Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 9, 2024

Administrator
Rochester Rehabilitation and Living Center
1900 Ballington Boulevard NW
Rochester, MN 55901

RE: CCN: 245626
Cycle Start Date: September 9, 2024

Dear Administrator:

On September 13, 2024, we notified you a remedy was imposed. On October 8, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 4, 2024.

As authorized by CMS, the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 28, 2024, be discontinued as of October 4, 2024. (42 CFR 488.417 (b))

In our letter of September 13, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 28, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 4, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

Electronically Delivered
October 9, 2024

Administrator
Rochester Rehabilitation and Living Center
1900 Ballington Boulevard NW
Rochester, MN 55901

RE: Y0P713

Dear Administrator:

On October 8, 2024, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of $350.00 was electronically issued to the above facility. An acknowledgement was electronically received by the Department stating that the violation had been corrected. A reinspection was held on October 8, 2024, and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is $350.00. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling $58.00, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $408.00 within 15 days of the receipt of this notice. That check should be forwarded to:

Department of Health
Health Regulation Division,
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

cc: Shellae Dietrich, Program Assurance Superviosr
Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 3, 2024

Administrator
Rochester Rehabilitation and Living Center
1900 Ballington Boulevard NW
Rochester, MN 55901

RE: CCN: 245626
Cycle Start Date: September 9, 2024

Dear Administrator:

On September 13, 2024, we informed you the Centers for Medicare and Medicaid Services (CMS) imposed the following enforcement remedies:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 28, 2024.

On October 1, 2024, the Minnesota Department(s) of Health completed a revisit, and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency(ies) not corrected is/are as follows:

F0686 -- S/S: D -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer
20900 -- S/S: -- MN Rule 4658.0525 Subp. 3 -- Rehab - Pressure Ulcers

As a result of the revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 28, 2024, remains in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 28, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 28, 2024.

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.

As we notified you in our letter of September 13, 2024, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 28, 2024.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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, Regional Operations Supervisor, Rapid Response
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

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 9, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

Feel free to contact me if you have questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING _____ B. WING _____	R 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER REHABILITATION AND LIVING CENTER	1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901

(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 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 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 observation, interview and document review the facility failed to ensure prevention interventions, daily wound monitoring and treatment orders were in place to mitigate the risk of pressure ulcer prevention or worsening for 2 of 4 residents (R3 and R4) reviewed for pressure ulcers. Findings include: Definitions of pressure ulcers: 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. A pressure injury will present as intact skin and may be painful. The appearance will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear.	{F 686}	Plan of Correction for: F686 D Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. Affected Residents(s): How corrective action will be accomplished for those residents found to have been affected by the deficient practice?	10/4/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/04/2024

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

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{F 686}	Continued From page 1 Stage 1 Pressure Injury: Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Stage 2 Pressure Ulcer: partial thickness skin loss with exposed dermis. Partial thickness skin loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink, or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Unstageable pressure ulcer: Full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If the slough or eschar is removed, a stage 3 or 4 pressure ulcer will be revealed. Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon, or purple discoloration. 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	{F 686}	Residents R3 and R4 were immediately evaluated and assessed. Hospice was contacted for the current skin treatment orders that they had already been providing to R3 and R4 on-site. Orders were transcribed into the resident charts and care planning was updated to reflect treatments and interventions. Care plans were also reviewed and updated to integrate care with the Hospice team. The point click care wound application was reviewed and updated with any current wounds for R3 and R4. Resident R3 had an air mattress ordered for skin protection. Resident R4 already had an air mattress in place, and the mattress settings were placed on the group sheet and in the care plan. Turning and repositioning program was also reviewed and updated in the care plans and group sheets of R3 and R4. Potential Affected Resident(s): All other residents with pressure ulcers have the potential to be affected by the same deficient practice? Skin assessments continue to be	

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{F 686}	Continued From page 2 cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. 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. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle, or other underlying structures are visible, this indicates a full thickness pressure ulcer. Once a deep tissue injury opens to an ulcer, reclassify the ulcer into the appropriate stage. Slough: non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed. Purulent drainage: any product of inflammation that contains pus (e.g., leukocytes, bacteria, and liquefied necrotic debris). Serosanguinous drainage: a thin, watery fluid that's often slightly yellow and has a light pink tinge that can ooze from a wound as a part of the wound healing process. Granulation Tissue: the pink-red moist tissue that fills an open wound, when it starts to heal. It contains new blood vessels, collagen, fibroblasts, and inflammatory cells. R3's hospital After Visit Summary (AVS) dated 9/13/24, indicated R3 had a diabetic neuropathic ulcer to the left heel from 8/21/24. The AVS had no treatment plan indicated for the wound.	{F 686}	reviewed every Monday through Friday during morning meeting. The weekend documentation is reviewed on the following Monday, and if there is a holiday that falls on Monday, they are reviewed on Tuesday. All staff had previously been educated on reporting of wounds when conducting weekly skin checks. This will continue to be brought through report. The interdisciplinary team continues to review all new admissions for skin checks, wound status, braeden score, any current skin treatment orders, Hospice status and interventions for skin breakdown curing the morning meeting. Measures/Systematic Changes: What measures will be put into place, or systematic changes will be made to ensure that the deficient practice will not recur> Who is your audience htat education needs to occur with? Policy and Procedure was reviewed and continues to be current. LPN A was immediately re-educated regarding responsibility of updating care plans with treatments and interventions, reporting of wounds, and assuring weekly skin checks completed. All staff had previously been educated on	

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{F 686}	Continued From page 3 R3's care plan dated 9/13/24, identified a focus of alteration in skin integrity related to diabetic foot ulcer to left heel. R3 was at risk for further breakdown related to requiring assist with mobility. Interventions included to turn and reposition ___ hours while awake. There was a blank space before the word hours which did not identify how often to do this intervention. Inspect skin daily with cares and nursing assistant to report any concerns to the nurse, elevate heels off the bed to maintain pressure relief. Final intervention was pressure reducing mattress type ____ and date applied ___. The spaces did not identify the intervention had been implemented. R3's progress note dated 9/13/24 at 11:27 a.m., identified a nutritional summary that indicated R3 had a pressure injury. An additional note at 12:01 p.m. indicated left heel had Mepilex in place with a wound measuring 1.75 centimeters (cm) x 1.5 cm. No further assessment of the left heel was documented. R3's care area assessment (CAA) dated 9/16/24, identified R3 had an alteration in skin integrity related to diabetic foot ulcer to left heel, treatment as ordered. At risk for further skin breakdown related to required assist with mobility, skin observed daily with cares and weekly by licensed nurse on bath days and as needed, and pressure reducing device to chair and bed ...proceed to care plan. R3's admission Minimum Data Set (MDS) dated 9/16/24 indicated R3's cognition was intact and had diagnoses of diabetes, morbid obesity, and malignant neoplasm (cancer) of prostate. R3 required two person assist with bed mobility, toilet	{F 686}	reporting of wounds when conducting weekly skin checks. This will continue to be brought through report with Nurse Managers. Monitoring: How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The wound rounding NP through Northern Lights will make recommendations for treatment that will be passed on to the provider when needed. She continues to round every Thursday. The Northern Lights team now has access to upload needed documents and notes. The wound rounding process is an interdisciplinary approach with the clinical team. All wound rounding will be completed with the clinical nurse manager and the wound rounding NP, Any needed interventions will be addressed in real time and will be care planned and placed on the group sheets as necessary. Any recommended orders will be reported to the primary provider for review and implementation of possible changes. Audits:	

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{F 686}	Continued From page 4 use and transfers. Further identified R3 had a diabetic ulcer with no pressure ulcers identified with a treatment of pressure reducing device to chair and bed and applications of dressings to feet (with or without topical medications). R3's order summary dated 9/16/24 did not identify a treatment for R3's left heel wound. R3's Medical Doctor (MD) visit dated 9/16/24, identified there was no skin breakdown on R3's buttocks and that R3 declined examination of his heels. MD visit did not include a diagnosis or treatment plan of a wound on R3's left heel. R3's Treatment Administration Record (TAR) dated September 2024, did not identify a treatment to address R3's heel or provide daily wound monitoring. R3's progress note dated 9/20/24 at 9:48 a.m. identified R3's hospice company was contacted for a wheelchair as R3 was wanting to get out of bed, they will order one. R3's Braden Scale For Predicting Pressure Sore Risk dated 9/24/24, identified R3 had very limited sensory perception, was bedfast and skin was occasionally moist, requiring an extra linen change once a day and very limited with mobility. R3 scored a 12 out of 18 indicating R3 was at high risk for the development of pressure sores. R3's progress note dated 9/26/24 at 6:49 p.m. identified R3 was seen by the wound team, please see nursing wound check under nursing not for wound skin care. R3's Skin and Wound Evaluation dated 9/26/24,	{F 686}	Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. DON/designee is responsible for compliance. Completion date is 10/4/24	

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{F 686}	Continued From page 5 identified R3 had a stage 2 pressure ulcer to the left heel that was present on admission. The ulcer was staged by a health care provider. Wound measurements were 1.7 centimeters (cm) x 0.9 cm, wound bed had 100% granulation tissue with a moderate amount of serosanguinous drainage with no odor noted. Edges of the ulcer were attached, and peri-wound had erythema (redness). Goal of care was slow to heal-wound healing is slow or stalled but stable, little/no deterioration. Treatment: dressing intact, cleansed with generic wound cleanser, and had mechanical debridement and primary dressing was a foam dressing. Under the Notifications tab there were boxes to check mark that were: practitioner notified, resident/responsible part notified, dietician notified, and therapy notified. None of the selections were checked. During an interview on 9/30/24 at 5:08 p.m., licensed practical nurse (LPN)-A stated there was no current order for R3's left heel wound and nothing on the TAR. LPN-A stated she would check into it and see why there was no order in place. During an interview on 9/30/24 at 5:16 p.m. interim director of nursing (IDON) stated she could not find an order for R3's left heel wound and nothing on R3's TAR for treatment order. IDON stated we will look into it, R3 was on hospice, and we (facility staff) could always use a standing house order (SHO). During an interview on 10/1/24 at 10:12 a.m., nursing assistant (NA)-A stated she was unaware of R3 having any pressure ulcers and was unaware of a turning and repositioning schedule for him. NA-A stated she did not hear anything in	{F 686}		

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{F 686}	Continued From page 6 report about R3 having a pressure ulcer and verified that R3 was dependent on staff for bed mobility and required the use of a full body mechanical lift for transfers. NA-A stated she had not offered R3 any repositioning since the start of her shift at 6:30 a.m. During a phone interview on 10/1/24 at 9:08 a.m., nurse practitioner (NP)-A stated she was a certified wound specialist who was recently contracted to come to the facility to do comprehensive wound assessments. NP-A stated she was at the facility on 9/26/24 and assessed six residents who had pressure ulcers, it was a lot of work as it was hard to identify through the documentation of exactly where the residents had their pressure ulcers. NP-A further stated she had not yet gotten access to the facility electronic health record so was unable to put her recommendations for treatment in the record and was told hospice teams and facility doctors will be putting in their recommendations for treatment orders. NP-A stated she planned to do assessments every Thursday and hope to implement new treatment interventions as allowed. NP-A stated she did a comprehensive assessment on R3's left heel and was identified as a stage 2 pressure ulcer and not a diabetic ulcer. During an observation and interview on 10/1/24 at 10:19 a.m., registered nurse (RN)-A stated she was just notified from hospice aide that R3 had a new wound on his bottom and had to go to his room to check it. RN-A stated she was unaware of a wound to R3's left heel as it was not identified in R3's provider orders or the TAR. R3 was lying on his back with the head of the bed slightly elevated. RN-A turned R3 to his left side	{F 686}		

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while R3 hung on to the side rail. R3's buttocks were noted to have a white cream over them, to the left buttock a small area that was bumpy was noticed. RN-A stated she could not tell what the area was and would have to reposition him to the other side and wipe some of the cream off. RN-A asked R3, "did you know you had a wound on your bottom?" R3 stated he had sores in his groin area before and he used zinc oxide in the past to heal them up and the hospice aide told him he had a sore on his bottom after he was given a bath earlier that morning.

During an observation and interview on 10/1/24 at 10:32 a.m., Licensed practical nurse (LPN)-A walked in the room identified herself as the nurse manager and stated she was going to take pictures of the wound on R3's left buttock. LPN-A wiped some of the cream off of R3's buttocks with a wash cloth and took a picture of the wound and stated the wound measured 2.2 cm x 1.6 cm, was unable to articulate the stage of the wound. LPN-A stated the wound was intact and dark reddish/purple in color. RN-A had left the room.

During an observation and interview on 10/1/24 at 10:35 a.m., hospice registered nurse (HRN)-A walked over to the side of R3's bed and indicated the wound on R3's left buttock was a deep tissue pressure injury (DTPI), stated she would cleanse it with wound cleanser, and applied a Mepilex for protection. HRN-A stated to LPN-A she had asked about ordering an alternating pressure mattress last week for R3 and LPN-A stated she would order that right away and left the room. HRN-A removed R3's left heel Mepilex (a foam dressing designed to help manage non to low exuding acute and chronic wounds) that was undated and stated there was a moderate

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{F 686}	Continued From page 8 amount of purulent foul-smelling drainage noted, HRN-A sprayed wound cleanser on three 4 x 4 gauze pads and wiped the bottom of R3's wound, wound started bleeding and a moderate amount of blood had dripped onto the bed sheet. HRN-A applied a dated Mepilex to the left heel. HRN-A stated R3 should have this heel dressing changed twice a week and as needed if the dressing had lots of drainage or became soiled. HRN-A was unaware the facility did not have any treatment orders in place for treatment of R3's heel. HRN-A stated we were told it was a diabetic ulcer, but it could very well be a stage 2 pressure ulcer and stated she would fax the treatment orders to the facility, so they have it. HRN-A stated R3 was admitted with this wound to his left heel so the facility should have been aware. HRN-A stated to prevent the pressure ulcers on his sacrum from worsening R3 should be offered to turn and reposition every two hours and an air mattress should have been ordered when it was asked for last week, this will help with distribution of bony prominences. HRN-A stated if R3 had the air pressure alternating air mattress and turning and repositioning program in place it may have prevented the DTPI to his left buttock from developing. During an interview on 10/1/24 at 11:32 a.m., director of nursing in training (DONIT)-A stated an unawareness if tissue tolerance tests were performed on admit for residents who are at high risk for pressure ulcers or for those with existing pressure ulcers to determine a turning and repositioning schedule that is person centered. DONIT-A stated the most recent documentation for R3 was he had a stage 2 pressure ulcer to his left heel and the facility did not have any current treatment orders in place. DONIT-A further	{F 686}		

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verified R3 did not have a pressure reducing air mattress or a turning and repositioning schedule and he should have.

R4
R4's admission MDS dated 9/5/24, indicated R4's cognition was intact and had diagnoses of lumbar laminectomy, malignant neoplasm (cancer) of right breast and lung, and right and left foot drop. R4 had a urinary catheter and was always incontinent of bowel. R4 required two person assist with bed mobility and toilet use and transfers did not occur. Further identified R4 had a surgical wound and no pressure ulcers identified. Treatments included a pressure reducing device to bed, surgical wound dressing, and application of ointments/medications other than to feet.

R4's progress note dated 9/10/24 at 12:37 p.m. identified during R4's cares Mepilex was removed on the coccyx there were four wounds found, appear to be two large pressure sores, area not measured, was cleansed and a new Mepilex was applied family and hospice notified.

R4's order summary dated 9/11/24 identified an order to use Vashe wound cleanser on slough area for 1-5 minutes daily, then pat dry and cover with a dressing in the morning for wound care, wound measurements once every 2 weeks by facility nurse. No orders identified for treatment of stage 1 pressure ulcer to left medial foot or to the deep tissue injury to right heel.

R4's Skin and Wound Evaluation dated 9/26/24 identified R4 had a stage 2 in house acquired pressure ulcer to the sacrum on 9/25/24. Wound measurements were 2.1 cm x 0.7 cm, no exudate

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{F 686}	Continued From page 10 noted. Edges of the ulcer were attached, and peri-wound had blanching (whitening of external tissue). Goal of care was healable. Treatment: dressing intact, cleansed with normal saline, no debridement and primary dressing was a foam dressing. Under the Notifications tab there were boxes to check mark that were: practitioner notified, resident/responsible part notified, dietician notified, and therapy notified. None of the selections were checked. R4's Skin and Wound Evaluation dated 9/26/24, identified R4 had a stage 1 in house acquired pressure ulcer to the left medial foot on 9/10/24. Wound measurements were 1.9 cm x 0.7 cm, wound bed had 90% granulation tissue with no exudate noted. Edges of the ulcer were attached, and peri-wound had blanching (whitening of external tissue). Goal of care was healable. Treatment: dressing intact, cleansed with normal saline, no debridement, primary dressing was a foam dressing air mattress with a pump and turning repositioning program. MD/provider diagnoses infection and mayo hospice made aware. R4's Hospice Visit dated 9/26/24, indicated a wound care order to R4's coccyx changed to every other day for skin protection, remove old dressing cleanse with saline, pat dry and place new sacral Mepilex over the wound. R4's Braden Scale For Predicting Pressure Sore Risk dated 9/29/24, identified R4 had very limited sensory perception, was bedfast and skin was occasionally moist, requiring an extra linen change once a day, very poor nutritional intake and very limited with mobility. R4 scored a 10 out of 18 indicating R4 was at high risk for the	{F 686}		

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{F 686}	Continued From page 11 development of pressure sores. R4's Skin and Wound Evaluation dated 9/30/24, identified R4 had a deep tissue injury (DTI) (persistent non blanchable deep red, maroon, or purple discoloration) in house acquired pressure ulcer to the left heel staged by hospice on 9/30/24. Wound measurements were 1.3 cm x 1.2 cm. Under the Notifications tab there were boxes to check mark that were: practitioner notified, resident/responsible part notified, dietician notified, and therapy notified. None of the selections were checked. R4's Hospice Visit dated 9/30/24, indicated a wound care order to R4's right heel blister. Change dressing every third day and as needed. Remove old dressing cleanse with saline, pat dry and place new Mepilex over the wound, do not intentionally pop blister. R4's Treatment administration Record (TAR) dated September 2024, identified an order to use Vashe wound cleanser on slough area for 1-5 minutes daily, then pat dry and cover with a dressing in the morning for wound care from 9/11/24 to 9/30/24. Does not identify a treatment order for stage 1 pressure ulcer to left medial foot or right heel blister. -9/12/24 and 9/27/24 a number 8 was charted which indicated to see progress note -9/30/24 a number 5 was charted hold see nurses notes Review of R4's medical record identified there was no progress note indicating the treatments to R4's sacrum was done on 9/12/24, 9/27/24 and 9/30/24. No treatment orders identified for	{F 686}		

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{F 686}	Continued From page 12 treatment of stage 1 pressure ulcer to left medial foot. During an observation and interview on 10/1/24 at 9:36 a.m., R4 was lying on her back with the head of her bed elevated about 30 degrees. R4 had a pillow under her heels, so her heels were not floating. R4 could not recall if she was repositioned at all during the night but stated it may not be a bad idea to turn to her side as her bottom was aching. NA-B and NA-C came into room to get R4 washed up and dressed for the day. NA-B and NA-C stated R4 should have the pillow under her legs, so her heels were floating and were not aware of any pressure ulcer to R4's heels. NA-B and NA-C both indicated this was the first time they had a chance to get to R4's room and had been on shift since 6:30 a.m. Both Na-B and NA-C verified R4 had not been repositioned and should have been because of the pressure ulcer to her buttocks. At 9:56 a.m. LPN-B came to the room to change R4's sacral dressing due to it being soiled with bowel movement. LPN-B stated there were no treatments ordered for R4's right heel or left medial foot. During an observation and interview on 10/1/24 at 10:51 a.m., R4 was lying on her back in bed with head of bed raised about 30 degrees. R4 stated my right heel is the one that hurts, it wouldn't hurt to lie on my side awhile and maybe my butt wouldn't hurt like it does. During an interview on 10/1/24 at 11:36 a.m., interim director of nursing (IDON) stated we just contracted a wound care company who came to the facility on 9/26/24 and the nurse practitioner (NP)-A who was a certified wound specialist did skin assessments on all of our residents with	{F 686}		

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{F 686}	Continued From page 13 wounds. IDON stated NP-A did all of the comprehensive wound assessments but did not have access to our electronic health record and did not make any recommendations as we were told our mayo providers and hospice providers will order the treatments. IDON indicated hospice never faxed the orders for R3 or R4 so we did not have anything for treatment orders for their pressure ulcers. IDON indicated R3 and R4 did not have prevention interventions in place to prevent pressure ulcer development or worsening such as every two-hour repositioning in place. IDON stated, we do not do tissue tolerance tests upon admission, every morning Monday through Friday during interdisciplinary team (IDT) meeting we have a new admission check list we go through to make sure a body audit was completed, check if they have wounds, if they are in PCC with measurements, check to see if it is care planned, a skin check was completed, a Braden score completed. IDON stated our current process was if Braden score is less than 18, the resident was incontinent, had immobility we have to have care planned interventions to prevent skin breakdown. During an observation and interview on 10/1/24 at 1:30 p.m. LPN-B removed the Mepilex that was dated 9/30/24 from R4's right heel, no drainage on dressing noted. LPN-B stated this was an unstageable pressure ulcer as the area to the back of the heel was a quarter sized fluid filled blister. LPN-B stated we will have to call the provider and get orders. During an interview on 10/1/24 at 2:12 p.m. LPN-A stated the reason why these care plans were a mess was because she was in charge of the rehab 2 (TCU) and the prairie unit (LTC). The	{F 686}		

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{F 686}	Continued From page 14 old MDS nurse used to put the care plan interventions in, but she quit a few weeks ago. LPN-A stated she had no idea the interventions were not being put in the care plan, was not aware she was responsible to do it and did not know how to add the interventions. LPN-A stated with new admits all residents who have existing pressure ulcers and are at risk for pressure ulcers should have pressure reducing devices in place and should be turned and repositioned every two hours at the very least. LPN-A verified that R3 and R4 did not have any prevention interventions in place such as repositioning every 2 hours and both developed pressure injuries that could potentially have been avoided. All residents who have a new pressure ulcer that has developed should have the provider notified to ensure a treatment plan is put into place. If the pressure ulcer is not identified on the TAR the nurses have no way of assessing the wound, without assessing the wound it could worsen and we would be unable to notify the provider of a change in condition. During a phone interview on 10/1/24 at 4:10 p.m., medical director (MD)-A stated she did see R3 for a visit on 9/16/24 and was unaware of any pressure ulcer to R3's sacrum, and he did not allow me to look at his heels at that time. MD-A stated any resident who was admitted with pressure ulcers or was at risk for pressure ulcers should be provided with prevention interventions such as turning and repositioning to mitigate the risk of pressure ulcer development or worsening of current pressure ulcers. We just contracted an outside wound provider, Northern Lights and NP-A had just started within the last week, if NP-A had recommendations for treatment one of our providers would review it and get the treatment	{F 686}		

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{F 686}	Continued From page 15 implemented. MD-A further stated we are still in the process of getting this figured out. Any resident who develops a pressure ulcer should be monitored daily for changes and the provider should be notified of any changes such as worsening or signs and symptoms of infection to put a treatment in place for healing. With no daily monitoring there would be no way to notice a change in the wound such as worsening or infection. Wounds should be comprehensively assessed weekly to ensure the current treatment plan in place promotes healing. Facility "Standing Orders for Skilled Nursing Facilities," revised April 2022, identified under Skin and Wound Management to institute facility wound management if available. If facility wound management process not available ...stage 2 or 3 Pressure injuries (moderate to heavy drainage): cleanse with normal saline or non-cytoxic wound cleanser. Apply adhesive foam dressing (facility stock); change every 2-3 days and prn. Notify provider next business day. Stage 2 or 3 Pressure injuries (minimal drainage): cleanse with normal saline or non-cytoxic wound cleanser. Apply hydrogel (facility stock) to wound bed. Cover with nonadherent dressing Change every 3 days and prn. Notify the provider the next business day. The Standing House orders does not identify a treatment for unstageable pressure ulcers. Facility policy reviewed, "Prevention and Treatment of Pressure Ulcers/Pressure Injury," revised 11/22/22, identified It is the policy of Volunteers of America National Services (VOANS) to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure	{F 686}		

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ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to professional standards of care. I. Prevention of Pressure Ulcers: A. Braden Scale* and Skin Risk Data Collection form will be done: Upon admission, Weekly for the first 4 weeks post admission, Quarterly, and With a change in status (i.e., pressure ulcer development, change in mobility, continence status, change in cognition, nutrition, etc.). B. Nursing: Monitoring of Skin Integrity: Skin will be observed daily with cares by the nursing assistant. If any skin concerns are noted, they are to be reported immediately to the designated nurse. Weekly skin audits will be performed by the Licensed Nurse (Refer to Body Audit Policy and Procedure). An alert will trigger from question B of the assessment to the clinical dashboard that will notify the IDT that a new skin issue has occurred and follow up is needed. If a dressing is ordered, it will be monitored for appropriate placement on resident. If a skin concern is noted, refer to section II. Treatment of Pressure Ulcers and Lower Extremity Ulcers (arterial, venous, neuropathy/diabetic, or mixed) procedure and Wound Care Protocols. If the assigned nurse identifies a wound upon the admission body audit. The nurse will need to complete the 1st weekly wound documentation and notify resident and/or resident representative as appropriate and the Physician/PA/CNP will be notified and the nurse will obtain orders utilizing the 3 M Protocol, complete an individualized care plan, and notify the IDT. If post admission there is an identification of a wound, the assigned nurse will complete the E-Interact COC or Paper SBAR, complete the Risk Management New Skin Integrity Concern. The Care Plan for Skin Integrity is to be evaluated and revised based on

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response, outcomes, and needs of the resident. II. Treatment of Pressure Ulcers and Lower Extremity Ulcers (arterial, venous, neuropathy/diabetic, or mixed) If a resident is admitted with or there is a new development of a pressure ulcer or lower extremity ulcer the following procedure is to be implemented: 1. Notify Physician/PA/CNP and Resident and/or Resident Representative 2. Initiate physician wound orders or 3M Wound Care Protocols, until order is obtained. 3. Notify Supervisor/Designee as assigned. 4. Notify Dietary for nutritional interventions. 5. Notify Therapy Department for seating surface evaluation and possible treatment interventions. 6. Notify other interdisciplinary team members as appropriate. 7. Initiate Braden Scale and Skin Risk Data Collection form. 8. Update the residents individualized Care Plan for Skin Integrity and nursing assistant Kardex with any skin concerns and interventions. Include appropriate risk factors, turning intervals and interventions as appropriate. 9. Initiate Weekly Wound Documentation to be completed every seven days and PRN in electronic health record which will include: type of wound, location, date, stage (pressure ulcers only) or indicate partial or full thickness (arterial, venous, neuropathy/diabetic ulcers), length, width, and depth; wound base description, wound edge description and if present: drainage, odor, undermining, tunneling, and/or pain. The Weekly Wound Documentation Progress Form should only have ONE WOUND per form. See Weekly Wound Documentation Progress Sheet & Wound Documentation Guidelines for instructions. 10. When a wound is present, daily wound monitoring should include: An evaluation of the wound, if no dressing is present, An evaluation of the status of the dressing, if present, The status of the area

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{F 686}	Continued From page 18 surrounding the ulcer/wound (that can be observed without removing the dressing), The presence of possible complications, such as signs of infections, Whether pain, if present, is being adequately controlled. Document on any changes or concerns in the nurses notes and re-evaluate prior steps 1-9 as appropriate. 11. Periodically IDT team review the resident for intervention for prevention and healing of pressure ulcer/pressure injury. 12. Notify the Physician/CNP, Resident and/or Resident Representative as appropriate and Supervisor/Designee if the ulcer(s) has not shown progress in 2 weeks and/or is deteriorating unexpectedly. Re-evaluate plan of care as appropriate.	{F 686}		

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Electronically delivered
October 8, 2024

Administrator
Rochester Rehabilitation and Living Center
1900 Ballington Boulevard NW
Rochester, MN 55901

Re: CCN: 245626
Cycle Start Date: September 9, 2024

Dear Administrator:

On October 1, 2024, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 9, 2024, with orders received by you electronically on September 13, 2024.

State licensing orders issued pursuant to the last survey completed on September 9, 2024, found not corrected at the time of this October 1, 2024 revisit, and subject to penalty assessment, are as follows:

20900 -- MN Rule 4658.0525 Subp. 3 -- Rehab - Pressure Ulcers $350.00

The details of the violations noted at the time of this revisit completed on October 1, 2024 (listed above), are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, § 144A.10, you will be assessed an amount of $350.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
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

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to:

Shellae Dietrich, Health Program Manager
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

Sincerely,

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

Enclosure

cc: Licensing and Certification File
Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29822	A. BUILDING: _____ B. WING _____	R 10/01/2024

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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 9/30/24 and 10/1/24, an onsite revisit was conducted to follow up on deficiencies issued related to a licensing survey exited on 9/9/24 by the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure. The original licensing order issued will remain in effect, and a penalty assessment was	{2 000}		

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{2 000}	Continued From page 1 issued. The complaint which was found to be out of compliance and issued at 0900 at the time of the survey, remained out of compliance. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE	{2 000}		

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{2 000}	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	{2 000}		
{2 900}	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure prevention interventions, daily wound monitoring and treatment orders were in place to mitigate the risk of pressure ulcer prevention or worsening for 2 of 4 residents (R3 and R4) reviewed for pressure ulcers.	{2 900}	Plan of Correction for: F686 D Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as	10/4/24

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{2 900}	Continued From page 3 Findings include: Definitions of pressure ulcers: 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. A pressure injury will present as intact skin and may be painful. The appearance will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Stage 2 Pressure Ulcer: partial thickness skin loss with exposed dermis. Partial thickness skin loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink, or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Unstageable pressure ulcer: Full thickness skin and tissue loss in which the extent of tissue	{2 900}	a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. Affected Residents(s): How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Residents R3 and R4 were immediately evaluated and assessed. Hospice was contacted for the current skin treatment orders that they had already been providing to R3 and R4 on-site. Orders were transcribed into the resident charts and care planning was updated to reflect treatments and interventions. Care plans were also reviewed and updated to integrate care with the Hospice team. The point click care wound application was reviewed and updated with any current wounds for R3 and R4. Resident R3 had an air mattress ordered for skin protection. Resident R4 already had an air mattress in place, and the mattress settings were placed on the group sheet and in the care plan. Turning and repositioning program was	

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{2 900}	Continued From page 4 damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If the slough or eschar is removed, a stage 3 or 4 pressure ulcer will be revealed. Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon, or purple discoloration. 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. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. 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. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle, or other underlying structures are visible, this indicates a full thickness pressure ulcer. Once a deep tissue injury opens to an ulcer, reclassify the ulcer into the appropriate stage. Slough: non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed. Purulent drainage: any product of inflammation that contains pus (e.g., leukocytes, bacteria, and liquefied necrotic debris). Serosanguinous drainage: a thin, watery fluid that's often slightly yellow and has a light pink tinge that can ooze from a wound as a part of the	{2 900}	also reviewed and updated in the care plans and group sheets of R3 and R4. Potential Affected Resident(s): All other residents with pressure ulcers have the potential to be affected by the same deficient practice? Skin assessments continue to be reviewed every Monday through Friday during morning meeting. The weekend documentation is reviewed on the following Monday, and if there is a holiday that falls on Monday, they are reviewed on Tuesday. All staff had previously been educated on reporting of wounds when conducting weekly skin checks. This will continue to be brought through report. The interdisciplinary team continues to review all new admissions for skin checks, wound status, braeden score, any current skin treatment orders, Hospice status and interventions for skin breakdown curing the morning meeting. Measures/Systematic Changes: What measures will be put into place, or systematic changes will be made to ensure that the deficient practice will not recur> Who is your audience htat education needs to occur with?	

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{2 900}	Continued From page 5 wound healing process. Granulation Tissue: the pink-red moist tissue that fills an open wound, when it starts to heal. It contains new blood vessels, collagen, fibroblasts, and inflammatory cells. R3's hospital After Visit Summary (AVS) dated 9/13/24, indicated R3 had a diabetic neuropathic ulcer to the left heel from 8/21/24. The AVS had no treatment plan indicated for the wound. R3's care plan dated 9/13/24, identified a focus of alteration in skin integrity related to diabetic foot ulcer to left heel. R3 was at risk for further breakdown related to requiring assist with mobility. Interventions included to turn and reposition ___ hours while awake. There was a blank space before the word hours which did not identify how often to do this intervention. Inspect skin daily with cares and nursing assistant to report any concerns to the nurse, elevate heels off the bed to maintain pressure relief. Final intervention was pressure reducing mattress type ____ and date applied ___. The spaces did not identify the intervention had been implemented. R3's progress note dated 9/13/24 at 11:27 a.m., identified a nutritional summary that indicated R3 had a pressure injury. An additional note at 12:01 p.m. indicated left heel had Mepilex in place with a wound measuring 1.75 centimeters (cm) x 1.5 cm. No further assessment of the left heel was documented. R3's care area assessment (CAA) dated 9/16/24, identified R3 had an alteration in skin integrity related to diabetic foot ulcer to left heel, treatment as ordered. At risk for further skin breakdown related to required assist with mobility, skin	{2 900}	Policy and Procedure was reviewed and continues to be current. LPN A was immediately re-educated regarding responsibility of updating care plans with treatments and interventions, reporting of wounds, and assuring weekly skin checks completed. All staff had previously been educated on reporting of wounds when conducting weekly skin checks. This will continue to be brought through report with Nurse Managers. Monitoring: How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The wound rounding NP through Northern Lights will make recommendations for treatment that will be passed on to the provider when needed. She continues to round every Thursday. The Northern Lights team now has access to upload needed documents and notes. The wound rounding process is an interdisciplinary approach with the clinical team. All wound rounding will be completed with the clinical nurse manager and the wound rounding NP, Any needed interventions will be addressed in real time and will be care planned and placed on	

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{2 900}	Continued From page 6 observed daily with cares and weekly by licensed nurse on bath days and as needed, and pressure reducing device to chair and bed ...proceed to care plan. R3's admission Minimum Data Set (MDS) dated 9/16/24 indicated R3's cognition was intact and had diagnoses of diabetes, morbid obesity, and malignant neoplasm (cancer) of prostate. R3 required two person assist with bed mobility, toilet use and transfers. Further identified R3 had a diabetic ulcer with no pressure ulcers identified with a treatment of pressure reducing device to chair and bed and applications of dressings to feet (with or without topical medications). R3's order summary dated 9/16/24 did not identify a treatment for R3's left heel wound. R3's Medical Doctor (MD) visit dated 9/16/24, identified there was no skin breakdown on R3's buttocks and that R3 declined examination of his heels. MD visit did not include a diagnosis or treatment plan of a wound on R3's left heel. R3's Treatment Administration Record (TAR) dated September 2024, did not identify a treatment to address R3's heel or provide daily wound monitoring. R3's progress note dated 9/20/24 at 9:48 a.m. identified R3's hospice company was contacted for a wheelchair as R3 was wanting to get out of bed, they will order one. R3's Braden Scale For Predicting Pressure Sore Risk dated 9/24/24, identified R3 had very limited sensory perception, was bedfast and skin was occasionally moist, requiring an extra linen change once a day and very limited with mobility.	{2 900}	the group sheets as necessary. Any recommended orders will be reported to the primary provider for review and implementation of possible changes. Audits: Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. DON/designee is responsible for compliance. Completion date is 10/4/24	

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{2 900}	Continued From page 7 R3 scored a 12 out of 18 indicating R3 was at high risk for the development of pressure sores. R3's progress note dated 9/26/24 at 6:49 p.m. identified R3 was seen by the wound team, please see nursing wound check under nursing not for wound skin care. R3's Skin and Wound Evaluation dated 9/26/24, identified R3 had a stage 2 pressure ulcer to the left heel that was present on admission. The ulcer was staged by a health care provider. Wound measurements were 1.7 centimeters (cm) x 0.9 cm, wound bed had 100% granulation tissue with a moderate amount of serosanguinous drainage with no odor noted. Edges of the ulcer were attached, and peri-wound had erythema (redness). Goal of care was slow to heal-wound healing is slow or stalled but stable, little/no deterioration. Treatment: dressing intact, cleansed with generic wound cleanser, and had mechanical debridement and primary dressing was a foam dressing. Under the Notifications tab there were boxes to check mark that were: practitioner notified, resident/responsible part notified, dietician notified, and therapy notified. None of the selections were checked. During an interview on 9/30/24 at 5:08 p.m., licensed practical nurse (LPN)-A stated there was no current order for R3's left heel wound and nothing on the TAR. LPN-A stated she would check into it and see why there was no order in place. During an interview on 9/30/24 at 5:16 p.m. interim director of nursing (IDON) stated she could not find an order for R3's left heel wound and nothing on R3's TAR for treatment order. IDON stated we will look into it, R3 was on	{2 900}		

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{2 900}	Continued From page 8 hospice, and we (facility staff) could always use a standing house order (SHO). During an interview on 10/1/24 at 10:12 a.m., nursing assistant (NA)-A stated she was unaware of R3 having any pressure ulcers and was unaware of a turning and repositioning schedule for him. NA-A stated she did not hear anything in report about R3 having a pressure ulcer and verified that R3 was dependent on staff for bed mobility and required the use of a full body mechanical lift for transfers. NA-A stated she had not offered R3 any repositioning since the start of her shift at 6:30 a.m. During a phone interview on 10/1/24 at 9:08 a.m., nurse practitioner (NP)-A stated she was a certified wound specialist who was recently contracted to come to the facility to do comprehensive wound assessments. NP-A stated she was at the facility on 9/26/24 and assessed six residents who had pressure ulcers, it was a lot of work as it was hard to identify through the documentation of exactly where the residents had their pressure ulcers. NP-A further stated she had not yet gotten access to the facility electronic health record so was unable to put her recommendations for treatment in the record and was told hospice teams and facility doctors will be putting in their recommendations for treatment orders. NP-A stated she planned to do assessments every Thursday and hope to implement new treatment interventions as allowed. NP-A stated she did a comprehensive assessment on R3's left heel and was identified as a stage 2 pressure ulcer and not a diabetic ulcer. During an observation and interview on 10/1/24 at 10:19 a.m., registered nurse (RN)-A stated she	{2 900}		

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{2 900}	Continued From page 9 was just notified from hospice aide that R3 had a new wound on his bottom and had to go to his room to check it. RN-A stated she was unaware of a wound to R3's left heel as it was not identified in R3's provider orders or the TAR. R3 was lying on his back with the head of the bed slightly elevated. RN-A turned R3 to his left side while R3 hung on to the side rail. R3's buttocks were noted to have a white cream over them, to the left buttock a small area that was bumpy was noticed. RN-A stated she could not tell what the area was and would have to reposition him to the other side and wipe some of the cream off. RN-A asked R3, "did you know you had a wound on your bottom?" R3 stated he had sores in his groin area before and he used zinc oxide in the past to heal them up and the hospice aide told him he had a sore on his bottom after he was given a bath earlier that morning. During an observation and interview on 10/1/24 at 10:32 a.m., Licensed practical nurse (LPN)-A walked in the room identified herself as the nurse manager and stated she was going to take pictures of the wound on R3's left buttock. LPN-A wiped some of the cream off of R3's buttocks with a wash cloth and took a picture of the wound and stated the wound measured 2.2 cm x 1.6 cm, was unable to articulate the stage of the wound. LPN-A stated the wound was intact and dark reddish/purple in color. RN-A had left the room. During an observation and interview on 10/1/24 at 10:35 a.m., hospice registered nurse (HRN)-A walked over to the side of R3's bed and indicated the wound on R3's left buttock was a deep tissue pressure injury (DTPI), stated she would cleanse it with wound cleanser, and applied a Mepilex for protection. HRN-A stated to LPN-A she had asked about ordering an alternating pressure	{2 900}		

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{2 900}	Continued From page 10 mattress last week for R3 and LPN-A stated she would order that right away and left the room. HRN-A removed R3's left heel Mepilex (a foam dressing designed to help manage non to low exuding acute and chronic wounds) that was undated and stated there was a moderate amount of purulent foul-smelling drainage noted, HRN-A sprayed wound cleanser on three 4 x 4 gauze pads and wiped the bottom of R3's wound, wound started bleeding and a moderate amount of blood had dripped onto the bed sheet. HRN-A applied a dated Mepilex to the left heel. HRN-A stated R3 should have this heel dressing changed twice a week and as needed if the dressing had lots of drainage or became soiled. HRN-A was unaware the facility did not have any treatment orders in place for treatment of R3's heel. HRN-A stated we were told it was a diabetic ulcer, but it could very well be a stage 2 pressure ulcer and stated she would fax the treatment orders to the facility, so they have it. HRN-A stated R3 was admitted with this wound to his left heel so the facility should have been aware. HRN-A stated to prevent the pressure ulcers on his sacrum from worsening R3 should be offered to turn and reposition every two hours and an air mattress should have been ordered when it was asked for last week, this will help with distribution of bony prominences. HRN-A stated if R3 had the air pressure alternating air mattress and turning and repositioning program in place it may have prevented the DTPI to his left buttock from developing. During an interview on 10/1/24 at 11:32 a.m., director of nursing in training (DONIT)-A stated an unawareness if tissue tolerance tests were performed on admit for residents who are at high risk for pressure ulcers or for those with existing pressure ulcers to determine a turning and	{2 900}		

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{2 900}	Continued From page 11 repositioning schedule that is person centered. DONIT-A stated the most recent documentation for R3 was he had a stage 2 pressure ulcer to his left heel and the facility did not have any current treatment orders in place. DONIT-A further verified R3 did not have a pressure reducing air mattress or a turning and repositioning schedule and he should have. R4 R4's admission MDS dated 9/5/24, indicated R4's cognition was intact and had diagnoses of lumbar laminectomy, malignant neoplasm (cancer) of right breast and lung, and right and left foot drop. R4 had a urinary catheter and was always incontinent of bowel. R4 required two person assist with bed mobility and toilet use and transfers did not occur. Further identified R4 had a surgical wound and no pressure ulcers identified. Treatments included a pressure reducing device to bed, surgical wound dressing, and application of ointments/medications other than to feet. R4's progress note dated 9/10/24 at 12:37 p.m. identified during R4's cares Mepilex was removed on the coccyx there were four wounds found, appear to be two large pressure sores, area not measured, was cleansed and a new Mepilex was applied family and hospice notified. R4's order summary dated 9/11/24 identified an order to use Vashe wound cleanser on slough area for 1-5 minutes daily, then pat dry and cover with a dressing in the morning for wound care, wound measurements once every 2 weeks by facility nurse. No orders identified for treatment of stage 1 pressure ulcer to left medial foot or to the deep tissue injury to right heel.	{2 900}		

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{2 900}	Continued From page 12 R4's Skin and Wound Evaluation dated 9/26/24 identified R4 had a stage 2 in house acquired pressure ulcer to the sacrum on 9/25/24. Wound measurements were 2.1 cm x 0.7 cm, no exudate noted. Edges of the ulcer were attached, and peri-wound had blanching (whitening of external tissue). Goal of care was healable. Treatment: dressing intact, cleansed with normal saline, no debridement and primary dressing was a foam dressing. Under the Notifications tab there were boxes to check mark that were: practitioner notified, resident/responsible part notified, dietician notified, and therapy notified. None of the selections were checked. R4's Skin and Wound Evaluation dated 9/26/24, identified R4 had a stage 1 in house acquired pressure ulcer to the left medial foot on 9/10/24. Wound measurements were 1.9 cm x 0.7 cm, wound bed had 90% granulation tissue with no exudate noted. Edges of the ulcer were attached, and peri-wound had blanching (whitening of external tissue). Goal of care was healable. Treatment: dressing intact, cleansed with normal saline, no debridement, primary dressing was a foam dressing air mattress with a pump and turning repositioning program. MD/provider diagnoses infection and mayo hospice made aware. R4's Hospice Visit dated 9/26/24, indicated a wound care order to R4's coccyx changed to every other day for skin protection, remove old dressing cleanse with saline, pat dry and place new sacral Mepilex over the wound. R4's Braden Scale For Predicting Pressure Sore Risk dated 9/29/24, identified R4 had very limited sensory perception, was bedfast and skin was occasionally moist, requiring an extra linen	{2 900}		

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{2 900}	Continued From page 13 change once a day, very poor nutritional intake and very limited with mobility. R4 scored a 10 out of 18 indicating R4 was at high risk for the development of pressure sores. R4's Skin and Wound Evaluation dated 9/30/24, identified R4 had a deep tissue injury (DTI) (persistent non blanchable deep red, maroon, or purple discoloration) in house acquired pressure ulcer to the left heel staged by hospice on 9/30/24. Wound measurements were 1.3 cm x 1.2 cm. Under the Notifications tab there were boxes to check mark that were: practitioner notified, resident/responsible part notified, dietician notified, and therapy notified. None of the selections were checked. R4's Hospice Visit dated 9/30/24, indicated a wound care order to R4's right heel blister. Change dressing every third day and as needed. Remove old dressing cleanse with saline, pat dry and place new Mepilex over the wound, do not intentionally pop blister. R4's Treatment administration Record (TAR) dated September 2024, identified an order to use Vashe wound cleanser on slough area for 1-5 minutes daily, then pat dry and cover with a dressing in the morning for wound care from 9/11/24 to 9/30/24. Does not identify a treatment order for stage 1 pressure ulcer to left medial foot or right heel blister. -9/12/24 and 9/27/24 a number 8 was charted which indicated to see progress note -9/30/24 a number 5 was charted hold see nurses notes Review of R4's medical record identified there was no progress note indicating the treatments to	{2 900}		

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{2 900}	Continued From page 14 R4's sacrum was done on 9/12/24, 9/27/24 and 9/30/24. No treatment orders identified for treatment of stage 1 pressure ulcer to left medial foot. During an observation and interview on 10/1/24 at 9:36 a.m., R4 was lying on her back with the head of her bed elevated about 30 degrees. R4 had a pillow under her heels, so her heels were not floating. R4 could not recall if she was repositioned at all during the night but stated it may not be a bad idea to turn to her side as her bottom was aching. NA-B and NA-C came into room to get R4 washed up and dressed for the day. NA-B and NA-C stated R4 should have the pillow under her legs, so her heels were floating and were not aware of any pressure ulcer to R4's heels. NA-B and NA-C both indicated this was the first time they had a chance to get to R4's room and had been on shift since 6:30 a.m. Both Na-B and NA-C verified R4 had not been repositioned and should have been because of the pressure ulcer to her buttocks. At 9:56 a.m. LPN-B came to the room to change R4's sacral dressing due to it being soiled with bowel movement. LPN-B stated there were no treatments ordered for R4's right heel or left medial foot. During an observation and interview on 10/1/24 at 10:51 a.m., R4 was lying on her back in bed with head of bed raised about 30 degrees. R4 stated my right heel is the one that hurts, it wouldn't hurt to lie on my side awhile and maybe my butt wouldn't hurt like it does. During an interview on 10/1/24 at 11:36 a.m., interim director of nursing (IDON) stated we just contracted a wound care company who came to the facility on 9/26/24 and the nurse practitioner (NP)-A who was a certified wound specialist did	{2 900}		

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{2 900}	Continued From page 15 skin assessments on all of our residents with wounds. IDON stated NP-A did all of the comprehensive wound assessments but did not have access to our electronic health record and did not make any recommendations as we were told our mayo providers and hospice providers will order the treatments. IDON indicated hospice never faxed the orders for R3 or R4 so we did not have anything for treatment orders for their pressure ulcers. IDON indicated R3 and R4 did not have prevention interventions in place to prevent pressure ulcer development or worsening such as every two-hour repositioning in place. IDON stated, we do not do tissue tolerance tests upon admission, every morning Monday through Friday during interdisciplinary team (IDT) meeting we have a new admission check list we go through to make sure a body audit was completed, check if they have wounds, if they are in PCC with measurements, check to see if it is care planned, a skin check was completed, a Braden score completed. IDON stated our current process was if Braden score is less than 18, the resident was incontinent, had immobility we have to have care planned interventions to prevent skin breakdown. During an observation and interview on 10/1/24 at 1:30 p.m. LPN-B removed the Mepilex that was dated 9/30/24 from R4's right heel, no drainage on dressing noted. LPN-B stated this was an unstageable pressure ulcer as the area to the back of the heel was a quarter sized fluid filled blister. LPN-B stated we will have to call the provider and get orders. During an interview on 10/1/24 at 2:12 p.m. LPN-A stated the reason why these care plans were a mess was because she was in charge of the rehab 2 (TCU) and the prairie unit (LTC). The	{2 900}		

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{2 900}	Continued From page 16 old MDS nurse used to put the care plan interventions in, but she quit a few weeks ago. LPN-A stated she had no idea the interventions were not being put in the care plan, was not aware she was responsible to do it and did not know how to add the interventions. LPN-A stated with new admits all residents who have existing pressure ulcers and are at risk for pressure ulcers should have pressure reducing devices in place and should be turned and repositioned every two hours at the very least. LPN-A verified that R3 and R4 did not have any prevention interventions in place such as repositioning every 2 hours and both developed pressure injuries that could potentially have been avoided. All residents who have a new pressure ulcer that has developed should have the provider notified to ensure a treatment plan is put into place. If the pressure ulcer is not identified on the TAR the nurses have no way of assessing the wound, without assessing the wound it could worsen and we would be unable to notify the provider of a change in condition. During a phone interview on 10/1/24 at 4:10 p.m., medical director (MD)-A stated she did see R3 for a visit on 9/16/24 and was unaware of any pressure ulcer to R3's sacrum, and he did not allow me to look at his heels at that time. MD-A stated any resident who was admitted with pressure ulcers or was at risk for pressure ulcers should be provided with prevention interventions such as turning and repositioning to mitigate the risk of pressure ulcer development or worsening of current pressure ulcers. We just contracted an outside wound provider, Northern Lights and NP-A had just started within the last week, if NP-A had recommendations for treatment one of our providers would review it and get the treatment implemented. MD-A further stated we are still in	{2 900}		

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{2 900}	Continued From page 17 the process of getting this figured out. Any resident who develops a pressure ulcer should be monitored daily for changes and the provider should be notified of any changes such as worsening or signs and symptoms of infection to put a treatment in place for healing. With no daily monitoring there would be no way to notice a change in the wound such as worsening or infection. Wounds should be comprehensively assessed weekly to ensure the current treatment plan in place promotes healing. Facility "Standing Orders for Skilled Nursing Facilities," revised April 2022, identified under Skin and Wound Management to institute facility wound management if available. If facility wound management process not available ...stage 2 or 3 Pressure injuries (moderate to heavy drainage): cleanse with normal saline or non-cytoxic wound cleanser. Apply adhesive foam dressing (facility stock); change every 2-3 days and prn. Notify provider next business day. Stage 2 or 3 Pressure injuries (minimal drainage): cleanse with normal saline or non-cytoxic wound cleanser. Apply hydrogel (facility stock) to wound bed. Cover with nonadherent dressing Change every 3 days and prn. Notify the provider the next business day. The Standing House orders does not identify a treatment for unstageable pressure ulcers. Facility policy reviewed, "Prevention and Treatment of Pressure Ulcers/Pressure Injury," revised 11/22/22, identified It is the policy of Volunteers of America National Services (VOANS) to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for	{2 900}		

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{2 900}	Continued From page 18 wounds according to professional standards of care. I. Prevention of Pressure Ulcers: A. Braden Scale* and Skin Risk Data Collection form will be done: Upon admission, Weekly for the first 4 weeks post admission, Quarterly, and With a change in status (i.e., pressure ulcer development, change in mobility, continence status, change in cognition, nutrition, etc.). B. Nursing: Monitoring of Skin Integrity: Skin will be observed daily with cares by the nursing assistant. If any skin concerns are noted, they are to be reported immediately to the designated nurse. Weekly skin audits will be performed by the Licensed Nurse (Refer to Body Audit Policy and Procedure). An alert will trigger from question B of the assessment to the clinical dashboard that will notify the IDT that a new skin issue has occurred and follow up is needed. If a dressing is ordered, it will be monitored for appropriate placement on resident. If a skin concern is noted, refer to section II. Treatment of Pressure Ulcers and Lower Extremity Ulcers (arterial, venous, neuropathy/diabetic, or mixed) procedure and Wound Care Protocols. If the assigned nurse identifies a wound upon the admission body audit. The nurse will need to complete the 1st weekly wound documentation and notify resident and/or resident representative as appropriate and the Physician/PA/CNP will be notified and the nurse will obtain orders utilizing the 3 M Protocol, complete an individualized care plan, and notify the IDT. If post admission there is an identification of a wound, the assigned nurse will complete the E-Interact COC or Paper SBAR, complete the Risk Management New Skin Integrity Concern. The Care Plan for Skin Integrity is to be evaluated and revised based on response, outcomes, and needs of the resident. II. Treatment of Pressure Ulcers and Lower Extremity Ulcers (arterial, venous,	{2 900}		

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{2 900}	Continued From page 19 neuropathy/diabetic, or mixed) If a resident is admitted with or there is a new development of a pressure ulcer or lower extremity ulcer the following procedure is to be implemented: 1. Notify Physician/PA/CNP and Resident and/or Resident Representative 2. Initiate physician wound orders or 3M Wound Care Protocols, until order is obtained. 3. Notify Supervisor/Designee as assigned. 4. Notify Dietary for nutritional interventions. 5. Notify Therapy Department for seating surface evaluation and possible treatment interventions. 6. Notify other interdisciplinary team members as appropriate. 7. Initiate Braden Scale and Skin Risk Data Collection form. 8. Update the residents individualized Care Plan for Skin Integrity and nursing assistant Kardex with any skin concerns and interventions. Include appropriate risk factors, turning intervals and interventions as appropriate. 9. Initiate Weekly Wound Documentation to be completed every seven days and PRN in electronic health record which will include: type of wound, location, date, stage (pressure ulcers only) or indicate partial or full thickness (arterial, venous, neuropathy/diabetic ulcers), length, width, and depth; wound base description, wound edge description and if present: drainage, odor, undermining, tunneling, and/or pain. The Weekly Wound Documentation Progress Form should only have ONE WOUND per form. See Weekly Wound Documentation Progress Sheet & Wound Documentation Guidelines for instructions. 10. When a wound is present, daily wound monitoring should include: An evaluation of the wound, if no dressing is present, An evaluation of the status of the dressing, if present, The status of the area surrounding the ulcer/wound (that can be observed without removing the dressing), The presence of possible complications, such as signs of infections, Whether pain, if present, is	{2 900}		

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{2 900}	Continued From page 20 being adequately controlled. Document on any changes or concerns in the nurses notes and re-evaluate prior steps 1-9 as appropriate. 11. Periodically IDT team review the resident for intervention for prevention and healing of pressure ulcer/pressure injury. 12. Notify the Physician/CNP, Resident and/or Resident Representative as appropriate and Supervisor/Designee if the ulcer(s) has not shown progress in 2 weeks and/or is deteriorating unexpectedly. Re-evaluate plan of care as appropriate. 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}		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 13, 2024

Administrator
Rochester Rehabilitation And Living Center
1900 Ballington Boulevard Nw
Rochester, MN 55901

RE: CCN: 245626
Cycle Start Date: September 9, 2024

Dear Administrator:

On September 9, 2024, a survey was completed at your facility by the Minnesota Department(s) 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 September 28, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 28, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 28, 2024.

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 September 28, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Rochester Rehabilitation And Living Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 28, 2024. 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 March 9, 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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

Nursing Home Informal Dispute Process
Minnesota Department of Health

Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

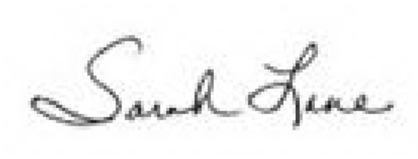
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

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

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING _____ B. WING _____	C 09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER REHABILITATION AND LIVING CENTER	1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901

(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 9/5/24 and 9/9/24, 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 complaints were reviewed H56267780C (MN106281 and MN106307) and H56268008C (MN106526) with a deficiency cited at F686 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 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		9/25/24

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

Electronically Signed | 09/17/2024

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

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F 686	Continued From page 1 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess pressure ulcers and monitor for skin breakdown to prevent and/or mitigate the risk of deterioration resulting in actual harm when 1 of 1 residents (R1) admitted with a stage 1 pressure ulcer developed into an unstageable pressure ulcer that caused pain and required antibiotic treatment. Findings include: Definitions of pressure ulcers: Pressure Ulcer/Injury (PU/PI) is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. The appearance will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Unstageable pressure ulcer: Full thickness skin	F 686	F686: Pressure Ulcer Severity G Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. Affected Resident(s): R1 (NA) was immediately assessed for safety and bruising. Investigation was initiated. The agency staff member (EP) was informed of the investigation and was walked out of the facility by the scheduler. The resident (NA)'s wound had already been addressed with the Ombudsman and Lisa the resident's daughter before the surveyor arrived. A wound process had been put into place August 23rd following the facility's identification of missed assessments. All residents were assessed for wounds and nursing made sure that there were	

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F 686	Continued From page 2 and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If the slough or eschar is removed, a stage 3 or 4 pressure ulcer will be revealed. R1's admission Minimum Data Set (MDS) dated 8/4/24 identified R1 had diagnoses of dementia and malnutrition. Further identified R1 was at risk for pressure ulcers. Interventions included a pressure reducing device for chair and bed. No pressure ulcers were identified on the MDS. R1's Braden Scale For Predicting Pressure Sore Risk assessment dated 7/29/24 identified a score of 16 indicated R1 was at risk for pressure ulcers. R1's Nursing Skilled Services Data Collection assessment, dated 7/29/24 identified R1 had a stage 1 pressure ulcer to the left buttock. R1's pressure ulcer assessment lacked measurements and description of pressure area, presence of pain, and lacked the treatment plan. Although the assessment identified a stage 1 pressure ulcer on 7/29/24, it was not evident R1's wound was comprehensively assessed nor ongoing monitoring was completed until 8/16/24, 18 days later when the record identified an unstageable pressure ulcer on R1's coccyx. R1's Nursing Skilled Services Data Collection assessment, dated 8/8/24 did not identify any skin concerns. R1's Incident-Post Incident Review note dated 8/16/24 at 6:00 p.m., identified R1 had an unstageable pressure ulcer to coccyx area, nursing assistant (NA)-C found the wound while changing R1's brief.	F 686	appropriate treatments in place. A house audit of skin checks was completed on September 10, 2024. Potential Affected Residents: All residents at risk for pressure ulcers have the potential to be affected. The IDT will monitor PCC skin assessments for any new abnormalities in morning meeting daily Monday through Friday. the weekend skin checks will be reviewed on Mondays. All wounds were documented and measured using the skin & wound module in Point Click Care beginning August 23, 2024. Residents are assessed on admission for appropriate treatments, measurements and characteristics. The wound will be downloaded in the wound application by the Nurse Manager on the unit. Wound rounds are completed weekly and as needed. Measures/Systematic Changes: Policy/Procedure titled Prevention and Treatment of Pressure Ulcers-Pressure Injury was reviewed and remains current. The facility is currently in the process of contracting an outside wound rounding service (Northern Lights) to round with	

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F 686	Continued From page 3 R1's Nursing Skilled Services Data Collection assessment, dated 8/16/24 identified R1 had an unstageable pressure ulcer. The assessment did not identify where the pressure ulcer was or description. Interventions were to reposition more often, air mattress in place and to perform wound assessment with monitoring. R1's progress note dated 8/16/24 at 6:23 p.m., identified R1 had an unstageable pressure ulcer to the coccyx area measuring 1.4 centimeters (cm) x 2.4 cm with surrounding redness measuring 0.5 cm, area was cleansed and a Mepilex (absorbent foam dressing) was applied. Wound bed had 95% slough (white or yellow soft dead tissue) and 5% eschar (dry, black, or brown, hardened scab-like covering of dead tissue that forms over deep wounds). In review of R1's record, the care plan was not revised until 8/29/24 and no immediate interventions including wound treatments and monitoring were implemented until 8/20/24, 4 days after the wound was identified. Further not evident the wound was treated or monitored between 8/17/24 through 8/20/24. R1's Nurse Practitioner (NP) visit note dated 8/20/24 identified R1 had a bilateral gluteal cleft wound that measured 2.0 cm x 2.5 cm, irregularly shaped, macerated peri wound with 100% white/yellow slough in the wound bed. Assessment and plan: Remove old dressing cleanse with saline, pat dry, open capsule of metronidazole (antibiotic) and sprinkle on the wound. Cut silver alginate (wound dressing to treat infected wounds or high risk for infected wounds) dressing to size of wound. Cover with	F 686	nursing on wound rounding day(s). They will be able to offer real time wound orders/treatments for the residents. Weekly skin checks will be audited/reviewed in morning meeting for compliance and to address any skin issues that may have been identified, and appropriate follow up will be implemented. Education will be provided to Licensed Nursing and Certified Nursing Assistants on identification, reporting and treatment of skin irregularities. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Wound rounding was completed August 23rd, 2024. Review of weekly skin checks was implemented September 16, 2024. Weekly skin checks and 24-hour report will be reviewed daily in the morning meeting for compliance and any skin irregularities will be addressed in real time with the interdisciplinary team for notifications, treatment plan, care plan, risk management and measurements if indicated. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of	

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F 686	Continued From page 4 Mepilex dressing and change daily. R1's treatment administration record (TAR) dated August 2024, included the aforementioned physician treatment order however, identified R1's pressure ulcer treatment was not implemented until 8/21/24. R1's Skin and Wound Evaluation dated 8/23/24, identified R1 had an in house acquired unstageable pressure ulcer due to slough and/or eschar that was staged by a health care provider. Pressure ulcer measurements were 1.8 cm x 1.2 cm, 70% wound filled with slough, increased pain and warmth noted. Exudate was moderate serosanguineous drainage with no odor. Peri wound was warm, fragile, erythema (redness) and was excoriated (superficial loss of tissue). R1 was on antibiotic therapy for the wound, had some moderate pain in the area that was controlled with pain medications and pharmacological interventions. R1's care plan revised 8/29/24 identified a focus, "R1 has potential for pressure ulcer. Risk factors include pain development of PU/skin condition and fluid risk..." Interventions dated 8/16/24 identified an air pressure mattress and on 8/29/24 indicated to reposition every two hours along with incontinence management, inspect skin daily and with cares, report any concerns to the nurse, monitor for signs and symptoms of infection, weekly wound progress assessment and daily monitoring of wound by nurse. During an observation on 9/9/24 at 1:37 p.m., R1 was lying in bed on her back. R1 stated, "my butt is sore I just have to get up." R1 tried to reposition self in bed but was unsuccessful. Staff	F 686	results. Completion Date: DON or designee are responsible for compliance. Completion Date: September 25, 2024.	

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F 686	Continued From page 5 came in and toileted R1 and brought R1 back to bed and positioned R1 on her right side. R1 stated, "yes that is better." During an interview on 9/9/24 at 10:29 a.m., via phone family member (FM)-A stated a nurse called her on 8/16/24 and told her that R1 had one little pressure ulcer upon admit they think she got it in the hospital. The nurse explained the facility had "missed" it until 8/16/24 when nursing had found the ulcer unstageable. R1 was supposed to discharge but could not now because R1 had to have wound care every day. R1's bottom had been very sore, R1 would grimace and moan. During an interview on 9/9/24 at 2:17 p.m., licensed practical nurse (LPN)-A stated there was an unstageable pressure ulcer on R1's coccyx and had changed the dressing this morning. The wound was looking better since the treatment had been started. LPN-A stated on admission we do a full body skin assessment; this would be documented under Data Collection assessment. Weekly skin checks were completed on each resident usually on their scheduled bath days. LPN-A stated pressure ulcer assessments and documentation needed to include the stage, wound bed, peri wound, drainage, measurements, and any signs and symptoms of infection. During an interview on 9/9/24 at 2:48 p.m., NA-C stated he worked on 8/16/24 and had helped R1 with incontinent care. NA-C indicated he had seen a Mepilex dressing on her coccyx that was not dated, was very soiled with bowel movement, and looked like it had been there for awhile. NA-C got the nurse to change the dressing, when the	F 686		

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F 686	Continued From page 6 nurse took the dressing off of R1's wound "it was bad looking and had black in it." NA-C remembered he had seen a Mepilex to the area a week prior that was not dated and questioned if the dressing he found on 8/16/24 was the same one. NA-C stated R1 would have pain with transfers and toileting in the coccyx area. During an interview on 9/9/24 at 2:30 p.m., licensed practical nurse (LPN)-B stated she worked on 8/16/24 when NA-C alerted her to go to R1's room to change the coccyx dressing. LPN-B stated R1 did not have any orders for a dressing at that time. When LPN-B went to R1's room, she removed the soiled Mepilex that had a large amount of yellow and brown pus. R1 had a large unstageable pressure ulcer to her coccyx that smelled bad, "like dead skin" and the wound bed was gray and black. LPN-B immediately reported to the nurse manager LPN-C. LPN-B stated that was on a Friday, when she came back on Monday August 19th, she went to assess R1's wound and change the dressing, however there was no dressing on R1's coccyx and there was not a physician ordered wound treatment. LPN-B again reported her findings to the nurse manager so a treatment order could be put into place. During an interview on 9/9/24 at 3:46 p.m., registered nurse (RN)-A and LPN-C indicated R1's unstageable pressure ulcer to the coccyx was first identified on 8/16/24. RN-A stated on 9/16/24 she measured the coccyx wound and LPN-C identified she documented RN-A's findings. RN-A indicated R1's wound was odd shaped and had eschar in it, there was no treatment order at that time. RN-A and LPN-C referenced the physician's standing orders for wound care which did not include a treatment for	F 686		

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F 686	Continued From page 7 unstageable pressure ulcers, so it was determined to follow the treatment for a Stage 3 ulcer. RN-A cleaned the wound with normal saline and applied a Mepilex to it per the standing house orders. LPN-C stated she completed an SBAR (communication tool used to report changes to physician) for the nurse practitioner to notify and request treatment orders. Both RN-A and LPN-C stated they had not revised the care plan and/or developed nursing orders that would inform staff of the pressure ulcer, direct them to monitor the wound, and apply any wound dressings or treatments. Treatment orders were not ordered until 8/20/24 indicating R1's wound was not monitored and/or treated for 4 days. LPN-C indicated R1's skin assessment on 7/29/24, indicated R1 had a stage 1 pressure ulcer to coccyx and a full body skin assessment was not performed again until 8/25/24. RN-A stated full body skin assessments should be done on admit, weekly and with changes. RN-A stated when doing a wound assessment, it should be staged, measured, description of the wound bed, peri wound, drainage, pain, and any signs and symptoms of infection. Both LPN-C and RN-A indicated they had not completed record reviews or audits on other residents at risk for pressure ulcers and/or residents with existing wounds in order to determine if the care plan and treatment was appropriate. During an interview on 9/9/24 at 4:40 p.m., interim director of nursing (IDON) indicated upon admission residents should have a full comprehensive skin assessment, then weekly and with any changes. IDON stated with any skin changes family and provider were supposed to notified and also to ensure a treatment plan was in place. IDON stated to ensure a pressure ulcer	F 686		

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F 686	Continued From page 8 was comprehensively assessed for treatment it should be staged, measured, description of the wound bed, peri wound, drainage, pain and any signs and symptoms of infection, IDON verified the facility policy was not followed for wound assessments and monitoring for R1. IDON stated since R1's wound was missed and the process was not followed the facility implemented an additional tracking system within the electronic health record with a plan for completing weekly skin inspections. However, the facility had not reviewed other residents possibly effected by the deficient practice which would include residents who were at risk for pressure ulcers and residents who had existing pressure ulcers. Facility, "Standing Orders for Skilled Nursing Facilities," revised April 2022, identified under Skin and Wound Management to institute facility wound management if available. If facility wound management process not available ...stage 2 or 3 Pressure injuries (moderate to heavy drainage): cleanse with normal saline or non-cytoxic wound cleanser. Apply adhesive foam dressing (facility stock); change every 2-3 days and prn. Notify provider next business day. Stage 2 or 3 Pressure injuries (minimal drainage): cleanse with normal saline or non-cytoxic wound cleanser. Apply hydrogel (facility stock) to wound bed. Cover with nonadherent dressing Change every 3 days and prn. Notify the provider the next business day. The Standing House orders does not identify a treatment for unstageable pressure ulcers. Facility policy reviewed, "Prevention and Treatment of Pressure Ulcers/Pressure Injury," revised 11/22/22, identified It is the policy of Volunteers of America National Services	F 686		

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F 686	Continued From page 9 (VOANS) to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to professional standards of care. I. Prevention of Pressure Ulcers: A. Braden Scale* and Skin Risk Data Collection form will be done: Upon admission, Weekly for the first 4 weeks post admission, Quarterly, and With a change in status (i.e., pressure ulcer development, change in mobility, continence status, change in cognition, nutrition, etc.). B. Nursing: Monitoring of Skin Integrity: Skin will be observed daily with cares by the nursing assistant. If any skin concerns are noted, they are to be reported immediately to the designated nurse. Weekly skin audits will be performed by the Licensed Nurse (Refer to Body Audit Policy and Procedure). An alert will trigger from question B of the assessment to the clinical dashboard that will notify the IDT that a new skin issue has occurred and follow up is needed. If a dressing is ordered, it will be monitored for appropriate placement on resident. If a skin concern is noted, refer to section II. Treatment of Pressure Ulcers and Lower Extremity Ulcers (arterial, venous, neuropathy/diabetic, or mixed) procedure and Wound Care Protocols. If the assigned nurse identifies a wound upon the admission body audit. The nurse will need to complete the 1st weekly wound documentation and notify resident and/or resident representative as appropriate and the Physician/PA/CNP will be notified and the nurse will obtain orders utilizing the 3 M Protocol, complete an individualized care plan, and notify the IDT. If post admission there is an identification of a wound, the assigned nurse will complete the E-Interact COC or Paper SBAR,	F 686		

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F 686	Continued From page 10 complete the Risk Management New Skin Integrity Concern. The Care Plan for Skin Integrity is to be evaluated and revised based on response, outcomes, and needs of the resident. II. Treatment of Pressure Ulcers and Lower Extremity Ulcers (arterial, venous, neuropathy/diabetic, or mixed) If a resident is admitted with or there is a new development of a pressure ulcer or lower extremity ulcer the following procedure is to be implemented: 1. Notify Physician/PA/CNP and Resident and/or Resident Representative 2. Initiate physician wound orders or 3M Wound Care Protocols, until order is obtained. 3. Notify Supervisor/Designee as assigned. 4. Notify Dietary for nutritional interventions. 5. Notify Therapy Department for seating surface evaluation and possible treatment interventions. 6. Notify other interdisciplinary team members as appropriate. 7. Initiate Braden Scale and Skin Risk Data Collection form. 8. Update the residents individualized Care Plan for Skin Integrity and nursing assistant Kardex with any skin concerns and interventions. Include appropriate risk factors, turning intervals and interventions as appropriate. 9. Initiate Weekly Wound Documentation to be completed every seven days and PRN in electronic health record which will include: type of wound, location, date, stage (pressure ulcers only) or indicate partial or full thickness (arterial, venous, neuropathy/diabetic ulcers), length, width, and depth; wound base description, wound edge description and if present: drainage, odor, undermining, tunneling, and/or pain. The Weekly Wound Documentation Progress Form should only have ONE WOUND per form. See Weekly Wound Documentation Progress Sheet & Wound Documentation Guidelines for instructions. 10. When a wound is present, daily wound monitoring	F 686		

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F 686	Continued From page 11 should include: An evaluation of the wound, if no dressing is present, An evaluation of the status of the dressing, if present, The status of the area surrounding the ulcer/wound (that can be observed without removing the dressing), The presence of possible complications, such as signs of infections, Whether pain, if present, is being adequately controlled. Document on any changes or concerns in the nurses notes and re-evaluate prior steps 1-9 as appropriate. 11. Periodically IDT team review the resident for intervention for prevention and healing of pressure ulcer/pressure injury. 12. Notify the Physician/CNP, Resident and/or Resident Representative as appropriate and Supervisor/Designee if the ulcer(s) has not shown progress in 2 weeks and/or is deteriorating unexpectedly. Re-evaluate plan of care as appropriate.	F 686		
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	F 880		9/25/24

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F 880	Continued From page 12 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 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.	F 880		

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F 880	Continued From page 13 §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 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure enhanced barrier precautions (EBP)-(an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.) were implemented for management of a pressure ulcer wound to reduce the risk of infection to others for 1 of 1 resident (R1) reviewed for transfers. Further the facility failed to implement hand hygiene for 1 of 1 resident (R1) observed during toileting and transfers. Findings include: R1's significant change Minimum Data Set (MDS) dated 8/28/24 identified R1 had diagnoses of dementia and a urinary tract infection (UTI) within the last 30 days. Further identified R1 was at risk for pressure ulcers, had one unstageable pressure ulcer and was on antibiotics. R1's progress note dated 8/16/24 at 6:23 p.m., identified R1 had an unstageable pressure ulcer to the coccyx area measuring 1.4 centimeters (cm) x 2.4 cm with surrounding redness measuring 0.5 cm, area was cleansed and a	F 880	F880 SS:D Enhanced Barrier Precautions Preparation, submission and implementation of this plan of Correction does not constitute and admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. Potential Affected Resident(s): The potential for infection is facility wide. Measures/Systematic Changes: The Enhanced Barrier Precaution Policy/Procedure was reviewed and remains current. Staff will be re-educated for Enhanced Barrier Precautions and handwashing. The educational materials will consist of regulatory guidance from the CDC/MDH, and VOANS P&P titled	

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F 880	Continued From page 14 Mepilex (absorbent foam dressing) was applied. Wound bed had 95% slough (white or yellow soft dead tissue) and 5% eschar (dry, black, or brown, hardened scab-like covering of dead tissue that forms over deep wounds). R1's care plan dated 8/19/24 identified a focus, "resident had a wound and meets the criteria of enhanced barrier precautions." Intervention indicated to don gown and gloves during high-contact resident care activities: dressing, bathing/showering, providing hygiene, changing linens, changing briefs, and assist with toileting. R1's order summary dated 8/20/24 identified R1's wound care to coccyx. Remove old dressing cleanse with saline, pat dry, open capsule of metronidazole (antibiotic) and sprinkle on the wound. Cut silver alginate (wound dressing to treat infected wounds or high risk for infected wounds) dressing to size of wound. Cover with Mepilex dressing and change daily. During an observation on 9/9/24 at 1:36 p.m., upon entrance to R1's room an orange paper sign was lying on top of a white cart with drawers to the right entrance of the room. Two red colored, "STOP" signs noted at the top on either side. Signage read: "ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following activities. Dressing, Bathing/Showering, Transferring, Changing linens, Providing Hygiene, Changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than	F 880	Enhanced Barrier Precautions. Monitoring: Staff audits will be conducted for proper PPE donning and doffing, and handwashing. This will include all disciplines in the facility that go into resident rooms. Staff audits will be conducted weekly for four weeks. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. The Infection Control RN or Designee is responsible for implementation and compliance. Completion Date: September 25, 2024	

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F 880	Continued From page 15 one person." The sign also had color pictures of hand cleanser, gloves, and gown. During an observation and on 9/9/24 at 1:37 p.m., nursing assistant (NA)-A walked into R1's room without doing hand hygiene, did not utilize gloves or a gown. NA-A then transferred R1 from the bed to the wheelchair, then again from R1's wheelchair to the toilet. NA-A did not perform hand hygiene after the transfer to the toilet. NA-A walked out of the room without doing hand hygiene. During an interview on 9/9/24 at 1:49 p.m., NA-A was unaware they had to use gowns and gloves for high contact care activities. NA-A indicated she did not wash her hands and should have. During an interview on 9/9/24 at 2:01 p.m., LPN-B stated staff should be using EBP with all cares for R1 due to a pressure ulcer. During an observation on 9/9/24 at 2:17 p.m., NA-B transferred R1 from the toilet to the wheelchair. NA-B and licensed practical nurse (LPN)-A transferred R1 from the wheelchair to the bed with no hand hygiene performed before or after and without gown or gloves. NA-B was unable to articulate when to use EBP. During an interview on 9/9/24 at 2:18 p.m., LPN-A stated all staff should be utilizing EBP to include gown and glove use with high resident care activities such as transfers and toileting if they have a pressure ulcer to help prevent the spread of infection and hand hygiene should be performed before and after cares. LPN-B stated hand hygiene should be performed before and after cares and admitted it was not done.	F 880		

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F 880	Continued From page 16 During an interview on 9/9/24 at 2:30 p.m., LPN-B stated all staff should be utilizing EBP to include gown and glove use with high resident care activities such as transfers and toileting if they have a pressure ulcer to help prevent the spread of infection. During an interview on 9/9/24 at 4:31 p.m., registered nurse (RN)-A stated, for a resident who has a pressure ulcer EBP precautions should be used with all high-risk resident activities including transfers and toileting. During an interview on 9/9/24 at 4:40 p.m., interim director of nursing (IDON) indicated staff should be using EBP's with transfers and toileting for R1 due to the pressure ulcer of the coccyx to help prevent the spread of infection. All residents with EBP have a sign clearly posted outside their room and staff should be looking for that and following the policy for EBP to help prevent the spread of infection. IDON further indicated All staff should be utilizing hand hygiene before and after resident cares. Facility policy, "enhance Barrier Precautions Policy and Procedure," revised 7/2/24, identified, It is the policy of this Volunteers of America National Services (VOANS) that Enhanced Barrier Precautions (EBP), in addition to Standard and Contact Precautions will be implemented during high contact resident care activities when caring for residents that have an increase risk from acquiring a multi-drug resistant organism (MDRO) such as a resident with wounds, indwelling medical devices or residents with "infection or colonization with an MDRO. Several routes transmit microorganisms in healthcare	F 880		

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F 880	Continued From page 17 facilities. Moreover, more than one route may transmit the same organism. Enhanced Barrier Precautions (EBP) is intended to prevent the spread of novel or targeted Multi-drug Resistant Organism (MDROs) when residents have an infection or colonization with a MDRO or if the resident has a wound or indwelling medical device, regardless of MDRO infection or colonization. When a resident contracts a MDRO, treatment is many times limited. Enhanced Barrier Precautions will not only focus on residents with infection or colonization with MDROs but will also address residents at risk for developing or becoming colonized. Focusing only on residents with active infection fails to address the continued risk of transmission from residents with MDRO colonization, who, by definition, have no symptoms of illness. MDRO colonization may persist for long periods of time (e.g., months) which contributes to the silent spread of MDROs. Enhanced Barrier Precautions are precautions that are between Standard Precautions and Contact Precautions. Enhanced Barrier Precautions require gown and glove use for residents with a novel or targeted MDRO or any resident with a wound or indwelling medical device during specific high-contact resident care activities ... The purpose of Enhanced Barrier Precautions is to prevent opportunities for transfer of MDRSs to employee's hands and clothing during cares, beyond situations in which staff anticipate exposure to blood and body fluids. High-Contact Resident Care Activities include: Dressing, Bathing/Showering, Transferring, Providing Hygiene, Changing linens, Changing incontinent products or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. Wound care; any skin opening requiring a dressing.	F 880		

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F 880	Continued From page 18 (This generally includes chronic wound such as pressure ulcers, diabetic ulcers, and chronic venous stasis ulcers. This does not include those with shorter-lasting wounds, such as skin breaks or skin tears covered with a Band-aid or similar dressing. Ostomies, such as colostomies and ileostomies, are not defined as a wound or and indwelling medical device for indication for Enhanced Barrier Precautions).	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 13, 2024

Administrator
Rochester Rehabilitation And Living Center
1900 Ballington Boulevard Nw
Rochester, MN 55901

Re: State Nursing Home Licensing Orders
Event ID: Y0P711

Dear Administrator:

The above facility was surveyed on September 5, 2024 through September 9, 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.

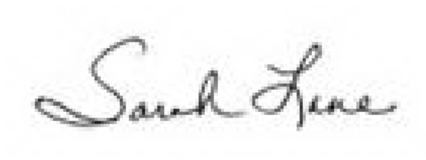
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29822	A. BUILDING: _____ B. WING _____	C 09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER REHABILITATION AND LIVING CE	1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901

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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 9/5/24 and 9/9/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H56267780C (MN106281 and MN106307) and H56268008C (MN106526) with a licensing order issued at 0900 and 1375. 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 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess pressure ulcers and monitor for skin breakdown to prevent and/or mitigate the risk of deterioration resulting in actual harm when 1 of 1 residents (R1) admitted with a stage 1 pressure ulcer developed into an unstageable pressure ulcer that caused pain and required antibiotic	2 900	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all	9/25/24

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2 900	Continued From page 3 treatment. Findings include: Definitions of pressure ulcers: Pressure Ulcer/Injury (PU/PI) is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. The appearance will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Unstageable pressure ulcer: Full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If the slough or eschar is removed, a stage 3 or 4 pressure ulcer will be revealed. R1's admission Minimum Data Set (MDS) dated 8/4/24 identified R1 had diagnoses of dementia and malnutrition. Further identified R1 was at risk for pressure ulcers. Interventions included a pressure reducing device for chair and bed. No pressure ulcers were identified on the MDS. R1's Braden Scale For Predicting Pressure Sore	2 900	applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. Affected Resident(s): R1 (NA) was immediately assessed for safety and bruising. Investigation was initiated. The agency staff member (EP) was informed of the investigation and was walked out of the facility by the scheduler. The resident (NA)'s wound had already been addressed with the Ombudsman and Lisa the resident's daughter before the surveyor arrived. A wound process had been put into place August 23rd following the facility's identification of missed assessments. All residents were assessed for wounds and nursing made sure that there were appropriate treatments in place. A house audit of skin checks was completed on September 10, 2024. Potential Affected Residents: All residents at risk for pressure ulcers have the potential to be affected. The IDT will monitor PCC skin assessments for any new abnormalities in morning meeting daily Monday through Friday. the weekend skin checks will be reviewed on Mondays.	

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2 900	Continued From page 4 Risk assessment dated 7/29/24 identified a score of 16 indicated R1 was at risk for pressure ulcers. R1's Nursing Skilled Services Data Collection assessment, dated 7/29/24 identified R1 had a stage 1 pressure ulcer to the left buttock. R1's pressure ulcer assessment lacked measurements and description of pressure area, presence of pain, and lacked the treatment plan. Although the assessment identified a stage 1 pressure ulcer on 7/29/24, it was not evident R1's wound was comprehensively assessed nor ongoing monitoring was completed until 8/16/24, 18 days later when the record identified an unstageable pressure ulcer on R1's coccyx. R1's Nursing Skilled Services Data Collection assessment, dated 8/8/24 did not identify any skin concerns. R1's Incident-Post Incident Review note dated 8/16/24 at 6:00 p.m., identified R1 had an unstageable pressure ulcer to coccyx area, nursing assistant (NA)-C found the wound while changing R1's brief. R1's Nursing Skilled Services Data Collection assessment, dated 8/16/24 identified R1 had an unstageable pressure ulcer. The assessment did not identify where the pressure ulcer was or description. Interventions were to reposition more often, air mattress in place and to perform wound assessment with monitoring. R1's progress note dated 8/16/24 at 6:23 p.m., identified R1 had an unstageable pressure ulcer to the coccyx area measuring 1.4 centimeters (cm) x 2.4 cm with surrounding redness measuring 0.5 cm, area was cleansed and a Mepilex (absorbent foam dressing) was applied.	2 900	All wounds were documented and measured using the skin & wound module in Point Click Care beginning August 23, 2024. Residents are assessed on admission for appropriate treatments, measurements and characteristics. The wound will be downloaded in the wound application by the Nurse Manager on the unit. Wound rounds are completed weekly and as needed. Measures/Systematic Changes: Policy/Procedure titled Prevention and Treatment of Pressure Ulcers-Pressure Injury was reviewed and remains current. The facility is currently in the process of contracting an outside wound rounding service (Northern Lights) to round with nursing on wound rounding day(s). They will be able to offer real time wound orders/treatments for the residents. Weekly skin checks will be audited/reviewed in morning meeting for compliance and to address any skin issues that may have been identified, and appropriate follow up will be implemented. Education will be provided to Licensed Nursing and Certified Nursing Assistants on identification, reporting and treatment of skin irregularities. How the facility will monitor its corrective actions to ensure that the deficient	

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2 900	Continued From page 5 Wound bed had 95% slough (white or yellow soft dead tissue) and 5% eschar (dry, black, or brown, hardened scab-like covering of dead tissue that forms over deep wounds). In review of R1's record, the care plan was not revised until 8/29/24 and no immediate interventions including wound treatments and monitoring were implemented until 8/20/24, 4 days after the wound was identified. Further not evident the wound was treated or monitored between 8/17/24 through 8/20/24. R1's Nurse Practitioner (NP) visit note dated 8/20/24 identified R1 had a bilateral gluteal cleft wound that measured 2.0 cm x 2.5 cm, irregularly shaped, macerated peri wound with 100% white/yellow slough in the wound bed. Assessment and plan: Remove old dressing cleanse with saline, pat dry, open capsule of metronidazole (antibiotic) and sprinkle on the wound. Cut silver alginate (wound dressing to treat infected wounds or high risk for infected wounds) dressing to size of wound. Cover with Mepilex dressing and change daily. R1's treatment administration record (TAR) dated August 2024, included the aforementioned physician treatment order however, identified R1's pressure ulcer treatment was not implemented until 8/21/24. R1's Skin and Wound Evaluation dated 8/23/24, identified R1 had an in house acquired unstageable pressure ulcer due to slough and/or eschar that was staged by a health care provider. Pressure ulcer measurements were 1.8 cm x 1.2 cm, 70% wound filled with slough, increased pain and warmth noted. Exudate was moderate serosanguineous drainage with no odor. Peri	2 900	practice is being corrected and will not recur? Wound rounding was completed August 23rd, 2024. Review of weekly skin checks was implemented September 16, 2024. Weekly skin checks and 24-hour report will be reviewed daily in the morning meeting for compliance and any skin irregularities will be addressed in real time with the interdisciplinary team for notifications, treatment plan, care plan, risk management and measurements if indicated. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Completion Date: DON or designee are responsible for compliance. Completion Date: September 25, 2024.	

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2 900	Continued From page 6 wound was warm, fragile, erythema (redness) and was excoriated (superficial loss of tissue). R1 was on antibiotic therapy for the wound, had some moderate pain in the area that was controlled with pain medications and pharmacological interventions. R1's care plan revised 8/29/24 identified a focus, "R1 has potential for pressure ulcer. Risk factors include pain development of PU/skin condition and fluid risk..." Interventions dated 8/16/24 identified an air pressure mattress and on 8/29/24 indicated to reposition every two hours along with incontinence management, inspect skin daily and with cares, report any concerns to the nurse, monitor for signs and symptoms of infection, weekly wound progress assessment and daily monitoring of wound by nurse. During an observation on 9/9/24 at 1:37 p.m., R1 was lying in bed on her back. R1 stated, "my butt is sore I just have to get up." R1 tried to reposition self in bed but was unsuccessful. Staff came in and toileted R1 and brought R1 back to bed and positioned R1 on her right side. R1 stated, "yes that is better." During an interview on 9/9/24 at 10:29 a.m., via phone family member (FM)-A stated a nurse called her on 8/16/24 and told her that R1 had one little pressure ulcer upon admit they think she got it in the hospital. The nurse explained the facility had "missed" it until 8/16/24 when nursing had found the ulcer unstageable. R1 was supposed to discharge but could not now because R1 had to have wound care every day. R1's bottom had been very sore, R1 would grimace and moan. During an interview on 9/9/24 at 2:17 p.m.,	2 900		

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2 900	Continued From page 7 licensed practical nurse (LPN)-A stated there was an unstageable pressure ulcer on R1's coccyx and had changed the dressing this morning. The wound was looking better since the treatment had been started. LPN-A stated on admission we do a full body skin assessment; this would be documented under Data Collection assessment. Weekly skin checks were completed on each resident usually on their scheduled bath days. LPN-A stated pressure ulcer assessments and documentation needed to include the stage, wound bed, peri wound, drainage, measurements, and any signs and symptoms of infection. During an interview on 9/9/24 at 2:48 p.m., NA-C stated he worked on 8/16/24 and had helped R1 with incontinent care. NA-C indicated he had seen a Mepilex dressing on her coccyx that was not dated, was very soiled with bowel movement, and looked like it had been there for awhile. NA-C got the nurse to change the dressing, when the nurse took the dressing off of R1's wound "it was bad looking and had black in it." NA-C remembered he had seen a Mepilex to the area a week prior that was not dated and questioned if the dressing he found on 8/16/24 was the same one. NA-C stated R1 would have pain with transfers and toileting in the coccyx area. During an interview on 9/9/24 at 2:30 p.m., licensed practical nurse (LPN)-B stated she worked on 8/16/24 when NA-C alerted her to go to R1's room to change the coccyx dressing. LPN-B stated R1 did not have any orders for a dressing at that time. When LPN-B went to R1's room, she removed the soiled Mepilex that had a large amount of yellow and brown pus. R1 had a large unstageable pressure ulcer to her coccyx that smelled bad, "like dead skin" and the wound	2 900		

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2 900	Continued From page 8 bed was gray and black. LPN-B immediately reported to the nurse manager LPN-C. LPN-B stated that was on a Friday, when she came back on Monday August 19th, she went to assess R1's wound and change the dressing, however there was no dressing on R1's coccyx and there was not a physician ordered wound treatment. LPN-B again reported her findings to the nurse manager so a treatment order could be put into place. During an interview on 9/9/24 at 3:46 p.m., registered nurse (RN)-A and LPN-C indicated R1's unstageable pressure ulcer to the coccyx was first identified on 8/16/24. RN-A stated on 9/16/24 she measured the coccyx wound and LPN-C identified she documented RN-A's findings. RN-A indicated R1's wound was odd shaped and had eschar in it, there was no treatment order at that time. RN-A and LPN-C referenced the physician's standing orders for wound care which did not include a treatment for unstageable pressure ulcers, so it was determined to follow the treatment for a Stage 3 ulcer. RN-A cleaned the wound with normal saline and applied a Mepilex to it per the standing house orders. LPN-C stated she completed an SBAR (communication tool used to report changes to physician) for the nurse practitioner to notify and request treatment orders. Both RN-A and LPN-C stated they had not revised the care plan and/or developed nursing orders that would inform staff of the pressure ulcer, direct them to monitor the wound, and apply any wound dressings or treatments. Treatment orders were not ordered until 8/20/24 indicating R1's wound was not monitored and/or treated for 4 days. LPN-C indicated R1's skin assessment on 7/29/24, indicated R1 had a stage 1 pressure ulcer to coccyx and a full body skin assessment was not performed again until 8/25/24. RN-A stated full	2 900		

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2 900	Continued From page 9 body skin assessments should be done on admit, weekly and with changes. RN-A stated when doing a wound assessment, it should be staged, measured, description of the wound bed, peri wound, drainage, pain, and any signs and symptoms of infection. Both LPN-C and RN-A indicated they had not completed record reviews or audits on other residents at risk for pressure ulcers and/or residents with existing wounds in order to determine if the care plan and treatment was appropriate. During an interview on 9/9/24 at 4:40 p.m., interim director of nursing (IDON) indicated upon admission residents should have a full comprehensive skin assessment, then weekly and with any changes. IDON stated with any skin changes family and provider were supposed to notified and also to ensure a treatment plan was in place. IDON stated to ensure a pressure ulcer was comprehensively assessed for treatment it should be staged, measured, description of the wound bed, peri wound, drainage, pain and any signs and symptoms of infection, IDON verified the facility policy was not followed for wound assessments and monitoring for R1. IDON stated since R1's wound was missed and the process was not followed the facility implemented an additional tracking system within the electronic health record with a plan for completing weekly skin inspections. However, the facility had not reviewed other residents possibly effected by the deficient practice which would include residents who were at risk for pressure ulcers and residents who had existing pressure ulcers. Facility, "Standing Orders for Skilled Nursing Facilities," revised April 2022, identified under Skin and Wound Management to institute facility wound management if available. If facility wound	2 900		

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2 900	Continued From page 10 management process not available ...stage 2 or 3 Pressure injuries (moderate to heavy drainage): cleanse with normal saline or non-cytoxic wound cleanser. Apply adhesive foam dressing (facility stock); change every 2-3 days and prn. Notify provider next business day. Stage 2 or 3 Pressure injuries (minimal drainage): cleanse with normal saline or non-cytoxic wound cleanser. Apply hydrogel (facility stock) to wound bed. Cover with nonadherent dressing Change every 3 days and prn. Notify the provider the next business day. The Standing House orders does not identify a treatment for unstageable pressure ulcers. Facility policy reviewed, "Prevention and Treatment of Pressure Ulcers/Pressure Injury," revised 11/22/22, identified It is the policy of Volunteers of America National Services (VOANS) to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to professional standards of care. I. Prevention of Pressure Ulcers: A. Braden Scale* and Skin Risk Data Collection form will be done: Upon admission, Weekly for the first 4 weeks post admission, Quarterly, and With a change in status (i.e., pressure ulcer development, change in mobility, continence status, change in cognition, nutrition, etc.). B. Nursing: Monitoring of Skin Integrity: Skin will be observed daily with cares by the nursing assistant. If any skin concerns are noted, they are to be reported immediately to the designated nurse. Weekly skin audits will be performed by the Licensed Nurse (Refer to Body Audit Policy and Procedure). An alert will trigger from question B of the assessment to the clinical dashboard	2 900		

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ROCHESTER REHABILITATION AND LIVING CE	1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901

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2 900	Continued From page 11 that will notify the IDT that a new skin issue has occurred and follow up is needed. If a dressing is ordered, it will be monitored for appropriate placement on resident. If a skin concern is noted, refer to section II. Treatment of Pressure Ulcers and Lower Extremity Ulcers (arterial, venous, neuropathy/diabetic, or mixed) procedure and Wound Care Protocols. If the assigned nurse identifies a wound upon the admission body audit. The nurse will need to complete the 1st weekly wound documentation and notify resident and/or resident representative as appropriate and the Physician/PA/CNP will be notified and the nurse will obtain orders utilizing the 3 M Protocol, complete an individualized care plan, and notify the IDT. If post admission there is an identification of a wound, the assigned nurse will complete the E-Interact COC or Paper SBAR, complete the Risk Management New Skin Integrity Concern. The Care Plan for Skin Integrity is to be evaluated and revised based on response, outcomes, and needs of the resident. II. Treatment of Pressure Ulcers and Lower Extremity Ulcers (arterial, venous, neuropathy/diabetic, or mixed) If a resident is admitted with or there is a new development of a pressure ulcer or lower extremity ulcer the following procedure is to be implemented: 1. Notify Physician/PA/CNP and Resident and/or Resident Representative 2. Initiate physician wound orders or 3M Wound Care Protocols, until order is obtained. 3. Notify Supervisor/Designee as assigned. 4. Notify Dietary for nutritional interventions. 5. Notify Therapy Department for seating surface evaluation and possible treatment interventions. 6. Notify other interdisciplinary team members as appropriate. 7. Initiate Braden Scale and Skin Risk Data Collection form. 8. Update the residents individualized Care Plan for Skin Integrity and nursing assistant Kardex with any	2 900		

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2 900	Continued From page 12 skin concerns and interventions. Include appropriate risk factors, turning intervals and interventions as appropriate. 9. Initiate Weekly Wound Documentation to be completed every seven days and PRN in electronic health record which will include: type of wound, location, date, stage (pressure ulcers only) or indicate partial or full thickness (arterial, venous, neuropathy/diabetic ulcers), length, width, and depth; wound base description, wound edge description and if present: drainage, odor, undermining, tunneling, and/or pain. The Weekly Wound Documentation Progress Form should only have ONE WOUND per form. See Weekly Wound Documentation Progress Sheet & Wound Documentation Guidelines for instructions. 10. When a wound is present, daily wound monitoring should include: An evaluation of the wound, if no dressing is present, An evaluation of the status of the dressing, if present, The status of the area surrounding the ulcer/wound (that can be observed without removing the dressing), The presence of possible complications, such as signs of infections, Whether pain, if present, is being adequately controlled. Document on any changes or concerns in the nurses notes and re-evaluate prior steps 1-9 as appropriate. 11. Periodically IDT team review the resident for intervention for prevention and healing of pressure ulcer/pressure injury. 12. Notify the Physician/CNP, Resident and/or Resident Representative as appropriate and Supervisor/Designee if the ulcer(s) has not shown progress in 2 weeks and/or is deteriorating unexpectedly. Re-evaluate plan of care as appropriate. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee,	2 900		

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2 900	Continued From page 13 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		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure enhanced barrier precautions (EBP)-(an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.) were implemented for management of a pressure ulcer wound to	21375	Enhanced Barrier Precautions Preparation, submission and implementation of this plan of Correction does not constitute and admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as	9/25/24

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21375	Continued From page 14 reduce the risk of infection to others for 1 of 1 resident (R1) reviewed for transfers. Further the facility failed to implement hand hygiene for 1 of 1 resident (R1) observed during toileting and transfers. Findings include: R1's significant change Minimum Data Set (MDS) dated 8/28/24 identified R1 had diagnoses of dementia and a urinary tract infection (UTI) within the last 30 days. Further identified R1 was at risk for pressure ulcers, had one unstageable pressure ulcer and was on antibiotics. R1's progress note dated 8/16/24 at 6:23 p.m., identified R1 had an unstageable pressure ulcer to the coccyx area measuring 1.4 centimeters (cm) x 2.4 cm with surrounding redness measuring 0.5 cm, area was cleansed and a Mepilex (absorbent foam dressing) was applied. Wound bed had 95% slough (white or yellow soft dead tissue) and 5% eschar (dry, black, or brown, hardened scab-like covering of dead tissue that forms over deep wounds). R1's care plan dated 8/19/24 identified a focus, "resident had a wound and meets the criteria of enhanced barrier precautions." Intervention indicated to don gown and gloves during high-contact resident care activities: dressing, bathing/showering, providing hygiene, changing linens, changing briefs, and assist with toileting. R1's order summary dated 8/20/24 identified R1's wound care to coccyx. Remove old dressing cleanse with saline, pat dry, open capsule of metronidazole (antibiotic) and sprinkle on the wound. Cut silver alginate (wound dressing to treat infected wounds or high risk for infected wounds) dressing to size of wound. Cover with	21375	a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. Potential Affected Resident(s): The potential for infection is facility wide. Measures/Systematic Changes: The Enhanced Barrier Precaution Policy/Procedure was reviewed and remains current. Staff will be re-educated for Enhanced Barrier Precautions and handwashing. The educational materials will consist of regulatory guidance from the CDC/MDH, and VOANS P&P titled Enhanced Barrier Precautions. Monitoring: Staff audits will be conducted for proper PPE donning and doffing, and handwashing. This will include all disciplines in the facility that go into resident rooms. Staff audits will be conducted weekly for four weeks. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. The Infection Control RN or Designee is responsible for implementation and	

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21375	Continued From page 15 Mepilex dressing and change daily. During an observation on 9/9/24 at 1:36 p.m., upon entrance to R1's room an orange paper sign was lying on top of a white cart with drawers to the right entrance of the room. Two red colored, "STOP" signs noted at the top on either side. Signage read: "ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following activities. Dressing, Bathing/Showering, Transferring, Changing linens, Providing Hygiene, Changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person." The sign also had color pictures of hand cleanser, gloves, and gown. During an observation and on 9/9/24 at 1:37 p.m., nursing assistant (NA)-A walked into R1's room without doing hand hygiene, did not utilize gloves or a gown. NA-A then transferred R1 from the bed to the wheelchair, then again from R1's wheelchair to the toilet. NA-A did not perform hand hygiene after the transfer to the toilet. NA-A walked out of the room without doing hand hygiene. During an interview on 9/9/24 at 1:49 p.m., NA-A was unaware they had to use gowns and gloves for high contact care activities. NA-A indicated she did not wash her hands and should have. During an interview on 9/9/24 at 2:01 p.m., LPN-B stated staff should be using EBP with all cares for R1 due to a pressure ulcer.	21375	compliance. Completion Date: September 25, 2024	

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21375	Continued From page 16 During an observation on 9/9/24 at 2:17 p.m., NA-B transferred R1 from the toilet to the wheelchair. NA-B and licensed practical nurse (LPN)-A transferred R1 from the wheelchair to the bed with no hand hygiene performed before or after and without gown or gloves. NA-B was unable to articulate when to use EBP. During an interview on 9/9/24 at 2:18 p.m., LPN-A stated all staff should be utilizing EBP to include gown and glove use with high resident care activities such as transfers and toileting if they have a pressure ulcer to help prevent the spread of infection and hand hygiene should be performed before and after cares. LPN-B stated hand hygiene should be performed before and after cares and admitted it was not done. During an interview on 9/9/24 at 2:30 p.m., LPN-B stated all staff should be utilizing EBP to include gown and glove use with high resident care activities such as transfers and toileting if they have a pressure ulcer to help prevent the spread of infection. During an interview on 9/9/24 at 4:31 p.m., registered nurse (RN)-A stated, for a resident who has a pressure ulcer EBP precautions should be used with all high-risk resident activities including transfers and toileting. During an interview on 9/9/24 at 4:40 p.m., interim director of nursing (IDON) indicated staff should be using EBP's with transfers and toileting for R1 due to the pressure ulcer of the coccyx to help prevent the spread of infection. All residents with EBP have a sign clearly posted outside their room and staff should be looking for that and following the policy for EBP to help prevent the	21375		

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21375	Continued From page 17 spread of infection. IDON further indicated All staff should be utilizing hand hygiene before and after resident cares. Facility policy, "enhance Barrier Precautions Policy and Procedure," revised 7/2/24, identified, It is the policy of this Volunteers of America National Services (VOANS) that Enhanced Barrier Precautions (EBP), in addition to Standard and Contact Precautions will be implemented during high contact resident care activities when caring for residents that have an increase risk from acquiring a multi-drug resistant organism (MDRO) such as a resident with wounds, indwelling medical devices or residents with "infection or colonization with an MDRO. Several routes transmit microorganisms in healthcare facilities. Moreover, more than one route may transmit the same organism. Enhanced Barrier Precautions (EBP) is intended to prevent the spread of novel or targeted Multi-drug Resistant Organism (MDROs) when residents have an infection or colonization with a MDRO or if the resident has a wound or indwelling medical device, regardless of MDRO infection or colonization. When a resident contracts a MDRO, treatment is many times limited. Enhanced Barrier Precautions will not only focus on residents with infection or colonization with MDROs but will also address residents at risk for developing or becoming colonized. Focusing only on residents with active infection fails to address the continued risk of transmission from residents with MDRO colonization, who, by definition, have no symptoms of illness. MDRO colonization may persist for long periods of time (e.g., months) which contributes to the silent spread of MDROs. Enhanced Barrier Precautions are precautions that are between Standard Precautions and Contact Precautions. Enhanced Barrier	21375		

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21375	Continued From page 18 Precautions require gown and glove use for residents with a novel or targeted MDRO or any resident with a wound or indwelling medical device during specific high-contact resident care activities ... The purpose of Enhanced Barrier Precautions is to prevent opportunities for transfer of MDRSs to employee's hands and clothing during cares, beyond situations in which staff anticipate exposure to blood and body fluids. High-Contact Resident Care Activities include: Dressing, Bathing/Showering, Transferring, Providing Hygiene, Changing linens, Changing incontinent products or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. Wound care; any skin opening requiring a dressing. (This generally includes chronic wound such as pressure ulcers, diabetic ulcers, and chronic venous stasis ulcers. This does not include those with shorter-lasting wounds, such as skin breaks or skin tears covered with a Band-aid or similar dressing. Ostomies, such as colostomies and ileostomies, are not defined as a wound or and indwelling medical device for indication for Enhanced Barrier Precautions). SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), ICP, or designee could review facility policy and procedures regarding Enhanced Barrier Precautions (EBP) for the resident and provide staff education regarding the policies and educate staff on the appropriate PPE to wear. They could also do environmental rounds and audits, and re-education anytime EBP are placed. The DON, ICP or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for	21375		

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21375	Continued From page 19 a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		