within 30 minutes, no incontinence. R5 was unable to explain what happened. Predisposing factors included, confused. Immediate action taken: R5 was assessed for injury and noted to have bump on back of head. R5's record did not include a comprehensive analysis of the fall and R5's care plan was not revised. During an interview on 12/11/24 at 4:10 p.m., director of nursing (DON) confirmed causal analysis were not being completed and care plans were not revised. DON indicated she expected the facility policy be followed. After a fall occurs, a causal analysis was supposed to be completed and immediate interventions developed, implemented, and identified in the care plan. Review of the facility policy Falls, Clinical Protocol dated 10/4/2021, indicated the following: -Cause identification, 1) for an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. the staff; 3) the staff and practitioners will continue to collect and evaluate information until either the cause of the fall is identified, or it is determined the cause cannot be found or is not correct. -Treatment/management, 1) based on preceding	F 689		

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F 689	Continued From page 28 assessment, the staff and physician will identify interventions to try to prevent subsequent falls and to address the risk clinically significant consequences of falling. 2) if under lying causes cannot be readily identified or corrected, staff will try carious relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for it continuation.	F 689		
F 728 SS=E	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has	F 728		1/6/25

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F 728	Continued From page 29 worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 4 of 4 nursing assistants (NA-T, NA-D, NA-G, and NA-U) reviewed were deemed competent to complete cares for residents. This had the potential to affect all 45 residents residing in the facility. Findings include: Review of the facility job description Non-Certified Nursing Assistant (NA) and training requirements dated August 2021, indicated the primary purpose of this position is to provide resident with routine daily nursing care and services in accordance with the resident's assessment and care plan and as directed by supervisors. After completing facility competency training, all residents' lifts, transfers and activity of daily living (ADL) care, the non-certified aide must complete these tasks with the assistance of a facility Certified Nurse Aid (CNA). Review of NA-T's employee record indicated NA-T was hired on 9/10/24. NA-T's orientation sign off sheet was not completed with the date and sign off sections for training completed were left blank. Further, NA-T's file did not include	F 728	All facility non-certified nurse aides were removed from the staffing schedule and were competencied for ADL cares and feeding beginning 12/12/2024. All competency sheets have been placed in the resident record. There were no adverse resident events that occurred for this deficient practice. Future employees hired will have full general orientation along with competency evaluations completed upon hire. Facility DON, ADON and Human Resource Manager will be in-serviced on the Orientation Program Policy with emphasis on item #3 which lists areas that are covered during orientation and the written record will be kept in the employee record and on the Competency Nursing Policy which states that competency evaluations will be completed upon hire and annually and as deemed necessary. Director of Nursing and/or designee is responsible for compliance. Audits on orientation and competency completion and the written record in the employee record will begin 2x week for 2	

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F 728	Continued From page 30 competency training records that identified NA-T was deemed competent for resident lifts, transfer, and ADL's. During an interview on 12/11/24 at 12:52 p.m., NA-T stated she was an uncertified nursing assistant and began working 2 months ago. NA-T stated she assisted residents with dressing, toileting, and assists with transfers with the mechanical lifts. NA-T stated she was registered for a nursing assistant course in June of 2025 and training was done by a certified nursing assistant and indicated she was not signed off for skills competencies. Review of NA-D employee record indicated NA-D was hired on 10/9/24. NA-D's file did not include an orientation record nor competency training records that identified NA-D was deemed competent for resident lifts, transfer, and ADL's. There were no competencies noted in NA-D's file for resident lifts, transfers and ADL's. Review of NA-G's employee record indicated NA-G was hired on 8/12/24. NA-G's orientation sign off sheet was not completed with the date and sign off sections for training completed were left blank. Further, NA-G's file did not include competency training records that identified NA-G was deemed competent for resident lifts, transfer, and ADL's. During an interview on 12/10/24 at 3:51 p.m., NA-G stated he was an uncertified nursing assistant and began working in the facility about four months ago. NA-G stated he assisted residents with dressing, toileting and eating. NA-G stated he is not allowed to use the mechanical lifts. NA-G stated training was with a	F 728	weeks, weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 01/06/2025	

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F 728	Continued From page 31 certified nursing assistant and indicated he was not signed off for skills competencies. NA-G further stated he was not currently enrolled in and NA classes and the next was not until February 2025 and he had not decided if he was taking that class. Review of NA-U's employee file indicated NA-U was hired on 11/1/24. NA-U's orientation sign off sheet was not completed with the date and sign off sections for training completed were left blank. Further, NA-U's file did not include competency training records that identified NA-U was deemed competent for resident lifts, transfer, and ADL's. During an interview on 12/11/24 at 3:45 p.m., director of nursing (DON) stated the assistant director of nursing (ADON) was to have performed competencies for all new employees before they worked on the floor. DON indicated competency records should be located in the employee file and if they were not then she was not sure where they would be kept. DON stated it was her expectation all new employees were competency tested prior to working on the floor and the record of the training/testing be kept in their employee file. The facility training program requirements were requested and not received.	F 728		
F 849 SS=D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more	F 849		1/6/25

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F 849	Continued From page 32 Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status.	F 849		

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F 849	Continued From page 33 (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving	F 849		

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F 849	Continued From page 34 mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient	F 849		

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F 849	Continued From page 35 as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have a clear communication process between hospice and the facility of a change in hospice services to be provided and to designate a member of the facility's	F 849	Resident R 5 expired at the facility on 12/8/2024. Current residents who are receiving hospice services, their care plan for hospice services will be reviewed and updated as needed. Future residents who	

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F 849	Continued From page 36 interdisciplinary team to coordinate care to the resident by the facility and hospice staff for 1 of 1 (R5) resident who received hospice services. Findings include: R5's face sheet dated 12/16/24, identified diagnoses of malnutrition (condition where body does not get enough nutrients), chronic kidney disease (condition where kidneys have been damaged), osteoarthritis (condition with joint pain and stiffness), and weakness. R5's quarterly Minimum Data Set (MDS) dated 11/18/2024 identified severe cognitive impairment and dependent for dressing, grooming and hygiene. During an interview on 12/10/24 at 4:08 p.m., registered nurse (RN)-H reported that R5 was seen by hospice registered nurse (HRN)-D on 12/8/24. RN-H stated she did not receive any new recommendations about R5's plan of care from HRN-D during her shift. RN-H stated that hospice nurses normally notify the nurse on duty after visits and communicate any new recommendations. RN-H stated she did not inquire with HRN-D about R5's visit on 12/8/24. During an interview on 12/12/24 at 8:43 a.m., hospice registered nurse (HRN)-D stated R5 was admitted to hospice on 12/5/24 with a diagnosis of malnutrition. HRN-D visited R5 in the facility on 12/8/24 at 11:30 a.m. and stated she had told an unidentified nursing assistant that R5's plan of care changed and recommended R5 be turned, repositioned, and provided oral cares every two hours. HRN-D also indicated she had concerns pertaining to R5's care being completed. HRN-D	F 849	enter hospice services and social services will coordinate facility communication per facility policy. Licensed Nurses and Social Services will be in-serviced on Hospice Program Policy with emphasis on item #10 that the hospice nurse must make staff nurse aware of their presence and the staff nurse must report any changes in the level of care, document, and update the resident care plan as needed. Director of Nursing and/or designee is responsible for compliance. Audits on hospice nurse visit note review via the electronic record, hospice nurse visit note documentation from facility staff nurse for updates and hospice recommended changes in care and implementation of interventions will begin weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 01/06/2025	

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F 849	Continued From page 37 did not tell the nurse on duty of her recommendations for the changes to R5's care plan nor communicate the care related concerns. R5's care plan focus dated 12/5/24, identified R5 is at end of life and utilizing hospice. Interventions included coordinate care with hospice and other end of life services. R5's care plan did not identify or a address a repositioning schedule and oral cares. During an interview on 12/12/24 at 3:04 p.m., HRN-D stated she typically would tell the nurse on duty of any changes she recommended but did not communicate this to the nurse on duty after R5's visit on 12/8/24. HRN-D indicated no documentation was recorded in the facility's electronic health record (EHR) about the change in plan of care for R5. During an interview on 12/12/24 at 1:38 p.m., RN-A stated she was not aware of a designated person in the facility that hospice was supposed to communicate changes, and that hospice nurse should report any concerns or changes in plan of care to the nurse on duty. During an interview on 12/12/24 at 1:53 p.m., RN-C stated that he was not aware of a designated staff member in the facility that hospice is communicate changes, and hospice nurses should talk to the nurse on duty. During an interview on 12/12/24 at 1:35 p.m., the director of nursing (DON) stated her expectations for any hospice visit would be that the hospice nurse would report to the nurse on duty any updates or changes.	F 849		

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F 849	Continued From page 38 During an interview on 12/12/24 at 2:50 p.m., Administrator stated his expectations were for hospice to report to the nurse on duty and if concerns, they would report this to the DON, who would share the concerns to the Administrator. Review of the facility Hospice Program Policy (undated) identified facilities responsibility to communicate with the hospice provider to ensure that the needs of the resident are addressed and met.	F 849		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		1/6/25

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F 880	Continued From page 39 procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its	F 880		

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F 880	Continued From page 40 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interview and documents review the facility failed to ensure enhanced barrier precautions (EBP-where gown and gloves used for high contact resident care activities) was used for 1 of 1 resident (R7). In addition, the facility failed to ensure handwashing/hand hygiene was implemented for 2 of 2 residents (R7, R9) observed for handwashing/hand hygiene. Findings include: R9's Admission Minimum Data Set (MDS) dated 09/03/24, identified diagnosis of dementia and was dependent on staff for all mobility, grooming and hygiene. During an observation and interview on 12/11/24 at 10:16 a.m., R9 was in bed and nursing assistant (NA-N) and registered nurse (RN-F) were performing peri care for an incontinent bowel movement. RN-F did not perform hand hygiene prior to placing gloves on. RN-F removed R9's soiled pad, then completed incontinence cares on R9. RN-F placed soiled pad in trash, then removed gloves without performing hand hygiene. RN-F stated that hand washing/hand hygiene should be done before and after cares, and when hands are visibly soiled. RN-F stated she is aware that she did not perform proper hand hygiene while doing R9's incontinent cares. R7's face sheet dated 12/12/24, identified diagnoses of diabetes mellitus type 2 (a condition that affects how the body uses sugar) and cellulitis (potentially serious skin infection) of left	F 880	R9□s MD was notified that proper hand hygiene was not performed during care rendered on 12/11/2024. R7□s MD was notified that the proper PPE was not worn during IV care. The physician response will be recorded in the resident electronic record. There were no ill effects experienced for this deficient practice. All current residents from survey exit until present, their incontinent care was observed for the proper hand hygiene being performed and in-service education was given as needed. All residents on Enhanced Precautions will be reviewed and the appropriate signage will be displayed. Future residents who have wounds, IVs, hand hygiene and the appropriate PPE and for Enhanced Precautions will be worn at the appropriate intervals and signage posted per facility policy. Facility staff will be in-serviced on the Enhanced Precaution Policy with emphasis on items #2 and 3 which detail examples of when PPE should be worn when high contact resident care is being performed i.e., bathing, providing hygiene, changing linen. The Director of Nursing and Infection Preventionist will be responsible for sustained compliance. Audits on wearing the appropriate PPE during Enhanced Barrier Precaution status and proper hand hygiene during wound care will begin 2x week for 3 weeks, weekly x 3 weeks then monthly to	

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F 880	Continued From page 41 leg. During an observation and interview on 12/11/204 at 11:56 a.m., R7 was in her room and RN-A was administering intravenous (IV) antibiotics through R7's IV catheter. R7's room had signage by the door indicating enhanced barrier precautions were needed. RN-A disconnected and flushed the IV after completion of infusion, RN-A was only wearing gloves and no gown. RN-A did not perform hand washing/hand hygiene after removing gloves. RN-A stated R7 was on EBP due to having an IV catheter and she also was getting wound care. RN-A stated EBP would be needed for any dressing, toileting, foley care, wound care and IV care. RN-A stated that EBP would not need to be used during just transferring a resident. During an interview on 12/11/24 at 3:47 p.m., director of nursing (DON) stated that EBP should be used for any resident with an IV, urinary catheters or wounds and her expectation is that if a resident is on EBP that staff would use the appropriate precautions for any physical touch of that resident. The facility policy on enhanced barrier precautions undated, identified that EBP is required for any for any resident needing device care, such as a central line. The facility policy on hand washing/hand hygiene dated 8/25/21, identified hand hygiene to be performed before moving from contaminated body site to clean body site during resident care.	F 880	ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 01/06/2025	

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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 12/6/24, 12/10/24, 12/11/24 and 12/12/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you	2 000		

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	00885	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H55962180C (MN00108788), H55962181C (MN00108791), H55961820C (MN00108621), H55961393C (MN00108316) and H55962362C (MN00108936) with a licensing order issued at 0300, 0830, 0900, and 1390. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 4 of 4 nursing assistants (NA-T, NA-D, NA-G, and NA-U) reviewed were deemed competent to complete cares for residents. This had the potential to affect all 45 residents residing in the facility. Findings include: Review of the facility job description Non-Certified Nursing Assistant (NA) and training requirements dated August 2021, indicated the primary purpose of this position is to provide resident with routine daily nursing care and services in accordance with the resident's assessment and care plan and as directed by supervisors. After completing	2 300	Corrected	1/6/25

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2 300	Continued From page 3 facility competency training, all residents' lifts, transfers and activity of daily living (ADL) care, the non-certified aide must complete these tasks with the assistance of a facility Certified Nurse Aid (CNA). Review of NA-T's employee record indicated NA-T was hired on 9/10/24. NA-T's orientation sign off sheet was not completed with the date and sign off sections for training completed were left blank. Further, NA-T's file did not include competency training records that identified NA-T was deemed competent for resident lifts, transfer, and ADL's. During an interview on 12/11/24 at 12:52 p.m., NA-T stated she was an uncertified nursing assistant and began working 2 months ago. NA-T stated she assisted residents with dressing, toileting, and assists with transfers with the mechanical lifts. NA-T stated she was registered for a nursing assistant course in June of 2025 and training was done by a certified nursing assistant and indicated she was not signed off for skills competencies. Review of NA-D employee record indicated NA-D was hired on 10/9/24. NA-D's file did not include an orientation record nor competency training records that identified NA-D was deemed competent for resident lifts, transfer, and ADL's. There were no competencies noted in NA-D's file for resident lifts, transfers and ADL's. Review of NA-G's employee record indicated NA-G was hired on 8/12/24. NA-G's orientation sign off sheet was not completed with the date and sign off sections for training completed were left blank. Further, NA-G's file did not include competency training records that identified NA-G	2 300		

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2 300	Continued From page 4 was deemed competent for resident lifts, transfer, and ADL's. During an interview on 12/10/24 at 3:51 p.m., NA-G stated he was an uncertified nursing assistant and began working in the facility about four months ago. NA-G stated he assisted residents with dressing, toileting and eating. NA-G stated he is not allowed to use the mechanical lifts. NA-G stated training was with a certified nursing assistant and indicated he was not signed off for skills competencies. NA-G further stated he was not currently enrolled in and NA classes and the next was not until February 2025 and he had not decided if he was taking that class. Review of NA-U's employee file indicated NA-U was hired on 11/1/24. NA-U's orientation sign off sheet was not completed with the date and sign off sections for training completed were left blank. Further, NA-U's file did not include competency training records that identified NA-U was deemed competent for resident lifts, transfer, and ADL's. During an interview on 12/11/24 at 3:45 p.m., director of nursing (DON) stated the assistant director of nursing (ADON) was to have performed competencies for all new employees before they worked on the floor. DON indicated competency records should be located in the employee file and if they were not then she was not sure where they would be kept. DON stated it was her expectation all new employees were competency tested prior to working on the floor and the record of the training/testing be kept in their employee file. The facility training program requirements were requested and not received.	2 300		

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2 300	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise and implement policies and procedures related to nurse aide competencies and implement a training program and/or perform competencies on tasks performed. The administrator or designee should ensure oversight is provided to ensure appropriate competency and orientation is provided upon hire, yearly, and as needed. The director of nursing or designee, should re-educate staff on the policies and procedures and have a system for evaluating and monitoring consistent implementation of these policies, with results of those audits being brought to the facility's Quality Assurance Committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 300		
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.	2 830		1/6/25

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2 830	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to complete comprehensive fall analysis and implement individualized interventions to prevent re-current falls and/or mitigate the risk for falls with major injury for 2 of 3 residents (R7, R5) reviewed for falls. The facility's failures resulted in actual harm for R7 when she sustained left tibial fracture that required surgical repair. Finding include: R7's face sheet dated 12/12/24 identified R7 had diagnoses that included acquired absence of right leg above knee and type 2 diabetes. R7's admission Minimum Data Set (MDS) dated 9/10/24, identified R7 was admitted to the facility on 9/4/24 and had severe cognitive impairment with no signs or symptoms of delirium, behaviors or history of falls within six (6) months of admission. R7 had functional limitations in range of motion of one lower extremity, used a wheelchair, and was dependent on staff for hygiene needs, lower body dressing and chair to bed transfers. R7's ability to sit to stand and walk was not attempted due to medical condition. R7 was always incontinent of bowel and bladder, and administered insulin in addition to psychotropic, anticoagulant, and opioid medications. R7's undated fall Care Area Assessment (CAA) included, resident currently has falls related to cognitive deficits and amputation of "LRL" (sic). Resident will have less than 2 falls per month through the review date. The CAA indicated and identified R1 was at risk for falls related to	2 830	Corrected	

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2 830	Continued From page 7 cognitive impairment, diagnoses of cardiac dysrhythmias, incontinence, loss of limb, anxiety disorder, schizophrenia, and the medications as identified in the admission MDS. The CAA indicated falls would be addressed in the care plan with the overall objective to avoid complications and minimize risks. R7's fall risk evaluation dated 9/4/24, indicated R7 was at risk for falls with a history of three or more falls in the past three months. R7 was disoriented, chair bound/incontinent and was not able to perform gait/balance evaluation. The interventions listed were to evaluate for falls and if falls occur alert the provider. Although R7's fall risk evaluation and the MDS identified R7 was at risk for falls, R7's care plan dated 9/4/24 did not include and/or address a plan of care for falls. R7's care plan dated 9/4/24 identified the following focuses and interventions: -Current Functional Performance informed staff R7 required one person physical assist for toileting, for transfers R7 required total assist of two person with a full body mechanical lift using amputee sling. -Impaired physical mobility related to amputation leading to phantom limb included but was not limited the direction of for staff to allow R7 adequate time for response and ensure call light available. -Documented Safety -Concerns directed staff to perform safety risk evaluations on admission, as needed, and upon change of condition and Safety Measures- including strategies to reduce the risk of infection, falls, injury initiated as appropriate. In review of R7's fall record between 9/5/24 through 12/1/24 identified R7 had 11 total falls. R7's falls incident reports identified the following:	2 830		

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2 830	Continued From page 8 R7's fall incident report dated 9/5/24, at 5:25 a.m. indicated R7 had an unwitnessed fall in her room with no injury. R7 had been found on the floor next to her bed with blankets under her bottom, she appeared to have slid from the bed. R7 stated she needed to get up and use the bathroom so she wouldn't be late for school. The incident report identified predisposing factors as R7 was admitted within 72-hours and confused, but did not indicate/identify R7 had needed to use the bathroom as a factor. The report did not include comprehensive fall analysis nor identify immediate fall prevention interventions and not evident R7's care plan was revised. R7's fall incident report dated 9/7/24 at 4:51 a.m. indicated R7 who was wheelchair bound had an unwitnessed fall in her room with no injury. A nursing assistant (NA) had been completing the 30-minute checks and found R7 on the floor drinking water in good spirits with stool smeared on her floor mat. R7 had reported she wanted to get up and get her water. In response to staff asking how she got on the floor, R7 gestured her hand in a gliding motion towards the floor. Predisposing factors included R7 was admitted within 72-hours, but did not/indicate identify R7's bowel incontinence nor R7's location of water and/or need for water. The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. Furthermore not evident the care plan was revised to reflect the implementation of when/duration of 30-minute checks or usage of floor mat. R7's fall incident report dated 9/13/24 at 7:30 a.m. indicated R7 who was wheelchair bound normally does not ambulate at all had an	2 830		

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2 830	Continued From page 9 unwitnessed fall. R7 was found sitting on the floor next to her bed and could not clearly inform staff if she hit her head or if her bottom hurt or not. Education provided to resident not get out of bed by herself but due to confusion instructions may not be understood. Predisposing factors identified included: confused, impaired memory, and incontinent. The report did not specify if R7 was incontinent when she was found. The report did not include a comprehensive fall analysis nor identify other fall interventions other than the immediate education that may not have been understood by R7. Further not evident of an assessment/evaluation to identify effectiveness of the education provided nor evident the care plan was revised to include resident education. R7's fall incident report dated 9/22/24 at 8:58 a.m. p.m. indicated at 5:25 p.m. R7 was in her room when an NA saw her pulling on the mattress, causing R7 to slide out of her wheelchair onto floor. R7 reported she had wanted to go to bed. Predisposing factors identified as confusion. The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. Further not evident R7's care plan was revised. R7's fall incident report dated 10/19/24, indicated R7 had a witnessed fall with no injuries at 9:30 a.m. when she appeared to be repositioning herself in her wheelchair and slid out of her chair landing on her bottom. Prior to the fall during breakfast, R1 had been agitated/behavioral and very confused. R7 Unable to give description. Predisposing factors checked were none, but noted mental status as alert and confused. The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. Further not evident R7's care plan	2 830		

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2 830	Continued From page 10 was revised. R7's fall incident report dated 11/3/24, indicated R7 had unwitnessed fall around 3:15 p.m. with no injuries. R1 was found by housekeeping staff sitting on floor, on her blue mat, leaning against her bed around 3:15 p.m. Prior to fall NA had just been in room, and found R7 sitting at the edge of the bed. NA assisted R7 back to bed and bed was in the lowest position. R7 was at her night stand and going through her stuff when she lowered herself to the floor. R7 unable to say what she was doing when she lowered herself to the floor but told family she was trying to get into bed. R1 was alert and confused. Predisposing factors included, confused and impaired memory. The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. Further not evident the care plan was revised to include appropriate bed height and usage of the floor mat. R7's care plan was revised to include a fall focus on 11/15/24, that identified R7 was at risk for falls however did not have individualized interventions that would prevent and/or mitigate R7's risk for falls including the usage of the fall mat, 30-minute checks, resident education, and bed height that was identified in the fall incident reports. The fall care plan only directed staff to evaluate for falls on admission and as needed and if a fall occurs, notify the provider. R7's fall incident report dated 11/26/24 at 1:40 p.m. indicated R7 had an unwitnessed fall with no injuries. R7's physician found R7 sitting on her floor mat. R7 reported she purposely put herself on the floor to get up. R7 was alert and confused. No predisposing factors were identified. Additionally, the report did not include a	2 830		

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2 830	Continued From page 11 comprehensive fall analysis nor identify immediate fall prevention interventions. R7's fall incident report dated 11/27/24 at 6:45 a.m. indicated R7 had an unwitnessed fall in her room, she was found sitting on her floor mat next to her bed. R7 appeared calm but was not able to state what happened. The fall resulted in a skin tear to left lower leg with minor bleeding. Predisposing factors identified as confused. The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. R7's fall incident report dated 11/29/24 at 7:00 a.m., indicated R7 had an unwitnessed fall and had an open area to her left shin. NA found R7 sitting on the floor mat next to her bed. The report included when asked why she was on the floor resident pointed to room mate. Then resident stated that she wanted to get up. The predisposing factor was identified as "Resident is concerned about recent new room mate". The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. R7's fall incident report dated 11/30/24 at 2:00 p.m., indicated R7 had an unwitnessed fall. NA found resident sitting on the floor next to the bed. R7 was alert and confused. The bed was in waist high position with no fall mat next to bed. R7 reported her whole leg hurt when the nurse did range of motion (ROM). R7 was sent to the emergency room for further evaluation and the aide was provided with education on following the care plan. Predisposing factors included, confused. The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions.	2 830		

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2 830	Continued From page 12 R7's fall incident report 12/1/24 at 4:53 a.m. indicated R7 had an unwitnessed fall with no injuries. NA found R7 sitting on her floor mat next to her bed with her leg bent in front of her and incontinent of bowel, call light was in place and bed was in the lowest position. R7 was alert to person and place. Nurse had just been in her room at 4:35 a.m. to check on R7 since she was self-transferring from bed to the floor frequently. Predisposing factors identified as incontinent and R7 "is very curious about roommate-wants to know what she is doing all the times." The report did not include a comprehensive fall analysis nor identify immediate fall prevention interventions. R7's progress notes dated 12/2/24 at 7:02 a.m., R7 was sent to ER due to left lower extremity became swollen, red, and painful. At 11:54 a.m. the ER called the facility informing R7 was being sent to another hospital for broken leg and possible surgery. R7's emergency department note dated 12/2/24, identified a hematoma (collection of blood) to the proximal (near) the tibia/fibula are of left lower leg and a fracture of the left proximal end of left tibia and was sent to another hospital for surgery. R7's hospital discharge summary dated 12/10/24, identified R7 was admitted on 12/2/24 for a closed fracture of left proximal tibia that required surgery on 12/3/24, cellulitis and abscess of left lower extremity. R7 was discharged back to the facility on 12/10/24 on IV antibiotics. The records did not include and was not evident the facility completed a comprehensive fall analysis that identified potential causal factors and/or root cause(s) so that appropriate	2 830		

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2 830	Continued From page 13 determinations for individualized fall interventions could be developed and implemented to remove R7's fall risk associated with the potential causal factors/root cause. R5 R5's face sheet dated 12/16/24, identified diagnoses of malnutrition (condition where body does not get enough nutrients), chronic kidney disease (condition where kidneys have been damaged), osteoarthritis (condition with joint pain and stiffness), and weakness. R5's quarterly Minimum Data Set (MDS) dated 11/18/2024 identified R5 had severe cognitive impairment. R5 was dependent on staff for dressing, grooming and hygiene and required maximum assistance for all transfer. R5 had two or more falls with no injury and one fall with minor injury. R5's fall care plan dated 8/17/24, indicated R5 was high risk for falls related to weakness, history of falls with the following: "Call don't fall" signs posted in room, anticipate needs, call light within reach, physical therapy (PT) to evaluate and treat or as needed. R5's fall incident report dated 10/12/24, indicated R5 had an unwitnessed fall at 7:40 p.m. R5 was found in her room laying on her back next to walker. Predisposing risk factors included confusion and ambulating without assistance. Immediate action taken: R5 assessed with no injuries noted. Walker removed and call light placed within reach. R5's record did not include a comprehensive analysis of the fall and R5's care plan was not revised.	2 830		

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2 830	Continued From page 14 R5's fall incident report dated 10/13/24, indicated at 11:30 p.m. an NA witnessed R5 attempting to self-transfer in her room and was going to fall so NA assisted R5 to the floor. R5 stated I have to go I want to walk, can I go but she don't state where she want to go. No injuries were noted. Predisposing factors included confused, gait imbalance, using a walker, and alert but confused. Immediate actions taken: Walker removed and call light placed within reach. R5's record did not include a comprehensive analysis of the fall and R5's care plan was not revised. R5's fall incident report dated 10/15/24, indicated R5 had an unwitnessed fall at 6:00 a.m. R5 was yelling and when NA entered R5's room, R5 was found sitting upright behind a closed door. R5 was confused and unable to give any detail of what happened but kept asking staff to lock the door. Resident has delusions of men coming into her room and keeps trying to shut the door. No injuries noted. Predisposing factors included alert and confused, gait imbalance, impaired memory incontinent using a walker, and wanderer. Immediate action taken: R5 assessed for injuries and placed in wheelchair and took to dining area for close observation. R5's record did not include a comprehensive analysis of the fall and R5's care plan was not revised. R5's fall incident report dated 10/29/24, indicated R5 had an unwitnessed fall at 9:45 p.m., R5 had been in her bed and was found sitting on floor in front of wheelchair close to the bathroom, with gripper socks on, call light at bedside, and had been toileted within 30 minutes, no incontinence. R5 was unable to explain what happened. Predisposing factors included, confused. Immediate action taken: R5 was assessed for injury and noted to have bump on back of head.	2 830		

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2 830	Continued From page 15 R5's record did not include a comprehensive analysis of the fall and R5's care plan was not revised. During an interview on 12/11/24 at 4:10 p.m., director of nursing (DON) confirmed causal analysis were not being completed and care plans were not revised. DON indicated she expected the facility policy be followed. After a fall occurs, a causal analysis was supposed to be completed and immediate interventions developed, implemented, and identified in the care plan. Review of the facility policy Falls, Clinical Protocol dated 10/4/2021, indicated the following: -Cause identification, 1) for an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. the staff; 3) the staff and practitioners will continue to collect and evaluate information until either the cause of the fall is identified, or it is determined the cause cannot be found or is not correct. -Treatment/management, 1) based on preceding assessment, the staff and physician will identify interventions to try to prevent subsequent falls and to address the risk clinically significant consequences of falling. 2) if under lying causes cannot be readily identified or corrected, staff will try carious relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for it continuation. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being	2 830		

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2 830	Continued From page 16 implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to accurately comprehensive assess pressure ulcers in order to determine, develop, and implement individualized interventions to reduce the risk and/or prevent new pressure ulcers and/or deterioration of existing pressure	2 900	Corrected	1/6/25

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2 900	Continued From page 17 ulcers for 2 of 3 residents (R3, R4) reviewed for pressure ulcers. Findings include Definitions: Pressure ulcer/Injury (PU/PI): localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury occurs because of intense and/or prolonged pressure or pressure in combination with shear. Deep tissue pressure injury: Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. Stage 2 pressure ulcer: partial thickness loss of skin presenting as a shallow open area with a red or pink wound bed, without slough (a soft, stringy, white or yellow substance can appear in wounds and is made up of dead cells and other materials). May also present as an intact blister or open/ruptured serum filled blister. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Stage 3 pressure ulcer: full thickness skin loss.	2 900		

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2 900	Continued From page 18 Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough maybe present but does not block the depth of tissue loss. Stage 4 pressure ulcer: full thickness tissue loss with exposed bone, tendon or muscle. Slough and eschar (a hardened, dead tissue It can appear black, brown, red, tan and may be fluid filled or crusty.) Unstageable pressure ulcer: slough and/or eschar present and covers the wound bed making it impossible to stage the wound. R3's admission Minimum Data Set (MDS) dated 8/27/24, indicated R3 did not have cognitive impairment with diagnoses of diabetes, arthritis, and dementia. R3 was dependent on staff for activities of daily living (ADLs) except for eating and used a manual wheelchair for mobility. R3 was at risk for pressure ulcers and had four stage 3 pressure ulcers present on admission with interventions of pressure reducing device for chair and bed, nutrition/hydration, pressure ulcer care, applications of non-surgical dressings and applications of ointment/medications other than to her feet. R3's care plan history identified care focuses, goals, and revisions since admission, however implementation dates were not identified. The care plan identified R3 had a documented pressure ulcer (did not specify location). Interventions included encourage resident to shift weight frequently, low air loss mattress, wheelchair cushion, reposition resident as allows, monitor ulcer for signs of progression or decline and provide wound treatment.	2 900		

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2 900	Continued From page 19 R3's physician orders included wound treatments, however, also included heal protectors while in bed every night shift for offloading heels for wound prevention with a start date of 8/21/24. R3's wound records were reviewed between 10/8/24 through 12/6/24. The records included weekly wound assessments for multiple pressure ulcers varying in stages that were not consistently accurate nor comprehensive; one of which was a wound(s) on the right heel. The records indicated on 10/8/24 a large, ruptured blister on R8's heel was identified; the area deteriorated to two different pressure ulcers a stage 3 and an unstageable ulcer. Additionally, it was not evident the care plan was consistently evaluated and revised to include pressure relieving interventions to prevent or mitigate the risk deterioration, prevention, or mitigation of risk there of. R3's progress note dated 10/8/24 at 1:31 p.m., identified during wound rounds on 10/3/24 two new darkened areas to R3's right outer foot, and a new area to R3's right inner foot. R3's heel is macerated, and heel is open and fragile. R3's Skin and Wound Evaluation dated 10/8/24, identified wound type as a ruptured blister that had started on 10/6/24, however, R3's record does not identify the presence of an intact blister and could not be determined when the blister ruptured. Further, the record did not address cause of the blister so appropriate pressure reducing interventions could be developed and implemented to prevent re-current blisters. Description included, no drainage, edges attached and macerated; the wound was healable. Intervention was suspension/protection device; it was not evident R3's care plan was revised.	2 900		

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2 900	Continued From page 20 R3's corresponding photo of right heel dated 10/8/24, was not consistent with the evaluation. The photo identified a ruptured blister covering the bottom of the heel; the skin was macerated, "crack" or open area of the maceration from 12:00'oclock to 3:00 o'clock. Additionally, from 9:00 o'clock to 3:00 o'clock the underlying tissue was light purple which was not identified in the wound evaluation. R3's Skin and Wound Evaluation dated 10/11/24, identified shearing on right heel that started on 10/6/24 was described as shearing that measured 0.9 cm x 1.7 cm. Edges attached, fragile surrounding tissue, and improving. Interventions identified as heel suspension/protective device. It was not evident the care plan was revised. R3's corresponding photo was inconsistent with the evaluation dated 10/11/24. The identified sloughing skin from maceration, at the 10:00 o'clock to 12:00 o'clock position dark red area. This area was not identified on the evaluation. During an interview on 12/18/24 at 9:31 a.m., director of nursing (DON) stated the wound type was not shearing. R3's Skin and Wound Evaluation dated 10/20/24, identified wound on right heel was identified as a stage 2 pressure ulcer that measured 4.21 cm x 3.99 cm with no depth identified. No drainage, edges attached, calloused surrounding tissue, stable and healable. Interventions of cushion (was not specified), heel suspension/protection device (was not specified) and turning/repositioning program (was not specified). It was not evident the care plan was revised with the aforementioned interventions.	2 900		

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2 900	Continued From page 21 R3's corresponding photo of right heel, was inconsistent with the evaluation dated 10/20/24. The photo identified multiple dark purple areas that varied in size consistent with deep tissue injuries. These areas were not addressed in the evaluation. R3's physician progress note dated 10/22/24, indicated the wounds have extended in size, not improving, and now has maceration of the heel of the right lower extremity. R3's Skin and Wound Evaluation dated 10/25/24, identified wound on right heel was a stage 2 pressure ulcer with measurements of 0.64 cm x 0.69 cm. with no depth identified. Edges attached, surrounding tissue calloused, fragile, and improving. Goal of care was healable. Education: resident refused alternating pressure mattress. Interventions: suspension/protection device (was not specified) and turning/repositioning program (was not specified). It was not evident the care plan was revised. R3's corresponding photo of right heel was inconsistent with evaluation dated 10/25/24. Photo identified 5 purple areas consistent with deep tissue injuries; one area had a whitish/yellow center. These areas were not identified in the evaluation. During an interview on 12/18/24 at 9:31 a.m., DON stated R3's wound on 10/25/24 should have been marked as a deep tissue injury and not a stage 2. R3's Skin and Wound Evaluation dated 11/2/24, identified wound on right heel was a stage 2 pressure ulcer that measured 1.5 cm x 1.13 cm.	2 900		

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2 900	Continued From page 22 with no depth identified. 80% slough, 10% eschar, moderate serosanguineous drainage, edges attached, surrounding tissue calloused. Progress is stalled. Goal of care was healable. R3 refusing air mattress and prevalon boots. Interventions none. It was not evident the care plan was revised. R3's corresponding photo for 11/2/24 did not reflect the documentation. The photo identified the back of the heel had a reddened area and two purplish/red areas noted at the bottom of the heel that was not identified in the evaluation. R3's significant change Minimum Data Set (MDS) dated 11/06/24, indicated R3 had an increase in the number of pressure ulcers since admission MDS. R3 had one stage 2, and three stage 3, and one unstageable. R3's Skin and Wound Evaluation dated 11/8/24, identified the wound on right heel was stage 2. Wound measurements 1.27 cm x 3.45 cm with no depth identified. 100% eschar, moderate serosanguineous drainage. Progress is deteriorating. Goal of care was healable. Interventions of heel suspension/protection device (was not specified). It was not evident the care plan was revised. R3's corresponding photo for the 11/8/24 evaluation did not reflect the documentation. The photo identified two open wounds: one on each side of the heel. It could not be ascertained which wound the documentation was entered for. The pressure ulcer on the right side of the heel was larger than the left side. Right: had an open area with a yellowish base/center, surrounding tissue was whitish with purple border. Left: had depth, whitish center, surrounding tissue either black or	2 900		

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2 900	Continued From page 23 bluish (could not be further described because of the angle of the picture). R3's wound care nurse practitioner note dated 11/11/24, identified R3 was seen for an outpatient wound center follow up on 11/11/24 for right foot ulcer. Wound to right heel described as a Stage 3 with measurements of 1.5 cm x 1.2 cm x 0.2 cm. Ulcer base is 100% slough and near probe to bone. R3's Skin and Wound Evaluation dated 11/13/24, identified wound on right heel was a stage 2 pressure ulcer that measured 3.47 cm x 0.73 cm, no depth with 100% eschar, no drainage, edges attached, surrounding tissue calloused and stable. Interventions of cushion (was not specified) heel suspension/protection device (was not specified), moisture barrier, nutrition/dietary supplementation. It was not evident the care plan was revised. R3's corresponding photo for the 11/13/24 evaluation did not reflect the documentation. The photo identified two separate wounds both consistent with unstageable pressure ulcer. The evaluation did not identify which wound the description/measurements were for. During an interview on 12/18/24 at 9:31 a.m., DON stated after viewing image for 11/13/24, this should have been marked as an unstageable pressure ulcer. R3's Skin and Wound Evaluation dated 11/22/24, identified wound on left side of the right heel as a stage 2 that measured 2.0 cm x 1.85 cm x 0.4 cm. with 10% slough, 10% eschar, rolled edges, surrounding tissue fragile. Progress was deteriorating. Goal of care was healable. Note:	2 900		

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2 900	Continued From page 24 both areas increased in size, unable to capture both areas in 1 picture, obtained separate pictures. Noted resident has increased pain while lying in bed do to contracture of right lower leg, appears to increase pressure to right heel. Area cleansed with normal saline Used Kerlix to secure gauze in place, whole roll used to offer some padding and is willing to wear prevalon boots. Interventions cushion, heel suspension/protection device, moisture barrier, moisture control. It was not evident the care plan was revised. The right pressure wound was described as an unstageable ulcer that measured 2.46 cm x 1.88 cm x 0.2 cm (even though the wound was unstageable) 20% slough and 20% eschar. R3's corresponding photo for the 11/22/24 evaluation for the right heel wound (left side) did not reflect the documentation. The photo identified two wounds right wound larger than the left. Left wound: open with macerated edges with dark purple area that was consistent with a deep tissue injury that surrounded almost ½ the wound; this area was not identified on the evaluation. R3's Skin and Wound Evaluation dated 12/1/24, identified wound on right heel was a deep tissue injury that measured 2.7 cm x 1.9 cm, 10% slough, 80% eschar, attached edges, dry/flaky and fragile. Wound was deteriorating. Interventions: cushion (was not specified), nutrition, and positioning wedge. It was not evident the care plan was revised. The corresponding photo was consistent with the wound description, however, was not consistent with a deep tissue injury rather an unstageable ulcer according to the definition. R3's Skin and Wound Evaluation dated 12/5/24, identified wound on right heel was deep tissue	2 900		

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2 900	Continued From page 25 injury that measured 1.8 cm x 1.0 cm x 0.2 cm with 100% eschar, rolled edges, calloused, dry/flaky and fragile. The wound was stable and healable. Interventions included incontinence management and heel suspension/protection. The wound in the corresponding photo was not consistent with a deep tissue injury rather an unstageable ulcer according to the definition. It was not evident R3's care plan was revised however, physician order dated 12/5/24 directed prevelon boots to both feet. R3's Wound Care Clinic notes dated 12/6/24 identified Stage 4 pressure ulcer on right posterior heel acquired on 1/1/20 (conflicting information per previous facility wound assessments of start date of 10/6/24). Wound measurements are 2.2 cm x 2.0 cm, with no measurable depth with eschar. Right lateral heel identified as a chronic stage 2 pressure ulcer, acquired on 1/1/20 (conflicting information per previous facility wound assessments of start 10/6/24). Measurements 2.0 cm x 2.0 cm x 0.2 cm. Adipose tissue (body fat) exposed with slough and eschar. Wounds were debrided by provider. New orders for specialty bed/mattress for pressure reduction-keep pressure off right heel. R3's Wound Evaluation dated 12/12/24, identified wound on right heel was a stage 3 pressure ulcer that measured 0.45cm x 0.72 cm. no drainage, fragile surrounding skin, stable and healable. Interventions of heel suspension/protection device and nutritional supplement. During an interview on 12/18/24, DON stated the assistant director of nursing was monitoring the wounds and she noted there was inconsistency of the images and assessments of R3's wounds.	2 900		

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2 900	Continued From page 26 DON indicated R3 developed the wounds from propelling herself in her wheelchair with her feet and she refused the blue boots. R3's interventions did not make it in her care plan. DON stated her expectation for any wound that are deteriorating was to have a new intervention place in the care plan. DON stated R3 was refusing dressing changes at times and the dressing changes done at different intervals. R4 R4's quarterly MDS dated 10/31/24, indicated R4 did not have cognitive impairment with diagnoses that included diabetes, coronary artery disease, renal insufficiency, and dementia. R4 had range of motion impairment to one side of her body and required partial to substantial assist with dressing upper body and dependent on staff for lower body dressing. R4 did not have a toileting program and was always incontinent of bladder and frequently incontinent of bowel. R4 was at risk for pressure ulcers but had none. R4 did have a diabetic foot ulcer she received application of dressing to feet with or without topical medication. R4 had pressure relieving devices in bed and on her electric wheelchair. R4's skin integrity care plan dated 6/12/24 indicated R4 had actual skin impairment related to incontinence and history of vulvar cancer. R4 had areas of MASD to right upper thigh, left gluteal cleft, coccyx, and left buttocks. R4's Skin and Wound evaluation dated 11/27/24, identified MASD/IAD to coccyx that measured 1.1 cm x by 0.3 cm and no depth documented. The area was in house acquired and new as of 11/26/24. The area was 100% granulation filled, no evidence of infection. Light amount of serous drainage without odor. The surrounding skin is	2 900		

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	00885	A. BUILDING: _____ B. WING _____	12/12/2024

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2 900	Continued From page 27 dry and flaky, fragile skin at risk for breakdown. Notation of resident is on repositioning program, spends quite a bit of time lying in bed and up to recliner and power chair for short bits of time. Reminded resident to continue with repositioning. Staff educated on following resident care plan, repositioning every 2 hours and check and change. R4's corresponding photo dated 11/27/24, identified an open slit on R4's coccyx. The base was yellow in color and the surrounding tissue was pink. This wound is not consistent with MASD and by definition is consistent with a stage 2 pressure ulcer. R4's Skin and Wound evaluation dated 12/5/24, identified MASD/IAD to coccyx measured 1.3 cm x 0.3 cm and no depth documented. There was 90% granulation and slough were present over 10% of the wound. There was no evidence of infection. The edges appeared flushed with the wound bed or as sloping edge. The surrounding skin looked fragile, at risk for breakdown. Treatment was to cleanse with soap and water and apply barrier cream. Area was noted to be improving. R4's corresponding photo dated 12/5/24 was not consistent with the evaluation. Photo identified an open slit in the coccyx with visible depth that was not assessed/documented on the evaluation. During an interview on 12/12/24 at 2:11 p.m., registered nurse (RN)-D stated assistant director of nursing (ADON), was responsible to review the quarterly care plans when she does the care conferences and was to make updates. RN-D was responsible for the annual care plan updates when she completed the annual and significant	2 900		

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2 900	Continued From page 28 change MDS. RN-D further stated they had switched over to a different program and it did not allow them to make the care plans individualized. They had to use what was in the drop-down box. During an interview on 12/11/24 at 3:45 p.m., DON stated therapy decided the type of pressure relieving device or the wound care provider. All residents have a pressure relieving mattress throughout the facility. DON further stated her expectation was the residents care plan were updated with current interventions, so the staff knew what they were. Facility policy Pressure Injuries Overview 9/29/21, identified the purpos of the procedure was not provide information regarding definitions and clinical features of pressure injuries. The policy included the descriptions of pressure ulcers and associated terms used to desribe features of the pressure ulcer. This policy did not address components of a comprehensive assessment nor pressure relieving interventions. Facility policy Wound Care dated 9/29/21, indicated to 1) verify the physician's order for the procedure, 2) review resident's care plan for special needs, example: pain medication. Documentation included: 1) The type of wound care given. 2) The date and time the wound care was given. 3) The position in which the resident was placed. 4) The name and title of the individual performing the wound care. 5) Any change in the resident ' s condition. 6) All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 7) How the resident tolerated the procedure. 8) Any problems or complaints made by the resident related to the procedure. 10) If the resident refused the treatment and the reason(s)	2 900		

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2 900	Continued From page 29 why. Under Reporting 1) Notify supervisor if the resident refuses the wound care, 2) report other information in accordance with facility policy and professional standards of practice. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should 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 should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to	21390		1/6/25

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21390	Continued From page 30 reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observations, interview and documents review the facility failed to ensure enhanced barrier precautions (EBP-where gown and gloves used for high contact resident care activities) was used for 1 of 1 resident (R7). In addition, the facility failed to ensure handwashing/hand hygiene was implemented for 2 of 2 residents (R7, R9) observed for handwashing/hand hygiene. Findings include: R9's Admission Minimum Data Set (MDS) dated 09/03/24, identified diagnosis of dementia and was dependent on staff for all mobility, grooming and hygiene.	21390	Corrected	

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21390	Continued From page 31 During an observation and interview on 12/11/24 at 10:16 a.m., R9 was in bed and nursing assistant (NA-N) and registered nurse (RN-F) were performing peri care for an incontinent bowel movement. RN-F did not perform hand hygiene prior to placing gloves on. RN-F removed R9's soiled pad, then completed incontinence cares on R9. RN-F placed soiled pad in trash, then removed gloves without performing hand hygiene. RN-F stated that hand washing/hand hygiene should be done before and after cares, and when hands are visibly soiled. RN-F stated she is aware that she did not perform proper hand hygiene while doing R9's incontinent cares. R7's face sheet dated 12/12/24, identified diagnoses of diabetes mellitus type 2 (a condition that affects how the body uses sugar) and cellulitis (potentially serious skin infection) of left leg. During an observation and interview on 12/11/204 at 11:56 a.m., R7 was in her room and RN-A was administering intravenous (IV) antibiotics through R7's IV catheter. R7's room had signage by the door indicating enhanced barrier precautions were needed. RN-A disconnected and flushed the IV after completion of infusion, RN-A was only wearing gloves and no gown. RN-A did not perform hand washing/hand hygiene after removing gloves. RN-A stated R7 was on EBP due to having an IV catheter and she also was getting wound care. RN-A stated EBP would be needed for any dressing, toileting, foley care, wound care and IV care. RN-A stated that EBP would not need to be used during just transferring a resident. During an interview on 12/11/24 at 3:47 p.m., director of nursing (DON) stated that EBP should	21390		

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21390	Continued From page 32 be used for any resident with an IV, urinary catheters or wounds and her expectation is that if a resident is on EBP that staff would use the appropriate precautions for any physical touch of that resident. The facility policy on enhanced barrier precautions undated, identified that EBP is required for any for any resident needing device care, such as a central line. The facility policy on hand washing/hand hygiene dated 8/25/21, identified hand hygiene to be performed before moving from contaminated body site to clean body site during resident care. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21390		