Electronically delivered
May 21, 2019

Administrator
Moorhead Rehabilitation & Healthcare Center
2810 Second Avenue North
Moorhead, MN 56560

RE: Project Number H5052081C and H5052084C

Dear Administrator:

On April 25, 2019, we informed you that the following enforcement remedy was being imposed:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 24, 2019.

On April 30, 2019, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

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

This was based on the deficiencies cited by this Department for an abbreviated survey completed on April 9, 2019 that included an investigation of complaint number H5052084C. The most serious deficiency was found to be be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required and continued noncompliance was cited.

On April 30, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to abbreviated surveys, completed on March 5, 2019 and April 9, 2019. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 30, 2019. We have determined, based on our visit, that your facility has corrected as of April 30, 2019.

As a result of the revisit findings:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 24, 2019 be rescinded as of April 30, 2019. (42 CFR 488.417 (b))

In our letter of April 25, 2019, 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 was prohibited from conducting a Nursing

Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 24, 2019 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 30, 2019, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of April 30, 2019:

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

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 21, 2019

Administrator
Moorhead Rehabilitation & Healthcare Center
2810 Second Avenue North
Moorhead, MN 56560

Re: Reinspection Results - Complaint Number H5052081C and H5052084C

Dear Administrator:

On April 30, 2019 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigations completed on March 5, 2019 and April 9, 2019. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the president of your facility's governing body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered March 22, 2019

Administrator
Moorhead Rehabilitation & Healthcare Center
2810 Second Avenue North
Moorhead, MN 56560

RE: Project Number H5052071, H5052081C, H5052082C and H5052083C

Dear Administrator:

On March 5, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the March 5, 2019 abbreviated standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5052071, H5052081C, H5052082C and H5052083C.

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. In addition, at the time of the March 5, 2019 abbreviated standard survey the Minnesota Department of Health completed an investigation of complaint number H5052071, H5052082C and H5052083C were found to be unsubstantiated.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 24, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 24, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 24, 2019.

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

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

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

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by May 24, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Moorhead Rehabilitation & Healthcare Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 24, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 5, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

Nursing Home Informal Dispute Process
Minnesota Department of Health

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING _____ B. WING _____	C 03/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORHEAD REHABILITATION & HEALTHCARE CENTER	**2810 SECOND AVENUE NORTH MOORHEAD, MN 56560**

(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 February 27, 28, 2019, and March 1, 4, 5, 2019, an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found not to be in compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The following complaint(s) was/were found to be substantiated: H5052081C, Deficiencies issued at F Tag 686 and 684 The following complaints was/were found to be unsubstantiated: H5052071 H5052082C H5052083C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		4/5/19

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

Electronically Signed | 04/01/2019

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F 684	Continued From page 1 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure coordination of care with hospice services for 1 of 1 resident (R1) with multiple pressure ulcers and had been admitted to hospice services following an acute hospitalization. Findings include: Review of R1's Review of R1's admission Minimum Data Set (MDS) dated 11/5/18, identified R1 had moderate cognitive impairment and had diagnoses which included; cerebral vascular accident (CVA), (stroke,) hemiplegia (one sided paralysis) dementia and personality disorder. The MDS identified R1 required extensive assistance from two facility staff for activities of daily living (ADL's), which included bed mobility, dressing, bathing and toileting. The MDS identified R1 had no terminal diagnosis and had not received hospice services. Review of R1's discharge return anticipated MDS dated 1/9/19, identified R1 had an unplanned discharge to an acute hospital. The MDS identified R1 required extensive assistance with ADL's and had no pressure ulcers at the time of his unplanned discharge to the acute hospital. The MDS identified R1 had no rejection of cares and had no behaviors. The MDS revealed R1	F 684	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of Moorhead Rehabilitation and Healthcare Center that the facility ensures residents receive treatment and care in accordance with the professional standards of practice, residents' choices and the comprehensive person-centered care plan. In addition, the facility is to ensure coordination of care with hospice services for each resident upon identification to hospice, during admission to hospice and ongoing for proper care and treatment based on the individual needs and preferences as identified by the comprehensive resident assessment. The facility failed to ensure coordination of care with hospice services for resident R1 who was newly admitted to hospice services following an acute hospitalization. Resident R1 expired on January 20th, 2019. 2. All residents currently on hospice have	

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F 684	Continued From page 2 had no terminal diagnoses and had not received hospice services. Review of R1's care plan revised 11/9/18, revealed R1 required extensive assistance with ADL's, which included routine repositioning every two hours. R1's care plan lacked any revision following his return from the hospital in January and did not identify R1 had a terminal prognosis and was receiving hospice services. Review of R1's hospital discharge summary dated 1/18/19, revealed R1 had been hospitalized from 1/9/19, to 1/18/19, with the following diagnoses; pneumonia, sepsis (systemic blood infection) . The discharge summary revealed R1 was discharged from the hospital with hospice services for end of life cares. Review of R1's hospice admission note dated 1/18/19, revealed R1 had returned to the facility with hospice end of life services with a primary diagnosis of aspiration pneumonia with sepsis. The note revealed the hospice nurse had collaborated with the hospice physician regarding R1's hospitalization, diagnoses, progression of decline and medicaiton management. The note revealed R1 was totally dependent on facility staff for all ADL's and identified R1 had four pressure wounds and had shown little evidence of healing while he was hospitalized. The admission note identified R1 had a partial thickness loss pressure ulcer on his coccyx, a pressure ulcer with eschar on his left heel, a pressure ulcer with eschar on his right lateral ankle and a pressure ulcer with posterior left ear with red, pink, dry wound bed. The note did not indicate any type of	F 684	the potential to be affected by this deficient practice. Upon review, two resident recently resides at facility with hospice services. The resident's plan of care was reviewed and revised. The current agreement between hospice and facility was reviewed. Policies entitled Hospice Program, Palliative Care and Palliative Care End of Life Care – CP were reviewed and updated by IDT team. A meeting was held with Red River Valley hospice and facility IDT team on March 27th to review R1 and concerns regarding his care, identified opportunities to improve coordination of care for present resident and implemented processes to ensure proper coordination of care. Monthly meetings were planned as follow up to assure ongoing compliance with coordination of care. 3. On March 25, 2019 the MDS coordinator was educated on the need for a significant change MDS with all new hospice admissions. On March 27, 2019 an in-service education was provided to all nursing and HIM personnel which reviewed updated policies, procedures and ensuring proper coordination of care. In service education was provided by lecture, handouts, question and answer session and ongoing education as identified. 4.Weekly audits completed by DON/Designee on all hospice residents, including their electronic and paper charts to ensure proper coordination and communication of care. Findings reviewed, and upon identification of a	

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F 684	Continued From page 3 repositioning plan for R1. However, the hospice admission note revealed R1 had bilateral Prevalon boots (specialized pressure relieving boots) which were to be worn at all times. Review of R1's progress notes from 1/18/19, to 1/20/19, revealed the following; - 1/19/19, revealed a hospice nurse was in to review R1's orders and to check on him. The note revealed an assessment showed no changes from his original admission. The note lacked any indication of R1's skin condition upon return from the hospital. - 1/20/19, revealed R1 had passed away at 7:00 p.m. A later note revealed hospice had been notified of R1's death. R1's medical record lacked any documentation of his return to the facility on 1/18/19. R1's medical record lacked any documentation of his cognition, body systems, skin condition or any other information of his prognosis upon his return to the facility on 1/18/19. . During an interview on 2/28/19, at 2:04 p.m. the facility director of nursing (DON) stated R1 had a hospice referral at the hospital prior to his return to the facility on 1/18/19. The DON stated she believed R1's hospice nurse had come to the facility on 1/18/19, family had signed hospice admission orders and would complete an initial assessment. She indicated she had not been present in the facility when R1 had returned from the hospital. The DON confirmed R1's medical record lacked any documentation of R1's hospice nurses initial visit and was unaware of any	F 684	deficient practice, immediate education and appropriate interventions will be implemented and an ad hoc initiated to further dictate appropriate monitoring. Findings will be brought to monthly QAPI for continued IDT review and recommendation for continued ongoing monitoring to assure ongoing compliance. DON is responsible to monitor.	

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F 684	Continued From page 4	F 684		

coordination of care between the hospice nurse and the facility staff. Further, the DON confirmed the facility was not aware of the presence of multiple pressure ulcers for R1 and she was unaware R1's hospice nurse had been aware of R1's pressure ulcers.

During a telephone interview on 2/28/19, at 2:43 p.m. the registered nurse, primary case manager for hospice (RN-A) confirmed R1 had been admitted to hospice for end of life cares on 1/18/19, following his hospitalization. The RN-A indicated the hospice RN had reviewed the paperwork sent from the hospital and was aware R1 had four pressure ulcers. She indicated she was unaware of the hospice RN had communicated to the facilty staff regarding the presence of the pressure ulcers and was unsure if any coordination of R1's care had been discussed with the facility nursing staff. She stated hospice staff relied on hospital records and/or verbal reports from facility staff for resident information as they do not have access to the facility's electronic medical record system.

During a group interview with the DON and facility administrator on 2/28/19, at 3:52 p.m. the administrator stated the facility had been working on improving coordination of care with their hospice providers since November 2018. The administrator stated they were unaware of any coordination for R1's care with hospice staff and the facility had not received R1's hospice admission note prior to R1's death and had not obtained his hospice admission note following his death. The administrator stated the hospice company used by the facility had full access to residents electronic medical records.

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F 684	Continued From page 5 A facility policy and procedure for coordination of hospice services was not obtained.	F 684		
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 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct a comprehensive skin assessment for the prevention of pressure ulcer development for 1 of 1 resident (R1) who had a history of a recently healed pressure ulcer and who developed multiple pressure ulcers in the facility. This deficient practice caused R1 actual harm when he developed four pressure ulcers; three unstageable (Unstageable ulcer related to slough or eschar: wound bed cannot be visualized due to the presence of slough or eschar (eschar tissue; dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the	F 686	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of Moorhead Rehabilitation and Healthcare Center that the Director of Nursing or designee ensures, based on the comprehensive resident assessment, proper coordination and development of the nursing care	4/5/19

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F 686	Continued From page 6 sides/edges of the wound), and one deep tissue injury. The facilty failed to identify and implement appropriate interventions for R1 during his initial stay in the facility and when R1 returned to the facility post hospitalization with 2 unstageable pressure ulcers,1 stage 2 pressure ulcer and 1 deep tissue injury. Findings include: Review of R1's admission Minimum Data Set (MDS) assessment dated 11/5/18, identified R1 had moderate cognitive impairment and diagnoses which included; cerebral vascular accident (CVA, otherwise referred to as a stroke,) hemiplegia (one sided paralysis), dementia and personality disorder. The MDS identified R1 required extensive assistance from two facility staff for activities of daily living (ADL's), which included bed mobility, dressing, bathing and toileting. The MDS identified R1 was dependent on two facility staff for transfers and had limited functional range of motion on one side of his upper and lower extremities. The MDS identified R1 had no behaviors, or rejection of care since his admission. The MDS identified R1 was at risk for pressure ulcer development and did not have any pressure ulcers at the time of the MDS. Further, the MDS identified R1 had pressure ulcer interventions in place which included; pressure relieving devices for his bed and chair. Review of R1's admission Care Area Assessment (CAA's) dated 11/5/18, identified R1 had diagnoses of vascular dementia with behavioral disturbance, anxiety disorder, major depressive disorder, personality disorder and had moderate cognitive impairment. The CAA identified R1 was	F 686	plan. Furthermore, this includes residents who enter the nursing home without pressure sores, that they do not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and that a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from development. R1 had sustained actual harm when facility failed to identify and implement appropriate interventions during his initial stay at the facility. In addition; R1 returned to the facility post hospitalization with multiple pressure ulcers. R1 expired on January 20th, 2019. 2. Residents who are admitted or readmitted to the facility have the potential to be affected in this area. The facility has implemented a new admission check list that has a list of tasks related to the identification and management of skin/wound issues. This check list includes entering into PCC under the User Defined Assessments (UDA) for skin inspections, Braden's, orders are attained for wound management, updating of the CNA care sheets, bath sheets. When new skin alterations are identified, they are entered into the UDA Assessment and reassessed weekly by a licensed staff until resolved. In addition, UDA will notify licensed staff of ongoing routine assessments, per significant change, quarterly and annual assessments. The IDT team monitors the UDA completion	

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F 686	Continued From page 7 able to use his call light, make his needs known, however, was at risk for potential harm due to his cognitive loss and indicated R1 was at risk of not remembering care that was provided or needed. The CAA's identified R1 required extensive assistance of two staff with bed mobility and had left sided flaccid hemiplegia which decreased his mobility, leading to pressure ulcer formation. Further, the CAA revealed R1 had no current pressure ulcers, was at low risk for developing pressure ulcers and had a pressure reducing mattress and cushion in his wheelchair. Review of R1's discharge return anticipated MDS dated 1/9/19, identified R1 had an unplanned discharge to an acute hospital and identified had no pressure ulcers at the time of his unplanned discharge to the acute hospital. Further, the MDS identified R1 had no rejection of cares and had no behaviors. Review of R1's care plan, revised 11/9/18, revealed R1 had limited mobility and required extensive assistance with ADL's. R1' care plan revealed R1's skin should be checked weekly and required routine repositioning every two hours, follow facility policies/procedures for the prevention/treatment of skin breakdown, inform the resident/family/caregivers of any new areas of skin breakdown, monitor/document/report as needed any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size, stage, and use of pressure relieving/reducing device in bed/chair. Review of R1's Braden Scale for Predicting Pressure Sore Risk form, dated 10/31/18, identified R1 had a problem with very moist	F 686	and scheduled assessments each morning during clinical review to assure compliance. The facility has also implemented a new nurse to nurse communication tool for hospital discharge report. 3. System change; implementation of new Admission Checklist, New nurse to nurse hospital discharge report tool. All licensed staff have been educated on this process and it has been included on the facility's competency checklist for licensed staff during initial orientation. In-service education for all nursing personnel was provided by the Director of Nursing and Regional Director of Clinical Services on March 27, 2019. This included re-education to staff on the updated policies and procedures including wound Care, Pressure Ulcer Risk Assessment, Pressure Ulcer Treatment, Prevention of Pressure Ulcers, Pressure Ulcer Skin Breakdown CP and Repositioning. In-service education was provided by lecture, handouts, question and answer session and ongoing education as identified. 4. Weekly audits completed by DON/Designee on all new admissions and readmissions, and 2 at risk residents per week in the following areas; compressive skin assessment on admission or readmission, care plan initiated on admit or readmission, weekly skin inspections, User Defined Assessments competed, weekly wound measurements, if wound not progressing X 14 days or shows signs of deterioration	

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F 686	Continued From page 8 skin,was chairfast, had slightly limited mobility, probable inadequate nutrition, and had a potential problem with friction and shear and identified R1 was at low risk for developing pressure ulcers. No further Braden's Scale forms or comprehensive skin assessments were found in R1's medical record. Review of R1's hospital history and physical dated 1/9/19, identified R1 presented to the emergency department with shortness of breath, had severe sepsis, right lower lobe pneumonia likely aspiration and was admitted to the hospital for antibiotic treatment. Review of R1's hospital certified wound and ostomy registered nurse (CWON) progress notes from 1/10/19, to 1/18/19, revealed the following: -deep tissue injury on R1's left midline, right sacrum, coccyx, which had been present upon admission to the hospital on 1/9/19. R1's deep tissue pressure injury measured 4 centimeters (cm) with an open area on the gluteal cleft which measured 0.5 cm The wound assessment indicated R1's sacral ulcer was consistent with a progressing deep tissue injury and indicated R1 had serosanguinous drainage from the pressure ulcer. Further, the assessment indicated a border dressing had been applied to R1's sacral deep tissue injury. The notes indicated on 1/14/19, deep tissue pressure injury had partial thickness skin loss pressure ulcer on his left midline, right sacrum/coccyx and had a small amount of serosanguinous drainage (watery pink) and was left open to air. On 1/17/19, deep tissue pressure	F 686	the PCP and responsible party will be updated. Ongoing monitoring of findings reviewed; upon identification of a deficient practice, immediate education and appropriate interventions will be implemented and an ad hoc initiated to further dictate appropriate monitoring. Findings brought to monthly QAPI as a PIP for continued IDT review and recommendations for continued monitoring to assure ongoing compliance.	

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F 686	Continued From page 9 injury of his sacrum/coccyx was pink, red and had partial thickness loss. - unstageable pressure ulcer on R1's left heel, which was present upon admission to the hospital on 1/9/19. R1's unstageable pressure ulcers measured 1.8 cm by 3 cm and was covered with black, eschar. The assessment revealed R1's left heel unstageable pressure ulcer was left open to air. On 1/14/19, the unstageable left heel pressure ulcer measured 1.8 cm by 2.4 cm and was covered with black eschar. On 1/17/19, unstageable left heel pressure ulcer was covered with dry eschar tissue. -an unstageable pressure ulcer on R1's right lateral ankle, which was present upon admission to the hospital on 1/9/19. R1's unstageable pressure ulcer measured 0.6 cm by 0.4 cm and was covered with black, eschar. The assessment revealed R1's right lateral ankle unstageable pressure ulcer was left open to air. On 1/14/19, unstageable right lateral ankle pressure ulcer measured 0.5 cm by 0.5 cm and was covered with black eschar. On 1/17/19, unstageable right lateral ankle pressure ulcer was covered with dry eschar tissue. -an unstageable pressure ulcer on R1's left posterior ear, which was present upon admission to the hospital on 1/9/19. R1's unstageable pressure ulcer measured 0.4 cm by 0.3 cm and was covered with black eschar tissue. The assessment revealed R1's unstageable pressure ulcer was likely from oxygen nasal cannula tubing. The assessment revealed R1 would have foam tubing protectors when he used a nasal	F 686		

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cannula and indicated to use oxygen mask versus nasal cannula tubing. On 1/14/19, unstageable left posterior ear pressure ulcer measured 0.4 cm by 0.3 cm and was covered with black, dry eschar. On 1/17/19, unstageable left posterior ear had dark red, dry pink wound bed.

-On 1/10/19, the notes indicated R1 had been on an every two hour side to side repositioning, had a specialized pressure relieving mattress and his heels were floated with pillows under his calves. The note indicated R1 would have Prevalon boots (specialized pressure relieving boots used to aid in healing pressure ulcers,) and to limit time on his back and limit his head of bed elevation greater than 30 degrees.

-On 1/14/19, the notes indicated R1 remained on a pressure relieving mattress, every two hour repositioning and continued to have his heels floated. The note indicated R1 was difficult to turn and did not move himself in bed and Prevalon heel protectors (specialized pressure relieving boots) in place.

-On 1/17/19, the notes indicated R1 continued to use a pressure relieving air mattress, bilateral lower extremity floating with heel protectors and continued to exhibit erythema (purplish red hue of the skin indicating injury or breakdown) and breakdown to his sacrum.

Review of a hospital Interagency Referral Form dated 1/18/19, and faxed to the facility on 1/18/19, at 1:14 p.m., identified R1 had been admitted to the hospital on 1/9/19, and had active problems of pneumonia due to infectious

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F 686	Continued From page 11 organism, severe sepsis, acute on chronic respiratory failure with hypoxemia and aspiration pneumonia. The interagency referral form indicated R1 had active skin wounds upon admission to the hospital, identified on right sacrum/coccyx, wound left heel, right lateral ankle and left posterior ear. The form identified the aforementioned wounds remained active at the time of R1's discharge. Review of R1's facility progress notes from 10/24/18, to 1/20/19, revealed the following; -10/24/18, R1 was admitted to the facility from another long term care skilled nursing facility and was alert, oriented and was able to make his needs known. The note revealed R1 required the use of a full body mechanical lift for transfers, had left sided weakness and had a 1.0 cm by 2.0 cm scab on his right shin, small reddened area on his groin. -10/25/18, R1's legs had been placed on a pillow to float his heels and was cooperative with cares. -10/26/18, had an order for a heel cup to his left heel for comfort and would be applied when available. -11/5/18, R1 had been in bed since the morning and refused to get up after encouraged several times. The note lacked any information of R1's repositioning. -11/7/18, R1 had displayed agitation towards facility night shift nursing assistants (NA) and had later refused to get out of bed. The note lacked documentation of R1's repositioning and any	F 686		

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F 686	Continued From page 12 education provided for the risks and benefits of offloading. -11/11/18, visual hallucinations of a baby bath floating in his room. No further documentation of refusal of cares, repositioning or R1's skin condition. -11/18/18, R1 had received a shower and had been verbally aggressive towards an NA. However, the note lacked any information of R1's skin condition. -11/24/18, refused to get dressed and out of bed. The note did not address R1's repositioning or education provided as to the risks and benefits of offloading. -11/26/18, refused a weekly skin check three times however, did not address education provided for the risks and benefits of offloading or information of R1's repositioning. -12/26/18, skin by his left ear was red, swollen and appeared painful and provider would come to the facility to assess R1's ear. -12/31/18, revealed R1's ear swelling and redness had minimized greatly. -1/9/19, not feeling well, had a temperature of 100.4 degrees Fahrenheit, elevated heart rate, abnormal lung sounds and was sent by ambulance to the hospital. -1/20/19, R1 passed away at 7:00 p.m. R1 returned from the hospital on 1/18/19,	F 686		

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however, his medical record lacked documentation of date or details of his return to the facility.

R1's medical record did not identify the development of R1's multiple pressure ulcers and lacked a comprehensive skin assessment, throughout his entire stay in the facility, prior to and upon return, from the hospital.

During an interview on 2/28/19, at 9:10 a.m. NA-E indicated she felt R1 was alert, oriented and able to make his own decisions. NA-E stated R1 had required extensive assistance with ADL's and required every two hour repositioning. NA-E indicated R1 would frequently refuse cares and was oftentimes combative whenever cares were offered. NA-E stated she was unaware if R1 had any pressure ulcer before his hospitalization or upon his return to the facility.

During an interview on 2/28/19, at 9:20 a.m. NA-A stated R1 had required assistance with his cares, though would refuse cares on a daily basis. NA-A stated she felt R1 was alert, knew what he wanted and was able to make his own decisions. NA-A stated she felt R1 would refuse cares from staff he did not like and felt he needed a lot of encouragement to allow cares. NA-A stated she felt R1 would allow cares, bathing approximately once every few weeks and repositioning approximately once a shift. NA-A stated R1 required routine assistance with repositioning, about every two hours and stated she was unaware of any pressure ulcers before or after R1's hospitalization. NA-A further indicated he had a cushion in his wheelchair and could not recall a specialized pressure relieving

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F 686	Continued From page 14 mattress or any other pressure relieving interventions used. During an interview on 2/28/19, at 10:10 a.m. licensed practical nurse (LPN)-D stated she felt R1 was verbally abusive towards facility staff and would routinely refuse cares, meals and would want to stay in his room throughout her shift. LPN-D stated she could not recall ever completing a skin check on R1 and indicated he would routinely refuse his baths. LPN-D indicated she was not aware if R1 had any pressure ulcers before he left and when he returned from the hospital. Further, LPN-D stated she did not recall R1 having had a pressure relieving mattress or any other specialized pressure relieving devices, such as Prevalon boots prior to or after his hospitalization. During an interview on 2/28/19, at 10:53 a.m. NA-E stated R1 would routinely refuse cares, yell, swear at staff and would put up his hands and attempt to block her from assisting him with cares. However, NA-E indicated she felt if R1 was approached a certain way, he would be more apt to comply with cares. NA-E stated she could not recall R1 ever having any pressure ulcers before or after his hospitalization in January. During an interview on 2/28/19, at 11:42 a.m. trained medication aid (TMA)-A indicated R1 was compliant with cares when he was approached the "right way." TMA-A stated she felt was able to make his wishes known and indicated there were times when R1 was confused. She indicated R1 was on a routine repositioning plan of every two hours and as needed. TMA-A stated R1's skin	F 686		

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F 686	Continued From page 15 was intact the last time she had observed his skin. TMA-A indicated she did not think R1 had specialized pressure relieving devices, such as Prevalon boots. Further, she stated R1 utilized a standard mattress and wheelchair cushion in place prior to his hospitalization in January. Review of R1's weekly skin checks forms from 11/4/18, to 1/6/19, revealed the following; -11/4/18, skin intact. -11/25/18, skin intact. -12/2/18, skin intact. -12/16/18, skin intact. -12/30/18, open area above his left ear, secondary to cellulitis, small scab on left shin and small bruise on the top of his left foot. -1/6/19, skin intact. R1's medical record lacked further documentation of ongoing monitoring of R1's skin condition. During an interview on 2/28/19, at 1:00 p.m. LPN-E stated R1 often refused any assistance, which included repositioning. LPN-E stated she could not recall if she had ever completed a skin check on R1 or had been aware of any pressure ulcers for R1. LPN-E stated she was unaware R1 had a history of pressure ulcer or had developed any pressure ulcers in the facility. During an interview on 2/28/19, at 1:04 p.m. LPN-B stated she had completed R1's skin check on 1/6/19, and had not identified any pressure ulcers. LPN indicated she could not recall R1 ever having had pressure ulcers, and indicated one of R1's heels was mushy at one time, though	F 686		

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she could not recall when. LPN-B stated she had been present when R1 had returned from the hospital with hospice services, and indicated she had not completed a skin check upon his return.

During an interview on 2/28/19, at 3:00 p.m. LPN-C stated he could not recall ever having completed a body skin check on R1, or any skin assessment before or after R1's hospitalization. LPN-C indicated R1 had a small scab on his heel upon his initial admission and had been admitted with an order for a heel cup to be applied for comfort. LPN-C stated he had never applied a heel cup to his heel, because the heel cup was not available in the facility. LPN-C stated he was unaware when R1's heel scab had resolved. LPN-C indicated he had noticed a sore above R1's left ear before he was hospitalized in January and indicated R1's practitioner came to see R1 and had ordered antibiotics for cellulitis. LPN-C stated he thought he had provided education to R1 on the risks and benefits of not allowing staff to provide cares, repositioning, but could not recall whether the education provided to R1 had ever been documented. LPN-C indicated he was unaware whether R1 had any pressure ulcers upon his return from the hospital and indicated he did not think R1 had any pressure ulcers before his hospitalization.

During an interview on 2/28/19, at 3:10 p.m. NA-H stated he could not recall any skin concerns with R1 before or after he had been hospitalized in January. NA-H stated R1 was routinely resistant to cares, was on an every two hour repositioning schedule and indicated R1 would allow assistance with cares, including repositioning approximately once a shift, at best.

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NA-H stated there were times R1 would refuse to let him enter his room and he would notify the nurse. NA-H indicated he could not remember any special pressure relieving devices used for R1.

During an interview on 2/28/19, at 3:24 p.m. NA-I stated R1 refused cares daily, would yell, swear and physically block her from assisting him with any cares, which she would then notify the facility nurses. NA-I stated she felt R1 could have went up to four or so hours without repositioning due to his refusals.

Review of R1's physician orders, signed 1/14/19, revealed an order dated 10/24/18, to apply a heel pad to R1's left heel while supine in bed or in wheelchair, monitor for improvement of heel pain. Another order dated 10/24/18, directed facility staff to monitor R1's left heel, keep pressure off left heel in bed and wheelchair with pillows, discontinue when resolved.

Review of R1's monthly Treatment Administration Record (TAR) from October 2018, through January 2019, listed the following treatment orders consistently documented as completed each shift:

-Heel Pad: apply to left heel while supine in bed or in wheelchair, every shift. Start date of 10/24/18

-Monitor left heel, keep pressure off left heel in bed and in wheelchair with pillows, discontinue when resolved, every shift. Start date of 10/24/18

-Right heel: float heel when in bed so it does not

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(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	Continued From page 18 touch bed, every shift. Start date of 10/24/18 During a group interview on 2/28/19 at 3:52 p.m., including the DON, facility administrator and consultant, R1's medical record was reviewed. The DON, administrator and consultant confirmed R1's medical record lacked a comprehensive assessment of R1's skin throughout the duration of his stay at the facility, from 10/24/18, to 1/9/19 and from 1/18/19, to 1/20/19. At that time, they confirmed the hospital certified wound and ostomy documentation had identified R1 had four pressure ulcers upon admission to the hospital from the facility on 1/9/19. The administrator confirmed R1's TAR had indicated R1 had been received pressure relieving interventions consistently, however, he stated he felt the facility staff were "documenting just to document." The administrator indicated the facility had been unaware R1 had any pressure ulcers, or history of pressure ulcers. The DON, administrator and consultant confirmed R1's medical record had several routine skin checks during his stay, which had indicated R1's skin was intact. The administrator stated he expected all residents which resided in the facility were to have a complete head to toe assessment to determine skin condition. During a telephone interview on 3/1/19, at 1:47 p.m. R1's hospital physician (MD)-A, stated R1 had presented to the hospital's emergency department (ED) and was subsequently admitted to the hospital with aspiration pneumonia, sepsis and hypoxemia. MD-A stated she felt R1 was in terrible condition when he was brought to the hospital as he had significant bruising throughout his body and four pressure ulcers upon	F 686		

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	245052	A. BUILDING _____ B. WING _____	C 03/05/2019

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F 686	Continued From page 19	F 686		

admission on 1/9/19. MD-A stated she felt as though R1's bruising was likely from staff not being careful when working with him as his bruising was on his arms, back, buttocks and legs. She stated R1 would be completely dependent on staff for all of his cares due to his hemiplegia which had affected his left side. MD-A stated R1's pressure ulcers were assessed and managed by the hospital's wound team which had certified wound and ostomy nurses. MD-A stated she had discussed R1's current condition, terminal prognosis with R1's family members, and stated they had been unable to find other placement for R1, therefore she had discharged R1 back to the facility with hospice end of life services. MD-A stated she felt R1's pressure ulcers were avoidable, had he received appropriate pressure relieving interventions such as off loading his heels, routine repositioning, applying a foam protector on R1's oxygen tubing and routine monitoring of his skin. MD-A stated R1 continued to have pressure ulcers upon discharge.

During a telephone interview on 3/4/19, at 3:49 p.m. the hospital's certified wound and ostomy nurse (CWON)-A confirmed R1 had been admitted to the hospital on 1/9/19 with four pressure ulcers. CWON-A stated she had completed an assessment of R1's pressure ulcers on the morning of 1/10/19. CWON-A confirmed R1 had the following pressure ulcers:

-deep tissue pressure injury of his sacrum/coccyx area, was deep purple in color and did not present as a typical "Kennedy ulcer" (type of ulcer often presents in the shape of a pear or butterfly on the buttocks of those close to death.)

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F 686	Continued From page 20 She stated she was not certain when R1 developed the deep tissue injury, but felt deep tissue pressure injury could have occurred within the last 48-72 hours. CWON-A stated during his hospitalization R1 was routinely turned side to side and had been placed on an air alternating pressure relieving mattress. She stated R1's sacral deep tissue pressure injury had began to improve prior to his discharge from the hospital, though would have expected continued pressure relieving interventions to be implemented. -an unstageable pressure ulcer of his left heel upon admission to the hospital, measured 1.8 cm by 3.0 cm on 1/10/19, and was covered with a thick eschar. CWON-A stated she felt R1's left heel ulcer had been there "long term" due to the extensive eschar which covered the wound bed. She stated R1's left heel was measured again on 1/14/19, and measured 1.8 cm by 2.8 cm and continued to be covered with thick, black eschar. CWON stated she felt heel ulcers were completely avoidable with offloading interventions. The CWON-A stated R1 had Prevalon boots on while he was hospitalized and his heel ulcer remained stable upon discharge. She stated she would have expected pressure relieving interventions to be implemented when he returned to the facility. Further, CWON-A stated R1's unstageable heel pressure ulcer was on his affected side (paralyzed) which significantly increased his risk for developing a pressure ulcer. -an unstageable pressure ulcer of his right medial malleolus (ankle bone) upon admission to the hospital, measured 0.6 cm by 0.4 cm and was covered with hard, black eschar tissue. She	F 686		

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F 686	Continued From page 21 indicated she also felt this pressure ulcer was avoidable as it was an area which was easily offloaded. The CWON-A stated she felt R1's unstageable pressure ulcer had also been there for "a while" and indicated he had the unstageable pressure ulcer upon discharge. -an unstageable pressure ulcer of his posterior left ear, which she felt was a "classic example" of a pressure ulcer related to the tubing of a nasal cannula that had been used at the facility. The CWON-A stated, while R1 had been hospitalized he had used a face mask for oxygen delivery. She stated R1's unstageable posterior had been present upon admission and at discharge, though had improved and was able to be staged at a two (partial loss of skin thickness.) CWON-A stated she would have expected pressure relieving interventions to be in place upon R1's hospital discharge on 1/18/19. She stated she had not ordered any specific treatments upon R1's discharge as he was not receiving any dressing changes, and felt nursing interventions of off-loading would have been sufficient. Review of R1's physician notes from 10/23/18 to 12/26/18 revealed the following: -10/23/18, R1 had transferred from another nursing home, with diagnoses which included stroke with left sided hemiparesis, multiple subacute cerebral infarctions and dysphagia (difficulty swallowing). The note revealed R1 had a history of left heel friction blister/unstageable wound that had recently resolved within the last month. Further, the note revealed R1 continued	F 686		

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F 686	Continued From page 22 with an offloading boot on his left heel and lotion twice daily on the left and Broda chair for positioning. -12/26/18, R1 had been seen at the facility for a red, swollen left ear. The note revealed R1 was diagnosed with perichondritis (infection of the outer ear tissue surrounding the cartilage) and had been prescribed an antibiotic and warm moist compresses both for seven days. An undated facility policy titled Pressure Ulcer Treatment, revealed the purpose of the policy was to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers. The policy identified general guidelines for assessment of current pressure ulcers, pressure ulcer care, interventions, treatment and infection control. The policy listed definitions and descriptions of all stages of pressure ulcers, interventions and care strategies, documentation and reporting to supervisor any worsening a pressure ulcer or refusals of interventions. The policy directed facility staff to provide ongoing assessment, monitoring and implement interventions and analyze interventions in order to aid in the healing of active pressure ulcers to prevent the worsening and/or new development of pressure ulcers.	F 686		

Electronically Delivered

March 22, 2019

Administrator
Moorhead Rehabilitation & Healthcare Center
2810 Second Avenue North
Moorhead, MN 56560

Re: State Nursing Home Licensing Orders - Complaint Number H5052071, H5052081C, H5052082C and H5052083C

Dear Administrator:

A complaint investigation was completed on March 5, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following investigator's findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00938	A. BUILDING: _____ B. WING _____	03/05/2019

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On February 27, 28, 2019, and March 1, 4, 5, 2019, an abbreviated survey was conducted to determine compliance for state licensure. The following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be substantiated: H5052081C Correction orders issued at MN Rule 4658.0520 subp.1 and MN Rule 4685.0525 subp.3 The following complaints were not found to be substantiated: H5052071 was found to be in compliance at the time of the survey. H5052082C was found to be in compliance at the time of the survey. H5052083C was found to be in compliance at the time of the survey. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		4/5/19

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2 830	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure coordination of care with hospice services for 1 of 1 resident (R1) with multiple pressure ulcers and had been admitted to hospice services following an acute hospitalization. Findings include: Review of R1's Review of R1's admission Minimum Data Set (MDS) dated 11/5/18, identified R1 had moderate cognitive impairment and had diagnoses which included; cerebral vascular accident (CVA), (stroke,) hemiplegia (one sided paralysis) dementia and personality disorder. The MDS identified R1 required extensive assistance from two facility staff for activities of daily living (ADL's), which included bed mobility, dressing, bathing and toileting. The MDS identified R1 had no terminal diagnosis and had not received hospice services. Review of R1's discharge return anticipated MDS dated 1/9/19, identified R1 had an unplanned discharge to an acute hospital. The MDS identified R1 required extensive assistance with ADL's and had no pressure ulcers at the time of his unplanned discharge to the acute hospital. The MDS identified R1 had no rejection of cares and had no behaviors. The MDS revealed R1 had no terminal diagnoses and had not received hospice services. Review of R1's care plan revised 11/9/18,	2 830	corrected	

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2 830	Continued From page 3 revealed R1 required extensive assistance with ADL's, which included routine repositioning every two hours. R1's care plan lacked any revision following his return from the hospital in January and did not identify R1 had a terminal prognosis and was receiving hospice services. Review of R1's hospital discharge summary dated 1/18/19, revealed R1 had been hospitalized from 1/9/19, to 1/18/19, with the following diagnoses; pneumonia, sepsis (systemic blood infection) . The discharge summary revealed R1 was discharged from the hospital with hospice services for end of life cares. Review of R1's hospice admission note dated 1/18/19, revealed R1 had returned to the facility with hospice end of life services with a primary diagnosis of aspiration pneumonia with sepsis. The note revealed the hospice nurse had collaborated with the hospice physician regarding R1's hospitalization, diagnoses, progression of decline and medicaiton management. The note revealed R1 was totally dependent on facility staff for all ADL's and identified R1 had four pressure wounds and had shown little evidence of healing while he was hospitalized. The admission note identified R1 had a partial thickness loss pressure ulcer on his coccyx, a pressure ulcer with eschar on his left heel, a pressure ulcer with eschar on his right lateral ankle and a pressure ulcer with posterior left ear with red, pink, dry wound bed. The note did not indicate any type of repositioning plan for R1. However, the hospice admission note revealed R1 had bilateral Prevalon boots (specialized pressure relieving boots) which were to be worn at all times.	2 830		

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2 830	Continued From page 4 Review of R1's progress notes from 1/18/19, to 1/20/19, revealed the following; - 1/19/19, revealed a hospice nurse was in to review R1's orders and to check on him. The note revealed an assessment showed no changes from his original admission. The note lacked any indication of R1's skin condition upon return from the hospital. - 1/20/19, revealed R1 had passed away at 7:00 p.m. A later note revealed hospice had been notified of R1's death. R1's medical record lacked any documentation of his return to the facility on 1/18/19. R1's medical record lacked any documentation of his cognition, body systems, skin condition or any other information of his prognosis upon his return to the facility on 1/18/19. . During an interview on 2/28/19, at 2:04 p.m. the facility director of nursing (DON) stated R1 had a hospice referral at the hospital prior to his return to the facility on 1/18/19. The DON stated she believed R1's hospice nurse had come to the facility on 1/18/19, family had signed hospice admission orders and would complete an initial assessment. She indicated she had not been present in the facility when R1 had returned from the hospital. The DON confirmed R1's medical record lacked any documentation of R1's hospice nurses initial visit and was unaware of any coordination of care between the hospice nurse and the facility staff. Further, the DON confirmed the facility was not aware of the presence of multiple pressure ulcers for R1 and she was unaware R1's hospice nurse had been aware of R1's pressure ulcers.	2 830		

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2 830	Continued From page 5 During a telephone interview on 2/28/19, at 2:43 p.m. the registered nurse, primary case manager for hospice (RN-A) confirmed R1 had been admitted to hospice for end of life cares on 1/18/19, following his hospitalization. The RN-A indicated the hospice RN had reviewed the paperwork sent from the hospital and was aware R1 had four pressure ulcers. She indicated she was unaware of the hospice RN had communicated to the facilty staff regarding the presence of the pressure ulcers and was unsure if any coordination of R1's care had been discussed with the facility nursing staff. She stated hospice staff relied on hospital records and/or verbal reports from facility staff for resident information as they do not have access to the facility's electronic medical record system. During a group interview with the DON and facility administrator on 2/28/19, at 3:52 p.m. the administrator stated the facility had been working on improving coordination of care with their hospice providers since November 2018. The administrator stated they were unaware of any coordination for R1's care with hospice staff and the facility had not received R1's hospice admission note prior to R1's death and had not obtained his hospice admission note following his death. The administrator stated the hospice company used by the facility had full access to residents electronic medical records. A facility policy and procedure for coordination of hospice services was not obtained. SUGGESTED METHOD OF CORRECTION: The director of nursing could develop policies and procedures related to development of plan of	2 830		

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2 830	Continued From page 6 care for hospice care, educate staff regarding these polices, and audit resident records for compliance to these policies and procedures. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to conduct a comprehensive skin assessment for the prevention of pressure ulcer development for 1 of 1 resident (R1) who had a history of a recently healed pressure ulcer and who developed multiple pressure ulcers in the facility. This deficient practice caused R1 actual harm when he developed four pressure ulcers; three unstageable (Unstageable ulcer related to	2 900	corrected	4/5/19

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2 900	Continued From page 7 slough or eschar: wound bed cannot be visualized due to the presence of slough or eschar (eschar tissue; dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound), and one deep tissue injury. The facilty failed to identify and implement appropriate interventions for R1 during his initial stay in the facility and when R1 returned to the facility post hospitalization with 2 unstageable pressure ulcers,1 stage 2 pressure ulcer and 1 deep tissue injury. Findings include: Review of R1's admission Minimum Data Set (MDS) assessment dated 11/5/18, identified R1 had moderate cognitive impairment and diagnoses which included; cerebral vascular accident (CVA, otherwise referred to as a stroke,) hemiplegia (one sided paralysis), dementia and personality disorder. The MDS identified R1 required extensive assistance from two facility staff for activities of daily living (ADL's), which included bed mobility, dressing, bathing and toileting. The MDS identified R1 was dependent on two facility staff for transfers and had limited functional range of motion on one side of his upper and lower extremities. The MDS identified R1 had no behaviors, or rejection of care since his admission. The MDS identified R1 was at risk for pressure ulcer development and did not have any pressure ulcers at the time of the MDS. Further, the MDS identified R1 had pressure ulcer interventions in place which included; pressure relieving devices for his bed and chair.	2 900		

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2 900	Continued From page 8 Review of R1's admission Care Area Assessment (CAA's) dated 11/5/18, identified R1 had diagnoses of vascular dementia with behavioral disturbance, anxiety disorder, major depressive disorder, personality disorder and had moderate cognitive impairment. The CAA identified R1 was able to use his call light, make his needs known, however, was at risk for potential harm due to his cognitive loss and indicated R1 was at risk of not remembering care that was provided or needed. The CAA's identified R1 required extensive assistance of two staff with bed mobility and had left sided flaccid hemiplegia which decreased his mobility, leading to pressure ulcer formation. Further, the CAA revealed R1 had no current pressure ulcers, was at low risk for developing pressure ulcers and had a pressure reducing mattress and cushion in his wheelchair. Review of R1's discharge return anticipated MDS dated 1/9/19, identified R1 had an unplanned discharge to an acute hospital and identified had no pressure ulcers at the time of his unplanned discharge to the acute hospital. Further, the MDS identified R1 had no rejection of cares and had no behaviors. Review of R1's care plan, revised 11/9/18, revealed R1 had limited mobility and required extensive assistance with ADL's. R1' care plan revealed R1's skin should be checked weekly and required routine repositioning every two hours, follow facility policies/procedures for the prevention/treatment of skin breakdown, inform the resident/family/caregivers of any new areas of skin breakdown, monitor/document/report as needed any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size, stage, and use of pressure	2 900		

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2 900	Continued From page 9 relieving/reducing device in bed/chair. Review of R1's Braden Scale for Predicting Pressure Sore Risk form, dated 10/31/18, identified R1 had a problem with very moist skin,was chairfast, had slightly limited mobility, probable inadequate nutrition, and had a potential problem with friction and shear and identified R1 was at low risk for developing pressure ulcers. No further Braden's Scale forms or comprehensive skin assessments were found in R1's medical record. Review of R1's hospital history and physical dated 1/9/19, identified R1 presented to the emergency department with shortness of breath, had severe sepsis, right lower lobe pneumonia likely aspiration and was admitted to the hospital for antibiotic treatment. Review of R1's hospital certified wound and ostomy registered nurse (CWON) progress notes from 1/10/19, to 1/18/19, revealed the following: -deep tissue injury on R1's left midline, right sacrum, coccyx, which had been present upon admission to the hospital on 1/9/19. R1's deep tissue pressure injury measured 4 centimeters (cm) with an open area on the gluteal cleft which measured 0.5 cm The wound assessment indicated R1's sacral ulcer was consistent with a progressing deep tissue injury and indicated R1 had serosanguinous drainage from the pressure ulcer. Further, the assessment indicated a border dressing had been applied to R1's sacral deep tissue injury. The notes indicated on 1/14/19, deep tissue pressure injury had partial thickness	2 900		

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2 900	Continued From page 10 skin loss pressure ulcer on his left midline, right sacrum/coccyx and had a small amount of serosanguinous drainage (watery pink) and was left open to air. On 1/17/19, deep tissue pressure injury of his sacrum/coccyx was pink, red and had partial thickness loss. - unstageable pressure ulcer on R1's left heel, which was present upon admission to the hospital on 1/9/19. R1's unstageable pressure ulcers measured 1.8 cm by 3 cm and was covered with black, eschar. The assessment revealed R1's left heel unstageable pressure ulcer was left open to air. On 1/14/19, the unstageable left heel pressure ulcer measured 1.8 cm by 2.4 cm and was covered with black eschar. On 1/17/19, unstageable left heel pressure ulcer was covered with dry eschar tissue. -an unstageable pressure ulcer on R1's right lateral ankle, which was present upon admission to the hospital on 1/9/19. R1's unstageable pressure ulcer measured 0.6 cm by 0.4 cm and was covered with black, eschar. The assessment revealed R1's right lateral ankle unstageable pressure ulcer was left open to air. On 1/14/19, unstageable right lateral ankle pressure ulcer measured 0.5 cm by 0.5 cm and was covered with black eschar. On 1/17/19, unstageable right lateral ankle pressure ulcer was covered with dry eschar tissue. -an unstageable pressure ulcer on R1's left posterior ear, which was present upon admission to the hospital on 1/9/19. R1's unstageable pressure ulcer measured 0.4 cm by 0.3 cm and was covered with black eschar tissue. The assessment revealed R1's unstageable pressure	2 900		

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2 900	Continued From page 11 ulcer was likely from oxygen nasal cannula tubing. The assessment revealed R1 would have foam tubing protectors when he used a nasal cannula and indicated to use oxygen mask versus nasal cannula tubing. On 1/14/19, unstageable left posterior ear pressure ulcer measured 0.4 cm by 0.3 cm and was covered with black, dry eschar. On 1/17/19, unstageable left posterior ear had dark red, dry pink wound bed. -On 1/10/19, the notes indicated R1 had been on an every two hour side to side repositioning, had a specialized pressure relieving mattress and his heels were floated with pillows under his calves. The note indicated R1 would have Prevalon boots (specialized pressure relieving boots used to aid in healing pressure ulcers,) and to limit time on his back and limit his head of bed elevation greater than 30 degrees. -On 1/14/19, the notes indicated R1 remained on a pressure relieving mattress, every two hour repositioning and continued to have his heels floated. The note indicated R1 was difficult to turn and did not move himself in bed and Prevalon heel protectors (specialized pressure relieving boots) in place. -On 1/17/19, the notes indicated R1 continued to use a pressure relieving air mattress, bilateral lower extremity floating with heel protectors and continued to exhibit erythema (purplish red hue of the skin indicating injury or breakdown) and breakdown to his sacrum. Review of a hospital Interagency Referral Form dated 1/18/19, and faxed to the facility on 1/18/19, at 1:14 p.m., identified R1 had been	2 900		

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2 900	Continued From page 12 admitted to the hospital on 1/9/19, and had active problems of pneumonia due to infectious organism, severe sepsis, acute on chronic respiratory failure with hypoxemia and aspiration pneumonia. The interagency referral form indicated R1 had active skin wounds upon admission to the hospital, identified on right sacrum/coccyx, wound left heel, right lateral ankle and left posterior ear. The form identified the aforementioned wounds remained active at the time of R1's discharge. Review of R1's facility progress notes from 10/24/18, to 1/20/19, revealed the following; -10/24/18, R1 was admitted to the facility from another long term care skilled nursing facility and was alert, oriented and was able to make his needs known. The note revealed R1 required the use of a full body mechanical lift for transfers, had left sided weakness and had a 1.0 cm by 2.0 cm scab on his right shin, small reddened area on his groin. -10/25/18, R1's legs had been placed on a pillow to float his heels and was cooperative with cares. -10/26/18, had an order for a heel cup to his left heel for comfort and would be applied when available. -11/5/18, R1 had been in bed since the morning and refused to get up after encouraged several times. The note lacked any information of R1's repositioning. -11/7/18, R1 had displayed agitation towards facility night shift nursing assistants (NA) and had later refused to get out of bed. The note lacked	2 900		

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2 900	Continued From page 13 documentation of R1's repositioning and any education provided for the risks and benefits of offloading. -11/11/18, visual hallucinations of a baby bath floating in his room. No further documentation of refusal of cares, repositioning or R1's skin condition. -11/18/18, R1 had received a shower and had been verbally aggressive towards an NA. However, the note lacked any information of R1's skin condition. -11/24/18, refused to get dressed and out of bed. The note did not address R1's repositioning or education provided as to the risks and benefits of offloading. -11/26/18, refused a weekly skin check three times however, did not address education provided for the risks and benefits of offloading or information of R1's repositioning. -12/26/18, skin by his left ear was red, swollen and appeared painful and provider would come to the facility to assess R1's ear. -12/31/18, revealed R1's ear swelling and redness had minimized greatly. -1/9/19, not feeling well, had a temperature of 100.4 degrees Fahrenheit, elevated heart rate, abnormal lung sounds and was sent by ambulance to the hospital. -1/20/19, R1 passed away at 7:00 p.m. R1 returned from the hospital on 1/18/19,	2 900		

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2 900	Continued From page 14 however, his medical record lacked documentation of date or details of his return to the facility. R1's medical record did not identify the development of R1's multiple pressure ulcers and lacked a comprehensive skin assessment, throughout his entire stay in the facility, prior to and upon return, from the hospital. During an interview on 2/28/19, at 9:10 a.m. NA-E indicated she felt R1 was alert, oriented and able to make his own decisions. NA-E stated R1 had required extensive assistance with ADL's and required every two hour repositioning. NA-E indicated R1 would frequently refuse cares and was oftentimes combative whenever cares were offered. NA-E stated she was unaware if R1 had any pressure ulcer before his hospitalization or upon his return to the facility. During an interview on 2/28/19, at 9:20 a.m. NA-A stated R1 had required assistance with his cares, though would refuse cares on a daily basis. NA-A stated she felt R1 was alert, knew what he wanted and was able to make his own decisions. NA-A stated she felt R1 would refuse cares from staff he did not like and felt he needed a lot of encouragement to allow cares. NA-A stated she felt R1 would allow cares, bathing approximately once every few weeks and repositioning approximately once a shift. NA-A stated R1 required routine assistance with repositioning, about every two hours and stated she was unaware of any pressure ulcers before or after R1's hospitalization. NA-A further indicated he had a cushion in his wheelchair and could not recall a specialized pressure relieving mattress or any other pressure relieving	2 900		

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2 900	Continued From page 15 interventions used. During an interview on 2/28/19, at 10:10 a.m. licensed practical nurse (LPN)-D stated she felt R1 was verbally abusive towards facility staff and would routinely refuse cares, meals and would want to stay in his room throughout her shift. LPN-D stated she could not recall ever completing a skin check on R1 and indicated he would routinely refuse his baths. LPN-D indicated she was not aware if R1 had any pressure ulcers before he left and when he returned from the hospital. Further, LPN-D stated she did not recall R1 having had a pressure relieving mattress or any other specialized pressure relieving devices, such as Prevalon boots prior to or after his hospitalization. During an interview on 2/28/19, at 10:53 a.m. NA-E stated R1 would routinely refuse cares, yell, swear at staff and would put up his hands and attempt to block her from assisting him with cares. However, NA-E indicated she felt if R1 was approached a certain way, he would be more apt to comply with cares. NA-E stated she could not recall R1 ever having any pressure ulcers before or after his hospitalization in January. During an interview on 2/28/19, at 11:42 a.m. trained medication aid (TMA)-A indicated R1 was compliant with cares when he was approached the "right way." TMA-A stated she felt was able to make his wishes known and indicated there were times when R1 was confused. She indicated R1 was on a routine repositioning plan of every two hours and as needed. TMA-A stated R1's skin was intact the last time she had observed his skin. TMA-A indicated she did not think R1 had	2 900		

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2 900	Continued From page 16 specialized pressure relieving devices, such as Prevalon boots. Further, she stated R1 utilized a standard mattress and wheelchair cushion in place prior to his hospitalization in January. Review of R1's weekly skin checks forms from 11/4/18, to 1/6/19, revealed the following; -11/4/18, skin intact. -11/25/18, skin intact. -12/2/18, skin intact. -12/16/18, skin intact. -12/30/18, open area above his left ear, secondary to cellulitis, small scab on left shin and small bruise on the top of his left foot. -1/6/19, skin intact. R1's medical record lacked further documentation of ongoing monitoring of R1's skin condition. During an interview on 2/28/19, at 1:00 p.m. LPN-E stated R1 often refused any assistance, which included repositioning. LPN-E stated she could not recall if she had ever completed a skin check on R1 or had been aware of any pressure ulcers for R1. LPN-E stated she was unaware R1 had a history of pressure ulcer or had developed any pressure ulcers in the facility. During an interview on 2/28/19, at 1:04 p.m. LPN-B stated she had completed R1's skin check on 1/6/19, and had not identified any pressure ulcers. LPN indicated she could not recall R1 ever having had pressure ulcers, and indicated one of R1's heels was mushy at one time, though she could not recall when. LPN-B stated she had been present when R1 had returned from the hospital with hospice services, and indicated she	2 900		

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2 900	Continued From page 17 had not completed a skin check upon his return. During an interview on 2/28/19, at 3:00 p.m. LPN-C stated he could not recall ever having completed a body skin check on R1, or any skin assessment before or after R1's hospitalization. LPN-C indicated R1 had a small scab on his heel upon his initial admission and had been admitted with an order for a heel cup to be applied for comfort. LPN-C stated he had never applied a heel cup to his heel, because the heel cup was not available in the facility. LPN-C stated he was unaware when R1's heel scab had resolved. LPN-C indicated he had noticed a sore above R1's left ear before he was hospitalized in January and indicated R1's practitioner came to see R1 and had ordered antibiotics for cellulitis. LPN-C stated he thought he had provided education to R1 on the risks and benefits of not allowing staff to provide cares, repositioning, but could not recall whether the education provided to R1 had ever been documented. LPN-C indicated he was unaware whether R1 had any pressure ulcers upon his return from the hospital and indicated he did not think R1 had any pressure ulcers before his hospitalization. During an interview on 2/28/19, at 3:10 p.m. NA-H stated he could not recall any skin concerns with R1 before or after he had been hospitalized in January. NA-H stated R1 was routinely resistant to cares, was on an every two hour repositioning schedule and indicated R1 would allow assistance with cares, including repositioning approximately once a shift, at best. NA-H stated there were times R1 would refuse to let him enter his room and he would notify the nurse. NA-H indicated he could not remember any special pressure relieving devices used for	2 900		

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2 900	Continued From page 18 R1. During an interview on 2/28/19, at 3:24 p.m. NA-I stated R1 refused cares daily, would yell, swear and physically block her from assisting him with any cares, which she would then notify the facility nurses. NA-I stated she felt R1 could have went up to four or so hours without repositioning due to his refusals. Review of R1's physician orders, signed 1/14/19, revealed an order dated 10/24/18, to apply a heel pad to R1's left heel while supine in bed or in wheelchair, monitor for improvement of heel pain. Another order dated 10/24/18, directed facility staff to monitor R1's left heel, keep pressure off left heel in bed and wheelchair with pillows, discontinue when resolved. Review of R1's monthly Treatment Administration Record (TAR) from October 2018, through January 2019, listed the following treatment orders consistently documented as completed each shift: -Heel Pad: apply to left heel while supine in bed or in wheelchair, every shift. Start date of 10/24/18 -Monitor left heel, keep pressure off left heel in bed and in wheelchair with pillows, discontinue when resolved, every shift. Start date of 10/24/18 -Right heel: float heel when in bed so it does not touch bed, every shift. Start date of 10/24/18 During a group interview on 2/28/19 at 3:52 p.m., including the DON, facility administrator and consultant, R1's medical record was reviewed.	2 900		

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2 900	Continued From page 19 The DON, administrator and consultant confirmed R1's medical record lacked a comprehensive assessment of R1's skin throughout the duration of his stay at the facility, from 10/24/18, to 1/9/19 and from 1/18/19, to 1/20/19. At that time, they confirmed the hospital certified wound and ostomy documentation had identified R1 had four pressure ulcers upon admission to the hospital from the facility on 1/9/19. The administrator confirmed R1's TAR had indicated R1 had been received pressure relieving interventions consistently, however, he stated he felt the facility staff were "documenting just to document." The administrator indicated the facility had been unaware R1 had any pressure ulcers, or history of pressure ulcers. The DON, administrator and consultant confirmed R1's medical record had several routine skin checks during his stay, which had indicated R1's skin was intact. The administrator stated he expected all residents which resided in the facility were to have a complete head to toe assessment to determine skin condition. During a telephone interview on 3/1/19, at 1:47 p.m. R1's hospital physician (MD)-A, stated R1 had presented to the hospital's emergency department (ED) and was subsequently admitted to the hospital with aspiration pneumonia, sepsis and hypoxemia. MD-A stated she felt R1 was in terrible condition when he was brought to the hospital as he had significant bruising throughout his body and four pressure ulcers upon admission on 1/9/19. MD-A stated she felt as though R1's bruising was likely from staff not being careful when working with him as his bruising was on his arms, back, buttocks and legs. She stated R1 would be completely dependent on staff for all of his cares due to his	2 900		

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(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) COMPLETE DATE
2 900	Continued From page 20 hemiplegia which had affected his left side. MD-A stated R1's pressure ulcers were assessed and managed by the hospital's wound team which had certified wound and ostomy nurses. MD-A stated she had discussed R1's current condition, terminal prognosis with R1's family members, and stated they had been unable to find other placement for R1, therefore she had discharged R1 back to the facility with hospice end of life services. MD-A stated she felt R1's pressure ulcers were avoidable, had he received appropriate pressure relieving interventions such as off loading his heels, routine repositioning, applying a foam protector on R1's oxygen tubing and routine monitoring of his skin. MD-A stated R1 continued to have pressure ulcers upon discharge. During a telephone interview on 3/4/19, at 3:49 p.m. the hospital's certified wound and ostomy nurse (CWON)-A confirmed R1 had been admitted to the hospital on 1/9/19 with four pressure ulcers. CWON-A stated she had completed an assessment of R1's pressure ulcers on the morning of 1/10/19. CWON-A confirmed R1 had the following pressure ulcers: -deep tissue pressure injury of his sacrum/coccyx area, was deep purple in color and did not present as a typical "Kennedy ulcer" (type of ulcer often presents in the shape of a pear or butterfly on the buttocks of those close to death.) She stated she was not certain when R1 developed the deep tissue injury, but felt deep tissue pressure injury could have occurred within the last 48-72 hours. CWON-A stated during his hospitalization R1 was routinely turned side to side and had been placed on an air alternating pressure relieving mattress. She stated R1's	2 900		

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	00938	A. BUILDING: _____ B. WING _____	03/05/2019

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2 900	Continued From page 21 sacral deep tissue pressure injury had began to improve prior to his discharge from the hospital, though would have expected continued pressure relieving interventions to be implemented. -an unstageable pressure ulcer of his left heel upon admission to the hospital, measured 1.8 cm by 3.0 cm on 1/10/19, and was covered with a thick eschar. CWON-A stated she felt R1's left heel ulcer had been there "long term" due to the extensive eschar which covered the wound bed. She stated R1's left heel was measured again on 1/14/19, and measured 1.8 cm by 2.8 cm and continued to be covered with thick, black eschar. CWON stated she felt heel ulcers were completely avoidable with offloading interventions. The CWON-A stated R1 had Prevalon boots on while he was hospitalized and his heel ulcer remained stable upon discharge. She stated she would have expected pressure relieving interventions to be implemented when he returned to the facility. Further, CWON-A stated R1's unstageable heel pressure ulcer was on his affected side (paralyzed) which significantly increased his risk for developing a pressure ulcer. -an unstageable pressure ulcer of his right medial malleolus (ankle bone) upon admission to the hospital, measured 0.6 cm by 0.4 cm and was covered with hard, black eschar tissue. She indicated she also felt this pressure ulcer was avoidable as it was an area which was easily offloaded. The CWON-A stated she felt R1's unstageable pressure ulcer had also been there for "a while" and indicated he had the unstageable pressure ulcer upon discharge. -an unstageable pressure ulcer of his posterior	2 900		

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2 900	Continued From page 22 left ear, which she felt was a "classic example" of a pressure ulcer related to the tubing of a nasal cannula that had been used at the facility. The CWON-A stated, while R1 had been hospitalized he had used a face mask for oxygen delivery. She stated R1's unstageable posterior had been present upon admission and at discharge, though had improved and was able to be staged at a two (partial loss of skin thickness.) CWON-A stated she would have expected pressure relieving interventions to be in place upon R1's hospital discharge on 1/18/19. She stated she had not ordered any specific treatments upon R1's discharge as he was not receiving any dressing changes, and felt nursing interventions of off-loading would have been sufficient. Review of R1's physician notes from 10/23/18 to 12/26/18 revealed the following: -10/23/18, R1 had transferred from another nursing home, with diagnoses which included stroke with left sided hemiparesis, multiple subacute cerebral infarctions and dysphagia (difficulty swallowing). The note revealed R1 had a history of left heel friction blister/unstageable wound that had recently resolved within the last month. Further, the note revealed R1 continued with an offloading boot on his left heel and lotion twice daily on the left and Broda chair for positioning. -12/26/18, R1 had been seen at the facility for a red, swollen left ear. The note revealed R1 was diagnosed with perichondritis (infection of the outer ear tissue surrounding the cartilage) and had been prescribed an antibiotic and warm	2 900		

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2 900	Continued From page 23 moist compresses both for seven days. An undated facility policy titled Pressure Ulcer Treatment, revealed the purpose of the policy was to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers. The policy identified general guidelines for assessment of current pressure ulcers, pressure ulcer care, interventions, treatment and infection control. The policy listed definitions and descriptions of all stages of pressure ulcers, interventions and care strategies, documentation and reporting to supervisor any worsening a pressure ulcer or refusals of interventions. The policy directed facility staff to provide ongoing assessment, monitoring and implement interventions and analyze interventions in order to aid in the healing of active pressure ulcers to prevent the worsening and/or new development of pressure ulcers. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents to determine if at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 900		