Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 22, 2023

Administrator
St Therese Of Woodbury LLC
7555 Bailey Road
Woodbury, MN 55129

RE: CCN: 245632
Cycle Start Date: June 13, 2023

Dear Administrator:

On July 18, 2023, we notified you a remedy was imposed. On November 17, 2023 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 13, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 13, 2023 be discontinued as of November 13, 2023. (42 CFR 488.417 (b))

In our letter of July 18, 2023, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 13, 2023. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

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Electronically delivered

November 22, 2023

Administrator
St Therese Of Woodbury LLC
7555 Bailey Road
Woodbury, MN 55129

Re: Reinspection Results
Event ID: X8KC12, SXEC12, and 4V7Q12

Dear Administrator:

On August 31, 2023, October 4, 2023, and November 17, 2023, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on July 10, 2023, July 27, 2023, and October 11, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

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October 23, 2023

Administrator
St Therese Of Woodbury LLC
7555 Bailey Road
Woodbury, MN 55129

RE: CCN: 245632
Cycle Start Date: June 13, 2023

Dear Administrator:

On June 23, 2023, we informed you of imposed enforcement remedies.

On October 11, 2023, the Minnesota Department of Health completed a survey 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.

As a result of the survey findings:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 13, 2023, will remain 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 RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 13, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 13, 2023.

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

As we notified you in our letter of June 23, 2023, 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 13, 2023.

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, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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 December 13, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at 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://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

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

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Electronically delivered
October 23, 2023

Administrator
St Therese Of Woodbury LLC
7555 Bailey Road
Woodbury, MN 55129

Re: State Nursing Home Licensing Orders
Event ID: 4V7Q11

Dear Administrator:

The above facility was surveyed on October 10, 2023 through October 11, 2023 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
18 Woodlake Drive, Rochester MN, 55904
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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245632	A. BUILDING _____ B. WING _____	C 10/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(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 10/10/23, 10/11/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed. H56326342C (MN00097482) with citation at F686. 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=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	F 686		11/13/23

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

Electronically Signed | 11/01/2023

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 complete weekly comprehensive skin assessments, failed to follow physician ordered treatments, and failed to revise the care plan for new ulcer development for 1 of 4 residents (R2). Additionally failed to complete an admission comprehensive skin assessment, develop a baseline care plan for pressure ulcers, and failed to implement pressure ulcer interventions for 1 of 4 residents (R4) reviewed for pressure ulcers. Findings include: Stage 2 Pressure Ulcer: Partial-thickness 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). Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of	F 686	CORRECTED Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. R2 had completed new care plan identifying new ulcer development and verified physician order to TAR; audit TAR for wound care completion weekly x4. Review findings and educate prn 1 to 1 with nursing staff. Care plan interventions identified and implemented. R4 had comprehensive skin assessment completed with baseline care plan developed for pressure ulcer identifying appropriate pressure ulcer intervention that were implemented. The facility has determined through all house skin and Braden audit that 36 residents have the potential to be affected. All house audit completed for current skin assessment completion and skin risk assessment. Education provided to nursing staff on policy and procedure on or by 10/26/2023	

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F 686	Continued From page 2 tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable PU/PI. 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. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur. Slough: is 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. Granulation tissue: is 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.	F 686	with ongoing 1 to 1 education with individuals up to and including corrective action. All new wounds identified will have comprehensive skin assessment completed weekly and routinely monitored between dressing changes per floor nurse. Any wound status changes will be communicated promptly to the nurse manager or DON. Process changes included updates and confirmation of PCC orders reflecting ongoing weekly skin assessment on all residents. Implemented process for wound rounding to include designation Nurse Manager as responsible party for timely completion of rounds, skin and wound evaluation documentation and any follow up physician notifications. Implementation of formal wound tracker for ongoing wound monitoring and use for weekly IDT wound/skin risk meetings. Wound tracker will include all pressure ulcers, surgical, vascular, diabetic and complex wounds. DON will be responsible for oversight and monitoring of tracker. Nurse Manager to be responsible for new admission chart review within 72 hours for completion of skin assessments, wound orders, baseline care plan, and interventions are in place.	

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F 686	Continued From page 3 R2's face sheet included diagnoses of pressure ulcer of left heel stage 3 (3/9/23), diabetes, peripheral vascular disease (PVD), personal history of diabetic foot ulcer, and Alzheimer's disease late onset. R2's quarterly MDS dated 8/18/23, indicated R2 was severely cognitively impaired, required extensive assistance of 2 with bed mobility, transfers, did not walk, needed extensive assist of one with toilet use and personal hygiene. MDS indicated R2 had no behaviors and did not reject cares. MDS further identified R2 was at risk for pressure ulcers, had a stage 3 pressure ulcer with interventions that included pressure reducing device for chair and bed and pressure ulcer care. R2's skin care plan revised on 3/9/23, identified R2 had a history of diabetic ulcer to left heel and had a current stage 3 pressure injury on her left heel. R2 was at risk for a decline in skin integrity related to diabetes, neuropathy, PVD, limited mobility, occasional moisture, edema, and anemia. R2 could make position changes to redistribute pressure in bed and wheelchair and was compliant with nursing and physician orders regarding skin care. Interventions included the following: -Monitor skin daily during cares and document skin condition weekly. -Monitor wound for sign/symptoms of infection including: foul odor after cleansing, purulent drainage, pain, warmth, redness. Update physician for further follow-up and evaluation. -When in chair right foot with diabetic shoe, left foot with cam boot. When in bed: right foot prevalon boot, left foot rooke boot (start date 8/14/23). -Remind R2 to elevate left foot throughout the	F 686	DON or designee will continue to monitor/audit the following: o Observation of treatments o Preventative skin care/appropriate interventions. o Weekly skin assessments o Treatment recommendations and orders are being added and processed into the EHR and ETAR o Auditing will occur weekly until in substantial compliance. And then monthly thereafter. Audit results will be reviewed during the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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F 686	Continued From page 4 day. Always keep the footrests on wheelchair (start date 8/17/23) R2's additional skin care plan revised on 2/12/23 identified R3 had actual skin impairment to skin integrity on the left heel related to unstageable pressure ulcer. Interventions included air mattress to bed, cushion to wheelchair-Vicair Vector cushion, and monitor/document/reprot abnormalities, failure to heal, signs/symptoms of infection, maceration to nurse and physician. During an observation on 10/10/23, at 12:37 p.m. R2 laid in bed with Prevelon boot on right foot and CAM boot on left foot. Nursing assistant (NA)-B and NA-C provided peri cares to R2. R2 was observed to have area of discoloration and open area to coccyx area. NA-B and NA-C both stated nurses were aware of the wound and that was why R2 had an order for barrier cream to be applied with incontinent episodes. R2's record did not identify the open coccyx wound. R2's provider note dated 6/14/23, indicated R2 had chronic left foot pain, skin was negative for color change and wound. R2's Skin Assessment dated 7/24/23, identified R2 had stage 3 pressure injury to left heel, no further description was included. R2's provider note dated 8/10/23, identified R2 had a left wound chronic stage 3 pressure ulcer and "has a non-healing foot ulcer due to which she has a boot on". R2's Skin assessment dated 8/13/23, identified R2 had left heel stage 3 pressure injury; no further description was included.	F 686		

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F 686	Continued From page 5 R2's Admission Assessment (Section 5. Skin Integrity) dated 8/14/23, did not identify stage 3 pressure ulcer to left heel. R2 Skin Assessment dated 8/14/23, identified left heel stage 3 pressure injury; no further description was included. R2's Skin Assessment dated 8/16/23, did not identify R2 had a pressure injury to the left heel. R2's wound clinic care visit note dated 8/17/23, indicated reason for appointment was left heel unstageable now stage 3 pressure injury. R2 had a new blood blister again. Husband stated she did not have the foot peddle on the wheelchair on Sunday and reports it was also not on yesterday (Wednesday.) R2 digs heels in and shuffles when foot peddle is not on. New purple discoloration today Open wound/damage area with blood blister 5.7 x 3.8cm 45% deep blook blister 55% granular. Slight maceration. Will enter foot peddle on wheelchair at all times on the left side. R2's Skin assessment dated 8/21/23, identified R2 had left heel stage 3 pressure injury; no other information was included on the assessment. R2's wound clinic care visit dated 8/24/23, indicated there was no new damage today. Wheelchair peddle in use all week. Wound treatment was changed once yesterday therfore moist today. Continue to twice a day however change to Dakin's moistened guaze packing. Assessment identified no new purple discoloration. Total area of discoloration 5.3 x 5 cm with open wound 4.0 x 4.5 x 0.4cm 45% slough 55% granular. Maceration noted extending out 1cm due to dressing completed once	F 686		

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	245632	A. BUILDING _____ B. WING _____	C 10/11/2023

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F 686	Continued From page 6 yesterday. Orders included: -When in chair: Right foot with diabetic shoe and left foot CAM boot -When in bed: Right foot with good Prevalon boot and left foot in Rooke boot -Treatment: cleanse with Dakins, apply Dakins moistened gauze to wound, cover with dry gauze, ABD pad (absorbent dressing) and secure with wrapping, change twice daily and as needed. -Continue: wheelchair must have left foot peddle on at all times to keep foot off the ground. In review of R2's record reviewed between 8/24/23 to 9/21/23, it was not evident comprehensive skin assessments were completed. R2's Admission Assessment (Section 5. Skin Integrity) dated 8/31/23, did not identify left foot stage 3 pressure ulcer. R2's Skin Assessment dated 9/4/23, included "left heel wound unchanged."; no further information about the wound was identified on the assessment. R2's Skin Assessment dated 9/18/23, identified "left heel wound"; no further information about the wound was identified on the assessment. R2's wound clinic care visit note dated 9/21/23, indicated R2's left heel wound was stable and green drainage on present; dressing last changed 9/19/23 and the dressing is ordered daily. Nurse manager spoke with staff and unit nurse manager this week about consistency of dressing changes. Assessment identified: No new purple discoloration today. Total area of wound 4.5cm x 2.5cm x 0.3cm with 20% slough and 80% healthy	F 686		

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F 686	Continued From page 7 granular tissue after aggressive cleansing. Orders included -When in chair: Right foot with diabetic shoe and left foot CAM boot -When in bed: Right foot with good Prevalon boot and left foot in Rooke boot -Treatment: cleanse with Acetic acid, apply acetic acid moistened gauze to wound, cover with dry gauze, ABD pad and secure with wrapping, change twice daily and as needed. -Continue: wheelchair must have left foot peddle on at all times to keep foot off the ground. R2's wound clinic care visit note dated 9/28/23, included area remains stable. Foot peddle in use. Green drainage still present. Staff report continuing to complete daily wound care and have not been completing twice daily dressing changes. Total wound area 4.5cm x 2.5cm x 0.2cm 100% healthy granular tissue after cleansing. Size is stable and wound bed improved. Continued interventions from aforementioned visit note dated 9/21/23. Treatment: Ensure dressing is changed TWICE daily; cleanse with Acetic acid, apply acetic acid moistened gauze to wound, cover with dry gauze, ABD pad and secure with wrapping, change twice daily and as needed. R2's provider visit note dated 10/4/23, indicated R2 skin stage 3 pressure ulcer to left heel followed by the wound care nurse. R2's wound clinic care visit note dated 10/5/23, identified wound remains stable and green drainage was improving. The wound was slow to heal due to two previous grafts and diabetes. "[FM-B] reports that patient did not have foot rests on wheelchair once when he visited this	F 686		

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F 686	Continued From page 8 weekend." This is the patients third pressure injury to the area. Physician has done previous grafts so area more at risk to re-opening. She had arterial work done on left leg and ever since that procedure she developed lymphedema in left leg and poor healing. Assessment identified: Total area is 4.0cm x 1.5 x 0.2cm and 100% healthy tissue. Peri wound with moist callus extending out from wound 0.3-0.5 cm. The orders included aforementioned interventions with wound treatment change to 1) daily and as needed cleanse with Acetic acid, apply Acetic acid moistened gauze to wound, cover with dry gauze, ABD pad (absorbent dressing), and secure with wrapping. Ensure dressing is changed according to orders. 2) Wheelchair must have LEFT foot peddle at all times to keep foot off the ground. 3) Please add a sign above bed ot alert staff to use wheelchair foot peddle if that is approved by unit manager. 4) AFO can never be used if wanting effective protection as she scoots and shuffles in wheelchair with her behaviors from dementia. AFO heel was down in less than two months' time. CAM boot started mid July 2023. During an interview on 10/11/23, at 8:12 a.m. licensed practical nurse (LPN)-B stated when nurses completed wound care, measurements should be recorded at least once a week. LPN-B stated she had not done any measurements or documentation for any wounds since she had begun working for this facility. LPN-B was informed of a new open area on R2 during her morning report. R2 had a meplex border dressing in place on her coccyx wound per facility standing orders. LPN-B reviewed R2's record and reported she did not see any measurements or documentation related to the coccyx wound.	F 686		

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F 686	Continued From page 9 During an interview on 10/10/23, at 11:53 a.m. Clinical Manager (CM)-A stated skin assessments were to be completed weekly on all residents on bath days. CM-A indicated the nurse practitioner and wound clinic are monitoring wounds in the facility. Director of nursing (DON) would assign a specific nurse weekly to complete progress notes on the residents that had been rounded on for the week. CM-A reviewed R2's record and indicated comprehensive assessments were not completed weekly and should have been. R4 R4's admission record indicated diagnoses of orthopedic aftercare following surgical amputation, non-pressure chronic ulcer of other part of right foot limited to breakdown of skin, diabetes mellitus without complications, osteomyelitis, sepsis, bacteremia. R4's admission skin assessment dated 10/4/23, 2:44 p.m. indicated coccyx wound stage 2. Documentation lacked location, description of wound and measurements. R4's care plan dated 10/4/23 indicated a risk for/have impaired skin integrity, as evidence by: [specify] (skin tear, diabetic wound, incontinence associated dermatitis, surgical wound, etc.) None had been specified. No goal identified; intervention included staff will ensure that a pressure reducing/relieving mattress is in place on the bed. Care plan did not include any other interventions. R4's documentation lacked any wound	F 686		

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F 686	Continued From page 10 interventions, measurements, and or wound descriptions. During an interview on 10/11/23, at 10:28 a.m. director of nursing (DON) stated the facility currently did not have a systematic approach for prevention and monitoring of pressure injuries risks or treatments in place. DON explained the facility has not been monitoring, measuring, or describing any of its current wounds. DON stated she has had discussions with the facilities current wound care provider, and they were not willing to see all residents in the facility with wounds weekly. DON stated she would expect that all residents would have skin risk assessments completed on admission, weekly and as needed then based on those assessments' interventions should be put in place. DON stated she did not feel the facility's residents were currently being assessed or monitored properly and proper care planning was not being completed for any skin risks or concerns. DON stated her expectation would be for the staff to follow the facility skin policies. DON stated R4 did not have a comprehensive skin assessment completed. Further, did not have an accurate or completed care plan in place. The current intervention on R4's care plan of a pressure reducing mattress was not in place and she thought it had been ordered but found it had not yet been ordered. DON stated no interventions were currently in place for R4 and stated it was concerning. Facility Policy titled, Skin Assessment, dated 4/22, indicated, it was the policy to perform a full body skin assessment as part of the systematic approach to pressure injury and management. The policy includes the following procedural guidelines in preforming the full body skin	F 686		

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F 686	Continued From page 11 assessment. A full body skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. Documentation of skin assessments should include, date and time of assessment, with name and title. Document observations such as skin condition, how resident tolerated procedure, type of wound, description of wound (measurements, color, type of tissue in wound bed, drainage, odor, pain). Document if resident refused assessment and why. Facility Policy titled, Pressure Injury Prevention and Management, dated 4/1/22, indicated, the facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. The facility shall establish and utilize a systematic approach for pressure injury prevention and management including prompt assessment and treatment, intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Interventions will be documented in the care plan and communicated to all relevant staff. Compliance with interventions will be documented in the weekly summary charting. The RN unit manager or designee will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly and document a summary of the findings in the medical record.	F 686		

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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 10/10/23, 10/11/23, 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. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was reviewed. H56326342C (MN00097482) with a licensing orders issued at 0900. 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 state form.	2 000		

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2 000	Continued From page 2 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 complete weekly comprehensive skin assessments, failed to follow physician ordered treatments, and failed to revise the care plan for new ulcer development for 1 of 4 residents (R2). Additionally failed to complete an admission comprehensive skin assessment, develop a baseline care plan for pressure ulcers, and failed to implement pressure ulcer interventions for 1 of 4 residents (R4) reviewed	2 900	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	11/13/23

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2 900	Continued From page 3 for pressure ulcers. Findings include: Stage 2 Pressure Ulcer: Partial-thickness 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). Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable PU/PI. 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. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or	2 900	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.	

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2 900	Continued From page 4 nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur. Slough: is 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. Granulation tissue: is 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. R2's face sheet included diagnoses of pressure ulcer of left heel stage 3 (3/9/23), diabetes, peripheral vascular disease (PVD), personal history of diabetic foot ulcer, and Alzheimer's disease late onset. R2's quarterly MDS dated 8/18/23, indicated R2 was severely cognitively impaired, required extensive assistance of 2 with bed mobility, transfers, did not walk, needed extensive assist of one with toilet use and personal hygiene. MDS indicated R2 had no behaviors and did not reject cares. MDS further identified R2 was at risk for pressure ulcers, had a stage 3 pressure ulcer with interventions that included pressure reducing device for chair and bed and pressure ulcer care.	2 900		

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2 900	Continued From page 5 R2's skin care plan revised on 3/9/23, identified R2 had a history of diabetic ulcer to left heel and had a current stage 3 pressure injury on her left heel. R2 was at risk for a decline in skin integrity related to diabetes, neuropathy, PVD, limited mobility, occasional moisture, edema, and anemia. R2 could make position changes to redistribute pressure in bed and wheelchair and was compliant with nursing and physician orders regarding skin care. Interventions included the following: -Monitor skin daily during cares and document skin condition weekly. -Monitor wound for sign/symptoms of infection including: foul odor after cleansing, purulent drainage, pain, warmth, redness. Update physician for further follow-up and evaluation. -When in chair right foot with diabetic shoe, left foot with cam boot. When in bed: right foot prevalon boot, left foot rooke boot (start date 8/14/23). -Remind R2 to elevate left foot throughout the day. Always keep the footrests on wheelchair (start date 8/17/23) R2's additional skin care plan revised on 2/12/23 identified R3 had actual skin impairment to skin integrity on the left heel related to unstageable pressure ulcer. Interventions included air mattress to bed, cushion to wheelchair-Vicair Vector cushion, and monitor/document/reprot abnormalities, failure to heal, signs/symptoms of infection, maceration to nurse and physician. During an observation on 10/10/23, at 12:37 p.m. R2 laid in bed with Prevelon boot on right foot and CAM boot on left foot. Nursing assistant (NA)-B and NA-C provided peri cares to R2. R2 was observed to have area of discoloration and open area to coccyx area. NA-B and NA-C both stated nurses were aware of the wound and that was	2 900		

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ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

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2 900	Continued From page 6 why R2 had an order for barrier cream to be applied with incontinent episodes. R2's record did not identify the open coccyx wound. R2's provider note dated 6/14/23, indicated R2 had chronic left foot pain, skin was negative for color change and wound. R2's Skin Assessment dated 7/24/23, identified R2 had stage 3 pressure injury to left heel, no further description was included. R2's provider note dated 8/10/23, identified R2 had a left wound chronic stage 3 pressure ulcer and "has a non-healing foot ulcer due to which she has a boot on". R2's Skin assessment dated 8/13/23, identified R2 had left heel stage 3 pressure injury; no further description was included. R2's Admission Assessment (Section 5. Skin Integrity) dated 8/14/23, did not identify stage 3 pressure ulcer to left heel. R2 Skin Assessment dated 8/14/23, identified left heel stage 3 pressure injury; no further description was included. R2's Skin Assessment dated 8/16/23, did not identify R2 had a pressure injury to the left heel. R2's wound clinic care visit note dated 8/17/23, indicated reason for appointment was left heel unstageable now stage 3 pressure injury. R2 had a new blood blister again. Husband stated she did not have the foot peddle on the wheelchair on Sunday and reports it was also not on yesterday (Wednesday.) R2 digs heels in and shuffles when foot peddle is not on. New purple discoloration	2 900		

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2 900	Continued From page 7 today Open wound/damage area with blood blister 5.7 x 3.8cm 45% deep blook blister 55% granular. Slight maceration. Will enter foot peddle on wheelchair at all times on the left side. R2's Skin assessment dated 8/21/23, identified R2 had left heel stage 3 pressure injury; no other information was included on the assessment. R2's wound clinic care visit dated 8/24/23, indicated there was no new damage today. Wheelchair peddle in use all week. Wound treatment was changed once yesterday therfore moist today. Continue to twice a day however change to Dakin's moistened guaze packing. Assessment identified no new purple discoloration. Total area of discoloration 5.3 x 5 cm with open wound 4.0 x 4.5 x 0.4cm 45% slough 55% granular. Maceration noted extending out 1cm due to dressing completed once yesterday. Orders included: -When in chair: Right foot with diabetic shoe and left foot CAM boot -When in bed: Right foot with good Prevalon boot and left foot in Rooke boot -Treatment: cleanse with Dakins, apply Dakins moistened gauze to wound, cover with dry gauze, ABD pad (absorbent dressing) and secure with wrapping, change twice daily and as needed. -Continue: wheelchair must have left foot peddle on at all times to keep foot off the ground. In review of R2's record reviewed between 8/24/23 to 9/21/23, it was not evident comprehensive skin assessments were completed. R2's Admission Assessment (Section 5. Skin Integrity) dated 8/31/23, did not identify left foot stage 3 pressure ulcer.	2 900		

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2 900	Continued From page 8 R2's Skin Assessment dated 9/4/23, included "left heel wound unchanged."; no further information about the wound was identified on the assessment. R2's Skin Assessment dated 9/18/23, identified "left heel wound"; no further information about the wound was identified on the assessment. R2's wound clinic care visit note dated 9/21/23, indicated R2's left heel wound was stable and green drainage on present; dressing last changed 9/19/23 and the dressing is ordered daily. Nurse manager spoke with staff and unit nurse manager this week about consistency of dressing changes. Assessment identified: No new purple discoloration today. Total area of wound 4.5cm x 2.5cm x 0.3cm with 20% slough and 80% healthy granular tissue after aggressive cleansing. Orders included -When in chair: Right foot with diabetic shoe and left foot CAM boot -When in bed: Right foot with good Prevalon boot and left foot in Rooke boot -Treatment: cleanse with Acetic acid, apply acetic acid moistened gauze to wound, cover with dry gauze, ABD pad and secure with wrapping, change twice daily and as needed. -Continue: wheelchair must have left foot peddle on at all times to keep foot off the ground. R2's wound clinic care visit note dated 9/28/23, included area remains stable. Foot peddle in use. Green drainage still present. Staff report continuing to complete daily wound care and have not been completing twice daily dressing changes. Total wound area 4.5cm x 2.5cm x 0.2cm 100% healthy granular tissue after cleansing. Size is stable and wound bed	2 900		

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2 900	Continued From page 9 improved. Continued interventions from aforementioned visit note dated 9/21/23. Treatment: Ensure dressing is changed TWICE daily; cleanse with Acetic acid, apply acetic acid moistened gauze to wound, cover with dry gauze, ABD pad and secure with wrapping, change twice daily and as needed. R2's provider visit note dated 10/4/23, indicated R2 skin stage 3 pressure ulcer to left heel followed by the wound care nurse. R2's wound clinic care visit note dated 10/5/23, identified wound remains stable and green drainage was improving. The wound was slow to heal due to two previous grafts and diabetes. "[FM-B] reports that patient did not have foot rests on wheelchair once when he visited this weekend." This is the patients third pressure injury to the area. Physician has done previous grafts so area more at risk to re-opening. She had arterial work done on left leg and ever since that procedure she developed lymphedema in left leg and poor healing. Assessment identified: Total area is 4.0cm x 1.5 x 0.2cm and 100% healthy tissue. Peri wound with moist callus extending out from wound 0.3-0.5 cm. The orders included aforementioned interventions with wound treatment change to 1) daily and as needed cleanse with Acetic acid, apply Acetic acid moistened gauze to wound, cover with dry gauze, ABD pad (absorbent dressing), and secure with wrapping. Ensure dressing is changed according to orders. 2) Wheelchair must have LEFT foot peddle at all times to keep foot off the ground. 3) Please add a sign above bed ot alert staff to use wheelchair foot peddle if that is approved by unit manager. 4) AFO can never be used if wanting effective protection as she scoots and shuffles in wheelchair with her behaviors from dementia.	2 900		

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2 900	Continued From page 10 AFO heel was down in less than two months' time. CAM boot started mid July 2023. During an interview on 10/11/23, at 8:12 a.m. licensed practical nurse (LPN)-B stated when nurses completed wound care, measurements should be recorded at least once a week. LPN-B stated she had not done any measurements or documentation for any wounds since she had begun working for this facility. LPN-B was informed of a new open area on R2 during her morning report. R2 had a meplex border dressing in place on her coccyx wound per facility standing orders. LPN-B reviewed R2's record and reported she did not see any measurements or documentation related to the coccyx wound. During an interview on 10/10/23, at 11:53 a.m. Clinical Manager (CM)-A stated skin assessments were to be completed weekly on all residents on bath days. CM-A indicated the nurse practitioner and wound clinic are monitoring wounds in the facility. Director of nursing (DON) would assign a specific nurse weekly to complete progress notes on the residents that had been rounded on for the week. CM-A reviewed R2's record and indicated comprehensive assessments were not completed weekly and should have been. R4 R4's admission record indicated diagnoses of orthopedic aftercare following surgical amputation, non-pressure chronic ulcer of other part of right foot limited to breakdown of skin, diabetes mellitus without complications, osteomyelitis, sepsis, bacteremia.	2 900		

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2 900	Continued From page 11 R4's admission skin assessment dated 10/4/23, 2:44 p.m. indicated coccyx wound stage 2. Documentation lacked location, description of wound and measurements. R4's care plan dated 10/4/23 indicated a risk for/have impaired skin integrity, as evidence by: [specify] (skin tear, diabetic wound, incontinence associated dermatitis, surgical wound, etc.) None had been specified. No goal identified; intervention included staff will ensure that a pressure reducing/relieving mattress is in place on the bed. Care plan did not include any other interventions. R4's documentation lacked any wound interventions, measurements, and or wound descriptions. During an interview on 10/11/23, at 10:28 a.m. director of nursing (DON) stated the facility currently did not have a systematic approach for prevention and monitoring of pressure injuries risks or treatments in place. DON explained the facility has not been monitoring, measuring, or describing any of its current wounds. DON stated she has had discussions with the facilities current wound care provider, and they were not willing to see all residents in the facility with wounds weekly. DON stated she would expect that all residents would have skin risk assessments completed on admission, weekly and as needed then based on those assessments' interventions should be put in place. DON stated she did not feel the facility's residents were currently being assessed or monitored properly and proper care planning was not being completed for any skin risks or concerns. DON stated her expectation would be for the staff to follow the facility skin policies. DON stated R4 did not have a	2 900		

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2 900	Continued From page 12 comprehensive skin assessment completed. Further, did not have an accurate or completed care plan in place. The current intervention on R4's care plan of a pressure reducing mattress was not in place and she thought it had been ordered but found it had not yet been ordered. DON stated no interventions were currently in place for R4 and stated it was concerning. Facility Policy titled, Skin Assessment, dated 4/22, indicated, it was the policy to perform a full body skin assessment as part of the systematic approach to pressure injury and management. The policy includes the following procedural guidelines in preforming the full body skin assessment. A full body skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. Documentation of skin assessments should include, date and time of assessment, with name and title. Document observations such as skin condition, how resident tolerated procedure, type of wound, description of wound (measurements, color, type of tissue in wound bed, drainage, odor, pain). Document if resident refused assessment and why. Facility Policy titled, Pressure Injury Prevention and Management, dated 4/1/22, indicated, the facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. The facility shall establish and utilize a systematic approach for pressure injury prevention and management including prompt assessment and treatment, intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the	2 900		

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2 900	Continued From page 13 interventions; and modifying the interventions as appropriate. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Interventions will be documented in the care plan and communicated to all relevant staff. Compliance with interventions will be documented in the weekly summary charting. The RN unit manager or designee will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly and document a summary of the findings in the medical record. 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		