P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically Delivered via Email
December 2, 2020

Administrator
Saint Anne Extended Healthcare
1347 West Broadway
Winona, MN 55987

RE: CCN: 245233
Cycle Start Date: October 5, 2020

Dear Administrator:

On November 24, 2020, the Minnesota Department(s) of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
October 15, 2020

Administrator
Saint Anne Extended Healthcare
1347 West Broadway
Winona, MN 55987

RE: CCN: 245233
Cycle Start Date: October 5, 2020

Dear Administrator:

On October 5, 2020, a 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.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: 507-206-2727

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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by January 5, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 5, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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

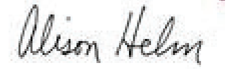
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245233	A. BUILDING ______ B. WING ______	C 10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY WINONA, MN 55987

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F 000	INITIAL COMMENTS On 10/1/20, 10/2/20 and 10/5/20 an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5233023C, with a deficiency cited at F580. 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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 580		11/2/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/19/2020

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

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F 580	Continued From page 1 mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).	F 580		

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F 580	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to notify the physician and/or nurse practitioner of a change in condition when 1 of 3 residents (R1) had a worsening pressure ulcer. Findings include: R1's face sheet included diagnoses of pressure ulcer of the sacral region stage 3, unspecified severe protein-calorie malnutrition, major depressive disorder and unspecified dementia without behavioral disturbance. R1's pressure ulcer care plan included, "I have a pressure injury located on Coccyx. It was present on re-entry from hospital stay." Interventions included, "Assess pressure injury and document any early signs and symptoms of complications. Document progress of pressure injury daily based on event charting. Measure pressure injury on coccyx weekly. Document in Wound Management Tab 2/5/20. Update Provider if no improvement in pressure injury healing within 2 weeks." R1's wound care nurse practitioner note dated 9-15-2020, "Included stage 3 pressure ulcer on coccyx. Co-morbidities- immobility. Tissue Type: granulation. Infection/Inflammation n/a. Moisture balance/Exudate: scant serous. Edging/tunneling: left blank and not answered. Surrounding: Intact. Support: AA [alternating air] mattress ...Wound care: Wound 1 exam: Wound Type Pressure Injury, Wound Stage Stage 3, Location: Left Ischium, Present on admission : Yes, Dimensions Length (cm) 1.5, Width (cm)	F 580	Facility has systems in place to ensure notification of changes in resident condition are reported to physician in a timely manner. (R1) was transferred to the hospital to receive care and is no longer in the facility. Facility policy related to Notification of Changes in Resident Condition will be reviewed with licensed nursing staff and will include instruction related to appropriate notification to physician. Re-education for licensed nursing staff will also include completion of wound management information in electronic medical record. Education will be completed by 11/02/2020. DON or their designee will perform weekly audits to assure wound management tab is complete and accurate per specific resident needs. DON or their designee will run daily Facility Activity Report (FAR) to determine and act on residents with a change in condition and notify MD as necessary. Results of audit findings will be discussed at IDT meetings and at the facility Quality Council meeting. Ongoing frequency and duration to be determined through analysis and review of results.	

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F 580	Continued From page 3 0.6, (cm) 0.2, drainage Serous, Describe consistency Thin, Drainage odor No, Drainage Amount Minimal, Wound Edges Clear and Defined, Periwound scarring NO, Periwound concerns Yes, Appearance Macerated, Granulation Tissue (new vascular tissue in granular form on an ulcer or the healing surface of a wound) Percentage 90 ...Follow Up: 2 Weeks ..." R1's progress notes were reviewed and revealed the following: -9/18/2020, "Dressing changed to pressure wound on coccyx early. No dressing in place found when getting up before lunch. Order calls for Santyl ointment but non available at this time so hydrogel was applied to wound base and covered with Medipore dressing as ordered. Wound bed is 100% slough (necrotic(dead) tissue that needs to be removed from the wound for healing to take place). Periwound intact. No erythema or increase in warmth noted. No odor noted following cleansing of wound. R1 continues on turning and repositioning q [every] 2 hours, has a pressure relieving w/c [wheelchair] cushion, and has an ordered supplement. Wound is also being followed by wound Nurse ..." -9/19/2020, "No coughing heard by this nurse, who has med [medication] cart in hallway by Resident's room. Open area on coccyx region is increasing in size and depth. Wound has a coating of white slough covering area. No odor present. Area cleaned and dressing applied. Area is right on boney area of coccyx. Resident positioned off area when in bed but will get herself back onto her back. Edema down in both	F 580	Director of Nursing or their designee are responsible for monitoring of this plan of correction. Completion Date: 11/02/2020	

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F 580		F 580		

Continued From page 4
lower extremities. Legs elevated on pillows when in bed."

-9/19/2020, "Dressing to coccyx area is dry and intact at this time, will change dressing if area is soiled and update note for appearance of wound."

-9/21/2020, "Turn and repositioning note: R1 is alert with confusion. Able to understand staff and makes self understood. Is unable to make position changes in bed or in wheelchair. Is repositioned every 2 hours and needs to lay down between meals to help with healing of coccyx. HOB [head of bed] raised 30-45 degrees to help with comfort, does not use control on bed by self. Braden score of 13, which indicates she is at moderate risk for skin breakdown. Pillow is use to help relief pressure on coccyx. Has a pressure injury to the coccyx area. Stage is unspecified, measures 0.5x 0.8cm. Resident is incontinent of bowel and bladder, wears an incontinent brief. Current plan is to reposition every 2 hrs [hours] and keep resident off coccyx unless up for meals.

-9/21/2020, "No dressing noted on open area on coccyx. Open area has white slough covering it. Has some depth to it. NO odor present. Area cleaned and another dressing applied."

-9/24/2020, "SW [social worker] sent an e-mail update to family and Ombudsman on this date ...SW [social worker] shared that in regards to R1 wound on her coxxyx {sik}, it is unfortunately worsening. R1 will be seen again next week by the wound care nurse who comes to the facility and we will continue with the treatments he

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F 580	Continued From page 5	F 580		

recommended last week, but we also did some follow up with dietary for promoting the wound healing. At this time, R1 is getting a magic cup (has been getting this)-ice cream with extra protein and also dietary indicated R1 did agree to some further protein additions at meals and at snacks which is good. The Dietician will update her snack sheet for staff to know to offer these items (magic cup at 2pm, mixed nuts at both snacks). Will also give her PB [peanut butter] for her toast at breakfast and cottage cheese with supper every other day ..."

-9/25/2020, "Dressing intact to bottom. Day shift nurse had passed through that he changed the dressing this morning- was also changed last PM [evening]."

-"[Recorded as Late Entry on 10/02/2020 08:22 AM] Skin/Wound 9/25/2020: Coccyx Ulcer: Dressing changed this shift as old one was soiled. Ulcer appearance grey in color and wound bed 100% slough. Undermining noted from 6 O'clock - 9 O'clock. Peri-wound noted to have blanchable erythema and skin is intact. Res. offered no c/o [complaints of] pain while dressing being completed. Toelrated [sik] well. R1 does offer c/o pain while sitting up in her chair for short intervals Treatment: Cleanse with NS . Apply Santyl ointment nickel thick to tissue, Cavilon to peri wound, cover with dressing (island dressing is equivalent to foam coccyx dressing) changed every three days and PRN [as needed]. R1 continues to be turned and repositioned using pillow turning her side to side every two hours, and often times is found back on her coccyx when staff return. R1 remains afebrile."

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F 580	Continued From page 6 -9/26/2020, "This Nurse hasn't see Resident's bottom since 9/21. Since that time area on coccyx region has gone from a white slough covering to a deep necrotic blackened tissue that is draining dark serrous {sik}with surrounding tissue red and inflamed. Q-tip is approximately .7cm depth. Sl.[slight] necrotic odor present. Denied area hurting when treatment was done. Resident has been left in bed and positioned off her bottom from side to side. Appetite has been declining. Wt. [weight] decreasing." -9/27/2020, "Foul odor present on open area on coccyx region. Drainage present covering entire Mepilex dressing. Dressing removed at this time. Red area measures 9 cm. x 7 cm. with open wound in middle. Necrotic, black tissue present inside of wound. Open wound measures 2.5 cm. x 2 cm. with a depth of straight down of 1.5 cm. Noted shelving occurring from noon to 6:00, with a measurement of 2.8 cm inward. Wound is stage 4. Denied having any discomfort during treatment to area. Surrounding tissue cleaned and tx. [treatment] completed as ordered. Resident has been positioned off bottom when in bed. Ceiling Trac {sik} used to lift Resident into her recliner. NO swelling in lower extremities. Tubi grips off at this time." -9/27/2020, "Writer did initital {sik} assessment on resident here to start the shift. Noted resident color to be not her usual. Continues to be very tired. Vitals were recorded. O2 [oxygen] ranged on RA [room air] between 86-88%. Lungs ausculated {sik} and no abnormal lung sounds noted by writer. Resident denied cough or wheezing when asked. Temp [temperature] 100.6	F 580		

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and skin clammy to touch. BP [blood pressure] 98/62 and HR [heart rate] 94. Staff have noted worsening recently to bottom on wound. Writer contacted nurse supervisor with concerns. Writer left a message for family member (FM)-A to call back for update and ok to send to ER [emergency room] for evaluation. Due to no answer writer contacted number 2 contact FM-B who did give verbal ok to send to ER [emergency room] for evaluation."

-9/27/2020, "Resident was sent to ER [emergency room] at 3:50pm via ambulance. At time of transfer O2 [oxygen saturation] has gone up to 94% on the 2L [liters], HR [heart rate] 85 and BP [blood pressure] up to 145/70. General color appearance improved with the O2 [oxygen] usage as well. Still appears very tired. Responding appropriately to staff and ambulance but very flat affect. Writer contacted ER [emergency room] and updated of the recent low grade temp, low O2 [oxygen saturations] this afternoon, lethargy and worsened wound."

R1's medical record (MR) lacked documentation a physician or wound nurse practitioner (WNP) had been made aware of R1's worsening wound.

During an interview on 10/1/20, at 2:09 p.m. licensed practical nurse (LPN)-B stated they are expected to report any changes in report and notify the nurse manager. LPN-B stated changes are documented in the communication book that was reviewed by the nurse manager and alert the director of nursing.

During an interview on 10/1/20, at 2:12 p.m. the

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WNP stated he was anticipating R1's pressure ulcer would get better when he last seen R1 on 9/15/2020. The WNP stated he saw R1 on 8/18/20, 9/1/20, 9/15/20 and stated he was scheduled to see R1 on 9/29/20. The WNP stated, "Absolutely, he would expect to be notified of a worsening pressure ulcer." The WNP stated the facility had not communicated any changes to R1's pressure ulcer to him since 9/15/20 when he last saw R1. The WNP stated when he saw the patient that R1 had slough covering the wound and that was why he issued the santyl ointment to debride that wound. The WNP stated he did want to be notified of any changes of the wound condition and stated he should have been notified in the acute change in wound condition. The WNP stated he would anticipate to be notified because of the risk of infection or spreading the infection to osteomyelitis. The WNP stated he would like to be notified as soon as the wound started to, "go south", we want them to be seen before the infection gets worse, we do not want them to go septic and that is the bottom line. The WNP stated we want them to be seen so they can be started on an antibiotic before the infection gets worse. The WNP stated the risk of the infection turning septic was death and multi-organ dysfunction. The WNP stated we cannot have a patient go septic they should be at the hospital for aggressive management. The WNP stated he expected the facility to monitor for signs of infection based on their training and competence. The WNP stated he did not know R1 had an infection related to the wound.

During an interview on 10/1/2020, 3:21 p.m. LPN-C stated was doing a dressing change as it

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	245233	A. BUILDING ______ B. WING ______	C 10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	**1347 WEST BROADWAY** **WINONA, MN 55987**

(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 580	Continued From page 9 was soiled on 9/26/20. LPN-C stated she had seen the pressure ulcer on 9/21/20 and at that time had a white slough covering on it. LPN-C stated that on 9/26/20, she noticed that the wound was more blackened tissue with a whole in it, so she then measured the depth. LPN-C stated there was a slight necrotic odor at that time that she noticed. LPN-C stated she asked R1 about pain and R1 stated she could not feel anything in her bottom and she could not feel me cleaning and measuring the wound. LPN-C stated this was a change since she had seen it last and stated the last time she had seen it was five days ago. LPN-C stated no she did not notify a provider because we had no provider on board because it was the weekend and stated it just did not happen overnight to this area. LPN-C she did not know when the doctor or nurse practitioner had last seen her bottom and stated she thought the providers would have already been aware of the condition of her bottom. LPN-C stated, "You hear in report that her bottom has gotten worse, however that was not charted." LPN-C stated this just did not happen and she remembered one of the other nurses was saying how bad her bottom got and she thought the doctor had seen it and that was why she did not notify the provider. LPN-C stated she notified the team leader when a resident has a change of condition and stated she thought the team leader knew about R1's bottom and stated she thought she talked to the team leader about her bottom on 9/26/20. LPN-C stated on Sunday R1 had temperature of 100.6 and she notified the RN that followed her and that was when we sent her in to the emergency room. During an interview on 10/1/20, at 2:41 p.m.	F 580		

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F 580	Continued From page 10 register nurse (RN)-A stated any new skin issue was immediately measured and family and/or hospice was updated. RN-A stated if considered non-emergent it was communicated in the communication book and would notify nurse supervisor via email or phone, as she was able to get in contact with physician if necessary. RN-A stated she sent R1 to emergency room on Sunday. RN-A stated resident was tired Friday but she has history of those kind of days. RN-A stated on Sunday she noticed R1 color was not right and she did an immediate assessment. RN-A stated R1 had a temperature, flat affect, low oxygen saturation and she put her on oxygen and called the nurse supervisor and family member (FM)-B because there was no answer from FM-A. RN-A stated R1's oxygen saturation, color, and blood pressure improved on oxygen. RN-A stated when she last saw R1's pressure ulcer, it was white base and seemed stable. RN-A stated the pressure ulcer had history of changing in size. RN-A stated she never seen it necrotic. RN-A stated it was ordered to be changed every 3 days or as needed if soiled. RN-A stated it was reported the wound had started to get necrotic and would have been followed up with the wound nurse this week. RN-A stated the most recent dressing change orders were to use santyl ointment as of 9/22/20. RN-A confirmed there was no documentation of changes of the pressure ulcer in the progress notes from 9/24/20 and 9/25/20. RN-A stated the pressure ulcer was measured weekly and documented. During an interview on 10/1//20, 3:49 p.m. LPN-D stated working as an aide on 9/24/20 when she changed the dressing on R1's wound. LPN-D	F 580		

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F 580	Continued From page 11 stated the wound had been progressively getting worse it had whitish yellow slough and it was opened more. LPN-D stated she did not see any black tissue. LPN-D stated the wound was opened up more and was not as small as it had been previous to that. R1's MR did not include a description of the worsening pressure ulcer from when the LPN completed the dressing change on 9/24/20. During an interview on 10/1/2020, at 3:54 p.m. RN-C stated a provider would have been notified of R1's wound worsening either on Monday (9/28/20) when the physician was at the facility or Tuesday (9/29/20) when either one of nurse practitioners were here. RN-C stated we do not have any providers on call over the weekend, we would wait until Monday or we would have to send them into the ER (emergency room). RN-C stated even at night after hours they have either to go to the ER (emergency room) or wait until the next day when the provider was available. RN-C stated we definitely would have notified the provider, but we sent her in (to the emergency room) on Sunday. RN-C stated it happened so fast over the weekend and stated if R1 was running a temperature, looked like she was septic then yes, R1 should have been sent in, but she did not look like that on Saturday and that is why we sent her in on Sunday. RN-C stated she received a call on Sunday R1's temperature was 100 something, she did not look good, stated her wound was worse and necrotic now and RN-C said to send her in. During a phone interview on 10/2/20, at 11:17 a.m. RN-B stated he completed a dressing change on 9/25/20 due to it being soiled. RN-B	F 580		

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F 580	Continued From page 12	F 580		

indicated he documented the dressing change today as this occurred at shift change and he got busy with report and forgot to chart it prior to leaving and this was his first day back on the unit. RN-B state he had not seen the pressure ulcer in a while but she has had this since admission. RN-B stated the wound itself was grey but not necrotic. RN-B stated the wound bed was covered in slough with peri wound pink, blanchable, and intact. RN-B stated there was a little undermining from 6pm-9 pm. RN-B stated R1 denied pain with treatment. RN-B stated he reported changes to nurse manager and the nurse manager did see the pressure ulcer before he dressed it that day. RN-B stated R1 was afebrile nor had any other symptoms of infection. RN-B stated they would continue to monitor as santyl was used for mechanical debridement so was hoping it would remove the slough. RN-B stated he use to do skin rounds until the wound nurse practitioner started about 3-4 weeks ago. RN-B stated staff are to call the medical director after hours or on weekends if needs can be manageable in house. RN-B stated the medical director would not be able to manage a wound they cannot see especially with slough so it would be followed up during the week if there were no other presenting symptoms of infection. RN-B stated it was expected for staff to complete a progress note for any dressing change whether changes or not.

During an interview on 10/2/20, at 5:04 p.m. the medical director (MD)-A stated she last seen R1 for memory loss and did not see the wound. MD-A stated she was available to be called after hours and on weekends, as she was the medical director. MD-A stated staff start by notifying the

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nurse supervisor and director of nursing first. MD-A stated she was not notified of wound changes Thursday, Friday, or Saturday. MD-A stated R1 was being seen by the wound nurse practitioner. MD-A stated she would expect the staff to send R1 to the emergency room as they did Sunday when R1 presented with unstable vital signs. MD-A stated R1 wound changed over 2-3 days and felt the staff handled the situation appropriately as they monitored the wound, vital signs, and pain. MD-A stated it would have been recommended to continue to monitor until could be seen by the wound care nurse practitioner had R1 vital signs remained stable. MD-A stated the nature of the wound had changed but unstable vital signs indicating infection were not present until Sunday and the staff responded appropriately by sending R1 to the emergency room. MD-A stated unstable vital signs, complaints of pain or increase pain, or other drastic changes would indicate infection and would expect the resident to be seen emergently.

During a phone interview on 10/5/2020, at 3:08 p.m. the director of nursing verified there was no documentation of a provider being notified of changes in R1's pressure ulcer from 9/15/20 when R1 was last seen by the WNP to when R1 was sent into the emergency on 9/27/2020.

The Prevention and Treatment of Skin Breakdown/Pressure Injury policy dated 2018 included, "Weekly the licensed nurse will stage, measure, and examine the wound bed and surrounding skin. If the Wound bed has deteriorated; notify attending provider. Notify the attending provider, resident/resident representative and supervisor if the skin injury

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has not shown progress in 2 weeks and/or is deteriorating unexpectedly. Re-evaluate plan of care as appropriate."

The Change in Condition policy dated 2018 included, "When a significant change in the resident's physical, mental or psychosocial status is identified by the licensed nurse, or when there is a need to alter treatment significantly, the licensed nursing associate consults with the attending provider and notify the resident/resident representative. Procedure Licensed nursing associate: Assess the significant change in the resident's condition noted through direct observation, interview or report from staff. Obtain a set of vital signs and repeat as needed or ordered. Open Matrix Event and conduct a symptom review and assessment, as condition warrants. Notify the attending provider of the change in condition and implement orders for treatment and appropriate monitoring as directed. If unable to contact the physician, contact the Medical Director, as appropriate. Notify the appropriate members of the IDT team. Notify the resident/resident representative. Document symptom(s), assessment, observations, resident/resident representative, and medical provider notification. Monitor and provide treatment as ordered by the attending provider. Update the care plan as appropriate."

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
October 15, 2020

Administrator
Saint Anne Extended Healthcare
1347 West Broadway
Winona, MN 55987

Re: State Nursing Home Licensing Orders
Event ID: WM8N11

Dear Administrator:

The above facility was surveyed on October 1, 2020 through October 5, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Jennifer Kolsrud Brown, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: 507-206-2727

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

Please 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.

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00955	A. BUILDING: ______ B. WING ______	C 10/05/2020

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SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY WINONA, MN 55987

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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 dates 10/1/20, 10/2/20 and 10/5/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date	2 000		

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2 000	Continued From page 1 when they will be completed. The following complaint was found to be SUBSTANTIATED: H5233023C with a licensing order issued at S0265. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265		11/2/20

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2 265	Continued From page 2 D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to notify the physician and/or nurse practitioner of a change in condition when 1 of 3 residents (R1) had a worsening pressure ulcer. Findings include: R1's face sheet included diagnoses of pressure ulcer of the sacral region stage 3, unspecified severe protein-calorie malnutrition, major depressive disorder and unspecified dementia without behavioral disturbance. R1's pressure ulcer care plan included, "I have a pressure injury located on Coccyx. It was present on re-entry from hospital stay." Interventions included, "Assess pressure injury and document any early signs and symptoms of complications. Document progress of pressure injury daily based on event charting. Measure pressure injury on coccyx weekly. Document in Wound Management Tab 2/5/20. Update Provider if no improvement in pressure injury healing within 2 weeks." R1's wound care nurse practitioner note dated 9-15-2020, "Included stage 3 pressure ulcer on coccyx. Co-morbidities- immobility. Tissue Type: granulation. Infection/Inflammation n/a. Moisture	2 265	corrected	

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2 265	Continued From page 3	2 265		

balance/Exudate: scant serous. Edging/tunneling: left blank and not answered. Surrounding: Intact. Support: AA [alternating air] mattress ...Wound care: Wound 1 exam: Wound Type Pressure Injury, Wound Stage Stage 3, Location: Left Ischium, Present on admission : Yes, Dimensions Length (cm) 1.5, Width (cm) 0.6, (cm) 0.2, drainage Serous, Describe consistency Thin, Drainage odor No, Drainage Amount Minimal, Wound Edges Clear and Defined, Periwound scarring NO, Periwound concerns Yes, Appearance Macerated, Granulation Tissue (new vascular tissue in granular form on an ulcer or the healing surface of a wound) Percentage 90 ...Follow Up: 2 Weeks ..."

R1's progress notes were reviewed and revealed the following:

-9/18/2020, "Dressing changed to pressure wound on coccyx early. No dressing in place found when getting up before lunch. Order calls for Santyl ointment but non available at this time so hydrogel was applied to wound base and covered with Medipore dressing as ordered. Wound bed is 100% slough (necrotic(dead) tissue that needs to be removed from the wound for healing to take place). Periwound intact. No erythema or increase in warmth noted. No odor noted following cleansing of wound. R1 continues on turning and repositioning q [every] 2 hours, has a pressure relieving w/c [wheelchair] cushion, and has an ordered supplement. Wound is also being followed by wound Nurse ..."

-9/19/2020, "No coughing heard by this nurse, who has med [medication] cart in hallway by Resident's room. Open area on coccyx region is

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increasing in size and depth. Wound has a coating of white slough covering area. No odor present. Area cleaned and dressing applied. Area is right on boney area of coccyx. Resident positioned off area when in bed but will get herself back onto her back. Edema down in both lower extremities. Legs elevated on pillows when in bed."

-9/19/2020, "Dressing to coccyx area is dry and intact at this time, will change dressing if area is soiled and update note for appearance of wound."

-9/21/2020, "Turn and repositioning note: R1 is alert with confusion. Able to understand staff and makes self understood. Is unable to make position changes in bed or in wheelchair. Is repositioned every 2 hours and needs to lay down between meals to help with healing of coccyx. HOB [head of bed] raised 30-45 degrees to help with comfort, does not use control on bed by self. Braden score of 13, which indicates she is at moderate risk for skin breakdown. Pillow is use to help relief pressure on coccyx. Has a pressure injury to the coccyx area. Stage is unspecified, measures 0.5x 0.8cm. Resident is incontinent of bowel and bladder, wears an incontinent brief. Current plan is to reposition every 2 hrs [hours] and keep resident off coccyx unless up for meals.

-9/21/2020, "No dressing noted on open area on coccyx. Open area has white slough covering it. Has some depth to it. NO odor present. Area cleaned and another dressing applied."

-9/24/2020, "SW [social worker] sent an e-mail update to family and Ombudsman on this date

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2 265	Continued From page 5 ...SW [social worker] shared that in regards to R1 wound on her coxxyx {sik}, it is unfortunately worsening. R1 will be seen again next week by the wound care nurse who comes to the facility and we will continue with the treatments he recommended last week, but we also did some follow up with dietary for promoting the wound healing. At this time, R1 is getting a magic cup (has been getting this)-ice cream with extra protein and also dietary indicated R1 did agree to some further protein additions at meals and at snacks which is good. The Dietician will update her snack sheet for staff to know to offer these items (magic cup at 2pm, mixed nuts at both snacks). Will also give her PB [peanut butter] for her toast at breakfast and cottage cheese with supper every other day ..." -9/25/2020, "Dressing intact to bottom. Day shift nurse had passed through that he changed the dressing this morning- was also changed last PM [evening]." -"[Recorded as Late Entry on 10/02/2020 08:22 AM] Skin/Wound 9/25/2020: Coccyx Ulcer: Dressing changed this shift as old one was soiled. Ulcer appearance grey in color and wound bed 100% slough. Undermining noted from 6 O'clock - 9 O'clock. Peri-wound noted to have blanchable erythema and skin is intact. Res. offered no c/o [complaints of] pain while dressing being completed. Toelrated [sik] well. R1 does offer c/o pain while sitting up in her chair for short intervals Treatment: Cleanse with NS . Apply Santyl ointment nickel thick to tissue, Cavilon to peri wound, cover with dressing (island dressing is equivalent to foam coccyx dressing) changed every three days and PRN [as needed]. R1 continues to be turned and	2 265		

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repositioned using pillow turning her side to side every two hours, and often times is found back on her coccyx when staff return. R1 remains afebrile."

-9/26/2020, "This Nurse hasn't see Resident's bottom since 9/21. Since that time area on coccyx region has gone from a white slough covering to a deep necrotic blackened tissue that is draining dark serrous {sik}with surrounding tissue red and inflamed. Q-tip is approximately .7cm depth. Sl.[slight] necrotic odor present. Denied area hurting when treatment was done. Resident has been left in bed and positioned off her bottom from side to side. Appetite has been declining. Wt. [weight] decreasing."

-9/27/2020, "Foul odor present on open area on coccyx region. Drainage present covering entire Mepilex dressing. Dressing removed at this time. Red area measures 9 cm. x 7 cm. with open wound in middle. Necrotic, black tissue present inside of wound. Open wound measures 2.5 cm. x 2 cm. with a depth of straight down of 1.5 cm. Noted shelving occurring from noon to 6:00, with a measurement of 2.8 cm inward. Wound is stage 4. Denied having any discomfort during treatment to area. Surrounding tissue cleaned and tx. [treatment] completed as ordered. Resident has been positioned off bottom when in bed. Ceiling Trac {sik} used to lift Resident into her recliner. NO swelling in lower extremities. Tubi grips off at this time."

-9/27/2020, "Writer did initital {sik} assessment on resident here to start the shift. Noted resident color to be not her usual. Continues to be very tired. Vitals were recorded. O2 [oxygen] ranged on RA [room air] between 86-88%. Lungs

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ausculated {sik} and no abnormal lung sounds noted by writer. Resident denied cough or wheezing when asked. Temp [temperature] 100.6 and skin clammy to touch. BP [blood pressure] 98/62 and HR [heart rate] 94. Staff have noted worsening recently to bottom on wound. Writer contacted nurse supervisor with concerns. Writer left a message for family member (FM)-A to call back for update and ok to send to ER [emergency room] for evaluation. Due to no answer writer contacted number 2 contact FM-B who did give verbal ok to send to ER [emergency room] for evaluation."

-9/27/2020, "Resident was sent to ER [emergency room] at 3:50pm via ambulance. At time of transfer O2 [oxygen saturation] has gone up to 94% on the 2L [liters], HR [heart rate] 85 and BP [blood pressure] up to 145/70. General color appearance improved with the O2 [oxygen] usage as well. Still appears very tired. Responding appropriately to staff and ambulance but very flat affect. Writer contacted ER [emergency room] and updated of the recent low grade temp, low O2 [oxygen saturations] this afternoon, lethargy and worsened wound."

R1's medical record (MR) lacked documentation a physician or wound nurse practitioner (WNP) had been made aware of R1's worsening wound.

During an interview on 10/1/20, at 2:09 p.m. licensed practical nurse (LPN)-B stated they are expected to report any changes in report and notify the nurse manager. LPN-B stated changes are documented in the communication book that was reviewed by the nurse manager and alert the director of nursing.

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2 265	Continued From page 8 During an interview on 10/1/20, at 2:12 p.m. the WNP stated he was anticipating R1's pressure ulcer would get better when he last seen R1 on 9/15/2020. The WNP stated he saw R1 on 8/18/20, 9/1/20, 9/15/20 and stated he was scheduled to see R1 on 9/29/20. The WNP stated, "Absolutely, he would expect to be notified of a worsening pressure ulcer." The WNP stated the facility had not communicated any changes to R1's pressure ulcer to him since 9/15/20 when he last saw R1. The WNP stated when he saw the patient that R1 had slough covering the wound and that was why he issued the santyl ointment to debride that wound. The WNP stated he did want to be notified of any changes of the wound condition and stated he should have been notified in the acute change in wound condition. The WNP stated he would anticipate to be notified because of the risk of infection or spreading the infection to osteomyelitis. The WNP stated he would like to be notified as soon as the wound started to, "go south", we want them to be seen before the infection gets worse, we do not want them to go septic and that is the bottom line. The WNP stated we want them to be seen so they can be started on an antibiotic before the infection gets worse. The WNP stated the risk of the infection turning septic was death and multi-organ dysfunction. The WNP stated we cannot have a patient go septic they should be at the hospital for aggressive management. The WNP stated he expected the facility to monitor for signs of infection based on their training and competence. The WNP stated he did not know R1 had an infection related to the wound. During an interview on 10/1/2020, 3:21 p.m.	2 265		

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2 265	Continued From page 9 LPN-C stated was doing a dressing change as it was soiled on 9/26/20. LPN-C stated she had seen the pressure ulcer on 9/21/20 and at that time had a white slough covering on it. LPN-C stated that on 9/26/20, she noticed that the wound was more blackened tissue with a whole in it, so she then measured the depth. LPN-C stated there was a slight necrotic odor at that time that she noticed. LPN-C stated she asked R1 about pain and R1 stated she could not feel anything in her bottom and she could not feel me cleaning and measuring the wound. LPN-C stated this was a change since she had seen it last and stated the last time she had seen it was five days ago. LPN-C stated no she did not notify a provider because we had no provider on board because it was the weekend and stated it just did not happen overnight to this area. LPN-C she did not know when the doctor or nurse practitioner had last seen her bottom and stated she thought the providers would have already been aware of the condition of her bottom. LPN-C stated, "You hear in report that her bottom has gotten worse, however that was not charted." LPN-C stated this just did not happen and she remembered one of the other nurses was saying how bad her bottom got and she thought the doctor had seen it and that was why she did not notify the provider. LPN-C stated she notified the team leader when a resident has a change of condition and stated she thought the team leader knew about R1's bottom and stated she thought she talked to the team leader about her bottom on 9/26/20. LPN-C stated on Sunday R1 had temperature of 100.6 and she notified the RN that followed her and that was when we sent her in to the emergency room. During an interview on 10/1/20, at 2:41 p.m.	2 265		

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2 265	Continued From page 10 register nurse (RN)-A stated any new skin issue was immediately measured and family and/or hospice was updated. RN-A stated if considered non-emergent it was communicated in the communication book and would notify nurse supervisor via email or phone, as she was able to get in contact with physician if necessary. RN-A stated she sent R1 to emergency room on Sunday. RN-A stated resident was tired Friday but she has history of those kind of days. RN-A stated on Sunday she noticed R1 color was not right and she did an immediate assessment. RN-A stated R1 had a temperature, flat affect, low oxygen saturation and she put her on oxygen and called the nurse supervisor and family member (FM)-B because there was no answer from FM-A. RN-A stated R1's oxygen saturation, color, and blood pressure improved on oxygen. RN-A stated when she last saw R1's pressure ulcer, it was white base and seemed stable. RN-A stated the pressure ulcer had history of changing in size. RN-A stated she never seen it necrotic. RN-A stated it was ordered to be changed every 3 days or as needed if soiled. RN-A stated it was reported the wound had started to get necrotic and would have been followed up with the wound nurse this week. RN-A stated the most recent dressing change orders were to use santyl ointment as of 9/22/20. RN-A confirmed there was no documentation of changes of the pressure ulcer in the progress notes from 9/24/20 and 9/25/20. RN-A stated the pressure ulcer was measured weekly and documented. During an interview on 10/1//20, 3:49 p.m. LPN-D stated working as an aide on 9/24/20 when she changed the dressing on R1's wound. LPN-D stated the wound had been progressively getting	2 265		

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worse it had whitish yellow slough and it was opened more. LPN-D stated she did not see any black tissue. LPN-D stated the wound was opened up more and was not as small as it had been previous to that. R1's MR did not include a description of the worsening pressure ulcer from when the LPN completed the dressing change on 9/24/20.

During an interview on 10/1/2020, at 3:54 p.m. RN-C stated a provider would have been notified of R1's wound worsening either on Monday (9/28/20) when the physician was at the facility or Tuesday (9/29/20) when either one of nurse practitioners were here. RN-C stated we do not have any providers on call over the weekend, we would wait until Monday or we would have to send them into the ER (emergency room). RN-C stated even at night after hours they have either to go to the ER (emergency room) or wait until the next day when the provider was available. RN-C stated we definitely would have notified the provider, but we sent her in (to the emergency room) on Sunday. RN-C stated it happened so fast over the weekend and stated if R1 was running a temperature, looked like she was septic then yes, R1 should have been sent in, but she did not look like that on Saturday and that is why we sent her in on Sunday. RN-C stated she received a call on Sunday R1's temperature was 100 something, she did not look good, stated her wound was worse and necrotic now and RN-C said to send her in.

During a phone interview on 10/2/20, at 11:17 a.m. RN-B stated he completed a dressing change on 9/25/20 due to it being soiled. RN-B indicated he documented the dressing change today as this occurred at shift change and he got

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busy with report and forgot to chart it prior to leaving and this was his first day back on the unit. RN-B state he had not seen the pressure ulcer in a while but she has had this since admission. RN-B stated the wound itself was grey but not necrotic. RN-B stated the wound bed was covered in slough with peri wound pink, blanchable, and intact. RN-B stated there was a little undermining from 6pm-9 pm. RN-B stated R1 denied pain with treatment. RN-B stated he reported changes to nurse manager and the nurse manager did see the pressure ulcer before he dressed it that day. RN-B stated R1 was afebrile nor had any other symptoms of infection. RN-B stated they would continue to monitor as santyl was used for mechanical debridement so was hoping it would remove the slough. RN-B stated he use to do skin rounds until the wound nurse practitioner started about 3-4 weeks ago. RN-B stated staff are to call the medical director after hours or on weekends if needs can be manageable in house. RN-B stated the medical director would not be able to manage a wound they cannot see especially with slough so it would be followed up during the week if there were no other presenting symptoms of infection. RN-B stated it was expected for staff to complete a progress note for any dressing change whether changes or not.

During an interview on 10/2/20, at 5:04 p.m. the medical director (MD)-A stated she last seen R1 for memory loss and did not see the wound. MD-A stated she was available to be called after hours and on weekends, as she was the medical director. MD-A stated staff start by notifying the nurse supervisor and director of nursing first. MD-A stated she was not notified of wound changes Thursday, Friday, or Saturday. MD-A

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2 265	Continued From page 13 stated R1 was being seen by the wound nurse practitioner. MD-A stated she would expect the staff to send R1 to the emergency room as they did Sunday when R1 presented with unstable vital signs. MD-A stated R1 wound changed over 2-3 days and felt the staff handled the situation appropriately as they monitored the wound, vital signs, and pain. MD-A stated it would have been recommended to continue to monitor until could be seen by the wound care nurse practitioner had R1 vital signs remained stable. MD-A stated the nature of the wound had changed but unstable vital signs indicating infection were not present until Sunday and the staff responded appropriately by sending R1 to the emergency room. MD-A stated unstable vital signs, complaints of pain or increase pain, or other drastic changes would indicate infection and would expect the resident to be seen emergently. During a phone interview on 10/5/2020, at 3:08 p.m. the director of nursing verified there was no documentation of a provider being notified of changes in R1's pressure ulcer from 9/15/20 when R1 was last seen by the WNP to when R1 was sent into the emergency on 9/27/2020. The Prevention and Treatment of Skin Breakdown/Pressure Injury policy dated 2018 included, "Weekly the licensed nurse will stage, measure, and examine the wound bed and surrounding skin. If the Wound bed has deteriorated; notify attending provider. Notify the attending provider, resident/resident representative and supervisor if the skin injury has not shown progress in 2 weeks and/or is deteriorating unexpectedly. Re-evaluate plan of care as appropriate."	2 265		

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The Change in Condition policy dated 2018 included, "When a significant change in the resident's physical, mental or psychosocial status is identified by the licensed nurse, or when there is a need to alter treatment significantly, the licensed nursing associate consults with the attending provider and notify the resident/resident representative. Procedure Licensed nursing associate: Assess the significant change in the resident's condition noted through direct observation, interview or report from staff. Obtain a set of vital signs and repeat as needed or ordered. Open Matrix Event and conduct a symptom review and assessment, as condition warrants. Notify the attending provider of the change in condition and implement orders for treatment and appropriate monitoring as directed. If unable to contact the physician, contact the Medical Director, as appropriate. Notify the appropriate members of the IDT team. Notify the resident/resident representative. Document symptom(s), assessment, observations, resident/resident representative, and medical provider notification. Monitor and provide treatment as ordered by the attending provider. Update the care plan as appropriate."

Suggested Method of Correction: The director of nursing (DON) or designee could work with the medical director to review policies and procedures for when to notify the physician of changes in the resident, and then educate staff. The DON or designee could also perform audits of resident records to determine if the physician had been notified as appropriate.

Time Period for Correction: twenty-one (21) days.

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