Electronically delivered
April 7, 2020

Administrator
Meadow Lane Rehabilitation & Healthcare Ctr
2209 Utah Avenue
Benson, MN 56215

RE: CCN: 245313
Cycle Start Date: March 20, 2020

Dear Administrator:

During this period of pandemic COVID-19 outbreak, the Centers for Medicare and Medicaid Services (CMS) has directed the State Agencies (MDH) to change the process for survey prioritization and enforcement remedies. CMS is delaying revisit surveys and are exercising enforcement discretion during this prioritization period, beginning March 23, 2020. As a result, the below enforcement actions resulting from this survey cycle will be suspended until revisits are again authorized.

This letter also requests that your facility submit an electronic plan of correction (ePOC). Although revisit surveys will not be conducted during the prioritization period, you may still submit your facility's ePOC during this time and the case will be held. Your facility may delay submission of an ePOC until the prioritization period is over.

On March 20, 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:

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 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 June 20, 2020 (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 September 20, 2020 (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,

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
April 7, 2020

Administrator
Meadow Lane Rehabilitation & Healthcare Ctr
2209 Utah Avenue
Benson, MN 56215

Re: State Nursing Home Licensing Orders
Event ID: RYL211

Dear Administrator:

The above facility was surveyed on March 19, 2020 through March 20, 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:

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 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.

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
	00930	A. BUILDING: _____ B. WING _____	C 03/20/2020

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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 3/19/20, to 3/20/20, a 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: H5313040C. Correction order issued at 4658.0520 Subp. 2B 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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, and implement interventions for 1 of 1 residents (R1) who developed moisture associated skin damage and was incontinent of bowel and bladder. Findings include:	2 830	corrected	4/21/20

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2 830	Continued From page 2 R1's annual Minimum Data Set (MDS) dated 1/2/20, identified R1 was cognitively intact and had diagnoses which included, irritable bowel syndrome with diarrhea, hypertension and depression. R1's MDS identified R1 required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, dressing, toilet care and personal hygiene. R1's care plan identified R1 was frequently incontinent of bowel and bladder and was not on a toileting program. The MDS revealed R1 had no moisture associated skin damage (MASD) or any other skin impairments. R1's annual Care Area Assessment (CAA) signed 1/15/20, identified R1 had a progressive neuromuscular condition and gradual decline over time. The CAA revealed R1 was alert, oriented and required extensive assistance with ADL's of bed mobility and toileting. The CAA identified R1 had no pressure ulcers or other skin alterations or impairments. The CAA revealed R1 was frequently incontinent of both bowel and bladder, required routine assistance with toileting and was not on a toileting plan. Review of R1's care plan revised 3/19/20, identified R1 required assistance with ADL's of bed mobility and toileting.. The care plan revealed R1 was incontinence of bowel, bladder, wore an incontinent product and required assistance with a mechanical lift to toilet. The care plan indicated R1 was at risk for pressure ulcer development and required assistance with repositioning every two hours. R1's care plan lacked identification of any non-pressure skin wounds (MASD) interventions for prevention or an indication of a toileting program.	2 830		

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2 830	Continued From page 3 Review R1's East Aide Sheet (nursing assistant (NA) care guide), revised 3/9/20, indicated R1 used a maxi pad,and used urinal at bedside. The NA care guide incorrectly listed R1 was continent of urine and did not identify a toileting schedule for R1. R1's care guide did not identify R1's MASD or any skin care needs. Review of R1's medical records revealed R1 had not had a comprehensive bowel and bladder assessment completed in last 11 months. A request was made for any skin breakdown risk assessments for R1, one was not provided. On 3/19/20, at 9:53 a.m. R1 was lying in bed on his back, at that time, nursing assistant (NA)-A proceeded to assist R1 with incontinence cares. NA-A removed R1's pants and incontinent brief. NA-A confirmed R1's pants and incontinent pad were saturated with urine and had loose bowel. R1's buttocks skin was wet, puckered with wrinkled skin grooves where his incontinent brief had rested. R1 remained on his left side, held onto the assist bar of his bed, while NA-A completed incontinence cares. R1's peri-rectal area was dark pink in color and his left buttocks had a red open area with areas of excoriation (skin that had been scraped or abraded) noted near his rectum and right buttocks. R1 had a duoderm dressing (gel forming flexible dressing with adhesive compound) slightly attached to his buttocks, folded in multiple areas and covered in bowel. NA-A removed the duoderm dressing the rest of the way, and cleansed the area with disposable wipes. NA-A then assisted R1 onto his back, covered him with an incontinent brief and sheet and left R1's room.	2 830		

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2 830	Continued From page 4 At 10:04 a.m. NA-A stated the last time she had assisted R1 with incontinence care was at 6:45 a.m, three hours (3) and eight (8) minutes prior to observation. At 11:04 a.m. R1 remained lying on his back in his room, at that time LPN-B indicated R1 had another bowel movement and she had just provided incontinence cares. LPN-B stated she had used a skin prep wipe (protective barrier wipe) on R1's skin to aid in the adherence of the dressing. Registered nurse (RN)-A entered R1's room to complete the wound assessment with LPN-B. The following was confirmed; R1's had a red open area on his left buttocks which measured 3.2 cm by 2 cm, by 0.1 cm. RN-A confirmed R1 had a second open area presented as a "slit" on his left buttocks underneath the coccyx (tailbone) measured 3.0 cm by 0.5 cm by 0.1 cm. RN-A confirmed R1 had a reddened area on his right buttocks with excoriation near his peri-rectal area. RN-A stated she felt R1's wounds were from shearing while he was in bed. LPN-B then applied the new duoderm dressing to the open wounds, and calmoseptine (protective skin ointment) to the rest of the buttocks, peri-rectal area and scrotum. RN-A indicated the above assessment was R1's first skin assessment since his return from the hospital the day prior. R1's weekly wound assessment dated 3/13/20, identified R1 had moisture excoriation (abraded skin) of the peri area/left buttock identified on 3/13/20. R1's wound assessment identified two sites with open areas. Left buttocks open area measured 3 cm (centimeters) length, 0.5 cm width and 0.1 cm in depth. R1's second left buttocks open area measured 2.5 cm by 0.5 cm	2 830		

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2 830	Continued From page 5 by 0.1 cm. The assessment revealed both open area wound beds were pink, moist and had a scant amount serous (thin watery) drainage. The assessment revealed R1 had a little pain and indicated a border foam dressing was applied and was to be changed daily and as needed. The form failed to identify if physician, family or dietary notification was completed and "not applicable" was documented for care plan review or update. The wound assessment failed to identify possible cause of wounds and interventions to prevent further wounds or impede healing. Review of R1's hospital Transfer and Referral form dated 3/18/20, identified R1 was hospitalized from 3/15/20, to 3/18/20, and returned to the facility with diagnoses of urospesis (a term used to describe a type of sepsis (blood infection)that is caused by an infection in the urinary tract), difficulty swallowing and type two diabetes. The referral form revealed R1 had open areas (shear) on both buttocks with orders to apply duoderm and change PRN (as needed). The referral form revealed R1 had redness of his scrotum with small open areas with orders to apply calmoseptine frequently. Review of R1's progress notes from 3/13/20, to 3/20/20, identified the following: -3/13/20, weekly wound assessment identified peri area/left buttocks with length 3 cm, width 0.5 cm and depth 0.1 cm. -3/15/20, change of condition noted which included; elevated blood sugar, slurred speech and confusion. R1 was seen by physician, urine specimen obtained, insulin ordered and R1 was	2 830		

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2 830	Continued From page 6 diagnosed with urinary tract infection. The note revealed R1's condition continued to decline and R1 was transferred to hospital. -3/16/20, charge nurse reported R1 had a slit on his coccyx due to moisture. R1's physician was notified and interventions were in place. R1 was admitted to the hospital for urospesis and was referred to hospice. -3/18/20, R1 returned to facilty from the hospital, with new orders which included Duoderm (is a hydrocolloid, moisture-retentive wound dressing, used for partial- and full-thickness wounds with exudate,) to open areas on buttocks and apply Calmoseptine (drying cream) to groin area frequently. On 3/19/20, at 2:54 p.m. R1 indicated he had sores on his bottom and was incontinent of both bowel and bladder. R1 indicated he would call for assistance and nursing staff would assist him with incontinence and toileting cares. On 3/19/20, at 2:04 p.m. NA-A indicated she had assisted R1 with morning cares at 6:45 a.m. and R1 had been incontinent of bowel and bladder at that time. NA-A indicated at that time R1's dressing to his buttocks was in place and firmly affixed to his buttocks at that time. NA-A stated R1 was not on a toileting schedule and indicated he was not assisted to check and change his brief at regular intervals. On 3/19/20, at 4:10 p.m. LPN-B indicated she observed R1's wounds on his buttocks on 3/13/20, had applied a border foam dressing and then notified R1's primary care physician (PCP)-A. LPN-B indicated when R1 returned	2 830		

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2 830	Continued From page 7 from the hospital, a day ago, R1's dressing was changed to the Duoderm dressing. LPN-B indicated R1 had a history of incontinence, more so with bowel, and had been incontinent of urine for at least 6 months. LPN-B indicated she thought R1 had been recently changed to an every 2 hour repositioning and incontinence care schedule. LPN-B indicated she would expect staff to assist R1 with repositioning, checking and changing him for incontinence every 2 hours. On 3/20/20, at 8:28 a.m. family member (FM)-A indicated they visited R1 frequently and had found R1 in a "dirty state", saturated with urine to the point the urine had overflowed into his chair and bed. FM-A stated R1 had informed them the nursing staff were not taking him to the bathroom, and indicated he "would just go in his brief." FM-A stated R1 had incontinence for the past few years, and they felt R1 was able to maintain some continence if he was on a toileting schedule. FM-A indicated they were made aware that R1 now had skin breakdown but were unsure of what the facility was doing to heal and/or prevent further skin breakdown. On 3/20/20, at 11:09 a.m. during a telephone interview with R1's primary care physician (PCP)-A, she indicated upon R1's arrival to the hospital he had required immediate incontinence cares and indicated the hospital nurses voiced concern regarding R1's incontinence and skin condition. PCP-A confirmed he felt R1 should not go three hours without being checked for incontinence. PCP-A stated he felt R1's skin breakdown could be caused from bowel and bladder incontinence. PCP-A indicated her expectation was for R1 to be checked and changed routinely by staff and to be assisted to	2 830		

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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
2 830	Continued From page 8 the toilet as he was able. On 3/20/20, at 12:36 p.m. director of nursing (DON) stated R1's MASD was likely caused by incontinence and confirmed she would have expected a comprehensive bowel and bladder assessment to have been completed to determine appropriate interventions to manage continence and prevent skin breakdown. The DON confirmed R1's medical record lacked a comprehensive bowel and bladder assessment. The DON indicated she expected R1 to receive incontinence cares every 2 hours and stated R1's skin should be kept clean and dry and indicated prolonged exposure to moisture could cause R1's skin to breakdown. The DON stated at that time she had updated R1's NA care guide to reflect every 2 hour check and change. A facility policy for non-pressure related skin wounds was not provided. Suggested Method of Correction: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to assure residents are receiving the necessary services to prevent or improve MASD from occurring. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 830		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin	2 840		4/21/20

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2 840	Continued From page 9 Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and	2 840		

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2 840	Continued From page 10 clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess 1 of 1 resident (R1) who was incontinent of urine. In addition, the facility failed to provide timely incontinence cares for 1 of 1 resident who was dependent on staff for incontinence care and had moisture associated skin damage (MASD.) Findings include: R1's annual Minimum Data Set (MDS) dated 1/2/20, identified R1 was cognitively intact and had diagnoses which included, irritable bowel syndrome with diarrhea, hypertension and depression. R1's MDS identified R1 required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, dressing, toilet care and personal hygiene. R1's care plan identified R1 was frequently incontinent of bowel and bladder and was not on a toileting program. The MDS revealed R1 had no moisture associated skin damage (MASD) or any other skin impairments. Review or R1's annual Care Area Assessment (CAA) signed 1/15/20, identified R1 had a progressive neuromuscular condition and gradual decliner over time. The CAA revealed R1 was alert, oriented and required extensive assistance with ADL's of transfers and toileting. The CAA revealed R1 was frequently incontinent of both bowel and bladder and was not on a toileting	2 840	corrected	

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2 840	Continued From page 11 program. Review of R1's care plan revised 3/19/20, identified R1 required assistance ADL's of bed mobility, transfers and toileting. . The care plan revealed R1 was incontinence of bowel, bladder, wore an incontinent product and required assistance with toileting. R1's care plan lacked identification of any non-pressure skin wounds (MASD) interventions for prevention or an indication of a toileting program. Review R1's East Aide Sheet (nursing assistant care guide), revised 3/9/20, indicated R1 used a maxi pad and used a urinal at bedside. R1's NA care guide incorrectly listed R1 was continent of urine. R1's nursing assistant care guide did not identify R1's toileting or incontinence needs. Review of R1's medical records lacked documentation of any bladder and bowel assessments within the last 11 months. On 3/19/20, at 9:53 a.m. R1 was lying in bed on his back, at that time, nursing assistant (NA)-A proceeded to assist R1 with incontinence cares. NA-A removed R1's pants and incontinent brief. NA-A confirmed R1's pants and incontinent pad were saturated with urine and had loose bowel. R1's buttocks skin was wet, puckered with wrinkled skin grooves where his incontinent brief had rested. R1 remained on his left side, held onto the assist bar of his bed, while NA-A completed incontinence cares. R1's peri-rectal area was dark pink in color and his left buttocks had a red open area with areas of excoriation (skin that had been scraped or abraded) noted near his rectum and right buttocks. R1 had a duoderm dressing (gel forming flexible dressing	2 840		

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2 840	Continued From page 12 with adhesive compound) slightly attached to his buttocks, folded in multiple areas and covered in bowel. NA-A removed the duoderm dressing the rest of the way, and cleansed the area with disposable wipes. NA-A then assisted R1 onto his back, covered him with an incontinent brief and sheet and left R1's room. At 10:04 a.m. NA-A confirmed the last time she had assisted R1 with incontinence care was at 6:45 a.m, three (3) hours and eight (8) minutes prior to observation. At 11:04 a.m. R1 remained lying on his back in his room, at that time LPN-B indicated R1 had another bowel movement and she had just provided incontinence cares. LPN-B stated she had used a skin prep wipe (protective barrier wipe) on R1's skin to aid in the adherence of the dressing. At that time registered nurse (RN)-A entered R1's room to complete the wound assessment with LPN-B. The following was confirmed; R1's had a red open area on his left buttocks which measured 3.2 cm by 2 cm, by 0.1 cm. RN-A confirmed R1 had a second open area presented as a "slit" on his left buttocks underneath the coccyx (tailbone) measured 3.0 cm by 0.5 cm by 0.1 cm. RN-A confirmed R1 had a reddened area on his right buttocks with excoriation near his peri-rectal area. RN-A stated she felt R1's wounds were from shearing while he was in bed. LPN-B then applied the new duoderm dressing to the open wounds, and calmoseptine (protective skin ointment) to the rest of the buttocks, peri- rectal area and scrotum. RN-A indicated the above assessment was R1's first skin assessment since his return from the hospital.	2 840		

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2 840	Continued From page 13 Review of R1's Emergency Room Report dated 3/15/20, identified R1 presented to the emergency department with a urinary tract infection (UTI,) hyperglycemia (elevated blood sugar) and dysphagia (difficulty swallowing.) The emergency room report revealed R1 had "soiled underwear with feces" and had a "partially dissolved tablet" underneath his chin when he presented to the emergency room. The report revealed R1 was "close to dying," and was admitted to the hospital for observation. On 3/19/20, at 2:54 p.m. R1 indicated he had sores on his bottom and was incontinent of both bowel and bladder. R1 indicated he would call for assistance and nursing staff would assist him with incontinence and toileting cares. On 3/19/20, at 2:04 p.m. during a follow up interview, NA-A indicated she had assisted R1 with morning cares at 6:45 a.m. and R1 had been incontinent of bowel and bladder at that time. NA-A indicated at that time R1's dressing to his buttocks was in place and firmly affixed to his buttocks at that time. NA-A stated R1 was not on a toileting schedule and indicated he was not assisted to check and change his brief at regular intervals. On 3/19/20, at 4:10 p.m. LPN-B indicated she observed R1's wounds on his buttocks on 3/13/20, had applied a border foam dressing and then notified R1's primary care physician (PCP)-A. LPN-B indicated when R1 returned from the hospital, a day ago, R1's dressing was changed to the Duoderm dressing. LPN-B indicated R1 had a history of incontinence, more so with bowel, and had been incontinent of urine for at least 6 months. LPN-B indicated she	2 840		

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2 840	Continued From page 14 thought R1 had been recently changed to an every 2 hour repositioning and incontinence care schedule. LPN-B indicated she would expect staff to assist R1 with repositioning, checking and changing him for incontinence every 2 hours. On 3/20/20, at 8:28 a.m. family member (FM)-A indicated they visited R1 frequently and had found R1 in a "dirty state", saturated with urine to the point the urine had overflowed into his chair and bed. FM-A stated R1 had informed them the nursing staff were not taking him to the bathroom, and indicated he "would just go in his brief." FM-A stated R1 had incontinence for the past few years, and they felt R1 was able to maintain some continence if he was on a toileting schedule.] FM-A indicated they were made aware that R1 now had skin breakdown but were unsure of what the facility was doing to heal and/or prevent further skin breakdown. On 3/20/20, at 11:09 a.m. during a telephone interview with R1's primary care physician (PCP)-A, she indicated upon R1's arrival to the hospital he had required immediate incontinence cares and indicated the hospital nurses voiced concern regarding R1's incontinence and skin condition. PCP-A confirmed he felt R1 should not go three hours without being checked for incontinence. PCP-A stated he felt R1's skin breakdown could be caused from bowel and bladder incontinence. PCP-A indicated her expectation was for R1 to be checked and changed routinely by staff and to be assisted to the toilet as he was able. On 3/20/20, at 12:16 p.m. NA-E stated R1 had been frequently incontinent of bowel more recently and was always incontinent of urine.	2 840		

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2 840	Continued From page 15 NA-E indicated R1 was not on a toileting schedule at that time. On 3/20/20, at 12:36 p.m. director of nursing (DON) stated R1's MASD was likely caused by incontinence and confirmed she would have expected a comprehensive bowel and bladder assessment to have been completed to determine appropriate interventions to manage continence and prevent skin breakdown. The DON confirmed R1's medical record lacked a comprehensive bowel and bladder assessment. The DON indicated she expected R1 to receive incontinence cares every 2 hours and stated R1's skin should be kept clean and dry and indicated prolonged exposure to moisture could cause R1's skin to breakdown. The DON stated at that time she had updated R1's NA care guide to reflect every 2 hour check and change. Review of the facility policy titled Urinary Incontinence-Clinical Protocol revised 2/1/18, identified as part of the initial assessment the physician would help identify individuals with impaired urinary incontinence. In addition the policy identified the nurse would assess and document as part of the assessment. For incontinent individuals, the nurse would identify and document circumstances related to the incontinence. The policy futher identified the staff would identify environmental interventions and assistive devises that facilitate toileting. Based on the assessment the staff would provide toileting or other interventions to try to improve the individuals continence status. The staff and physician would review the progress of the individual with impaired continence. The policy identified the review should be documented of the individuals responses to interventions to treat	2 840		

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2 840	Continued From page 16 incontinence. Suggested Method of Correction: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to assure residents are receiving the necessary services to prevent or improve incontinence. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 840		

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F 000	INITIAL COMMENTS On 3/19/20, to 3/20/20, 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: H5313040C 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 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 observation, interview and document review, the facility failed to comprehensively	F 684	It is the policy of Meadow Lane Rehabilitation and Healthcare Center that	5/4/20

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

Electronically Signed | 04/27/2020

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F 684	Continued From page 1 assess, and implement interventions for 1 of 1 residents (R1) who developed moisture associated skin damage and was incontinent of bowel and bladder. Findings include: R1's annual Minimum Data Set (MDS) dated 1/2/20, identified R1 was cognitively intact and had diagnoses which included, irritable bowel syndrome with diarrhea, hypertension and depression. R1's MDS identified R1 required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, dressing, toilet care and personal hygiene. R1's care plan identified R1 was frequently incontinent of bowel and bladder and was not on a toileting program. The MDS revealed R1 had no moisture associated skin damage (MASD) or any other skin impairments. R1's annual Care Area Assessment (CAA) signed 1/15/20, identified R1 had a progressive neuromuscular condition and gradual decline over time. The CAA revealed R1 was alert, oriented and required extensive assistance with ADL's of bed mobility and toileting. The CAA identified R1 had no pressure ulcers or other skin alterations or impairments. The CAA revealed R1 was frequently incontinent of both bowel and bladder, required routine assistance with toileting and was not on a toileting plan. Review of R1's care plan revised 3/19/20, identified R1 required assistance with ADL's of bed mobility and toileting.. The care plan revealed R1 was incontinence of bowel, bladder, wore an incontinent product and required	F 684	the facility ensures that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident□s choices. R1 no longer resides in the facility. At the time of the survey, The DON and Clinical Manager assessed, reviewed and updated R1□s NA care sheets, care plan and interventions. At like residents that are incontinent of bowel and bladder have the potential to be affected. Audits completed by the DON or designee, checking for completion of bowel and bladder assessments, skin care alterations, skin care needs and interventions for toileting. The care plans and NA care sheets have been reviewed and updated as needed. Physician orders obtain as needed. Licensed staff have been educated by the DON or designee on polices for bowel and bladder assessments/interventions, skin care guidelines, treatments and documentation. CNA□s have been educated on skin care guidelines and following NA care sheets. The DON or designee will complete random weekly audits, for 6 weeks, checking that appropriate assessments are completed, and interventions implemented for toileting and skin care needs. The audits will be submitted to QAPI for further review and recommendations.	

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F 684	Continued From page 2 assistance with a mechanical lift to toilet. The care plan indicated R1 was at risk for pressure ulcer development and required assistance with repositioning every two hours. R1's care plan lacked identification of any non-pressure skin wounds (MASD) interventions for prevention or an indication of a toileting program. Review R1's East Aide Sheet (nursing assistant (NA) care guide), revised 3/9/20, indicated R1 used a maxi pad,and used urinal at bedside. The NA care guide incorrectly listed R1 was continent of urine and did not identify a toileting schedule for R1. R1's care guide did not identify R1's MASD or any skin care needs. Review of R1's medical records revealed R1 had not had a comprehensive bowel and bladder assessment completed in last 11 months. A request was made for any skin breakdown risk assessments for R1, one was not provided. On 3/19/20, at 9:53 a.m. R1 was lying in bed on his back, at that time, nursing assistant (NA)-A proceeded to assist R1 with incontinence cares. NA-A removed R1's pants and incontinent brief. NA-A confirmed R1's pants and incontinent pad were saturated with urine and had loose bowel. R1's buttocks skin was wet, puckered with wrinkled skin grooves where his incontinent brief had rested. R1 remained on his left side, held onto the assist bar of his bed, while NA-A completed incontinence cares. R1's peri-rectal area was dark pink in color and his left buttocks had a red open area with areas of excoriation (skin that had been scraped or abraded) noted near his rectum and right buttocks. R1 had a	F 684	The DON will be responsible for compliance.	

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F 684	Continued From page 3	F 684		

duoderm dressing (gel forming flexible dressing with adhesive compound) slightly attached to his buttocks, folded in multiple areas and covered in bowel. NA-A removed the duoderm dressing the rest of the way, and cleansed the area with disposable wipes. NA-A then assisted R1 onto his back, covered him with an incontinent brief and sheet and left R1's room.

At 10:04 a.m. NA-A stated the last time she had assisted R1 with incontinence care was at 6:45 a.m, three hours (3) and eight (8) minutes prior to observation.

At 11:04 a.m. R1 remained lying on his back in his room, at that time LPN-B indicated R1 had another bowel movement and she had just provided incontinence cares. LPN-B stated she had used a skin prep wipe (protective barrier wipe) on R1's skin to aid in the adherence of the dressing. Registered nurse (RN)-A entered R1's room to complete the wound assessment with LPN-B. The following was confirmed; R1's had a red open area on his left buttocks which measured 3.2 cm by 2 cm, by 0.1 cm. RN-A confirmed R1 had a second open area presented as a "slit" on his left buttocks underneath the coccyx (tailbone) measured 3.0 cm by 0.5 cm by 0.1 cm. RN-A confirmed R1 had a reddened area on his right buttocks with excoriation near his peri-rectal area. RN-A stated she felt R1's wounds were from shearing while he was in bed. LPN-B then applied the new duoderm dressing to the open wounds, and calmoseptine (protective skin ointment) to the rest of the buttocks, peri-rectal area and scrotum. RN-A indicated the above assessment was R1's first skin assessment since his return from the hospital the

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F 684	Continued From page 4 day prior. R1's weekly wound assessment dated 3/13/20, identified R1 had moisture excoriation (abraded skin) of the peri area/left buttock identified on 3/13/20. R1's wound assessment identified two sites with open areas. Left buttocks open area measured 3 cm (centimeters) length, 0.5 cm width and 0.1 cm in depth. R1's second left buttocks open area measured 2.5 cm by 0.5 cm by 0.1 cm. The assessment revealed both open area wound beds were pink, moist and had a scant amount serous (thin watery) drainage. The assessment revealed R1 had a little pain and indicated a border foam dressing was applied and was to be changed daily and as needed. The form failed to identify if physician, family or dietary notification was completed and "not applicable" was documented for care plan review or update. The wound assessment failed to identify possible cause of wounds and interventions to prevent further wounds or impede healing. Review of R1's hospital Transfer and Referral form dated 3/18/20, identified R1 was hospitalized from 3/15/20, to 3/18/20, and returned to the facility with diagnoses of urospesis (a term used to describe a type of sepsis (blood infection)that is caused by an infection in the urinary tract), difficulty swallowing and type two diabetes. The referral form revealed R1 had open areas (shear) on both buttocks with orders to apply duoderm and change PRN (as needed). The referral form revealed R1 had redness of his scrotum with small open areas with orders to apply calmoseptine frequently.	F 684		

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F 684	Continued From page 5 Review of R1's progress notes from 3/13/20, to 3/20/20, identified the following: -3/13/20, weekly wound assessment identified peri area/left buttocks with length 3 cm, width 0.5 cm and depth 0.1 cm. -3/15/20, change of condition noted which included; elevated blood sugar, slurred speech and confusion. R1 was seen by physician, urine specimen obtained, insulin ordered and R1 was diagnosed with urinary tract infection. The note revealed R1's condition continued to decline and R1 was transferred to hospital. -3/16/20, charge nurse reported R1 had a slit on his coccyx due to moisture. R1's physician was notified and interventions were in place. R1 was admitted to the hospital for urospesis and was referred to hospice. -3/18/20, R1 returned to facilty from the hospital, with new orders which included Duoderm (is a hydrocolloid, moisture-retentive wound dressing, used for partial- and full-thickness wounds with exudate,) to open areas on buttocks and apply Calmoseptine (drying cream) to groin area frequently. On 3/19/20, at 2:54 p.m. R1 indicated he had sores on his bottom and was incontinent of both bowel and bladder. R1 indicated he would call for assistance and nursing staff would assist him with incontinence and toileting cares. On 3/19/20, at 2:04 p.m. NA-A indicated she had assisted R1 with morning cares at 6:45 a.m. and R1 had been incontinent of bowel and bladder at	F 684		

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F 684	Continued From page 6	F 684		

that time. NA-A indicated at that time R1's dressing to his buttocks was in place and firmly affixed to his buttocks at that time. NA-A stated R1 was not on a toileting schedule and indicated he was not assisted to check and change his brief at regular intervals.

On 3/19/20, at 4:10 p.m. LPN-B indicated she observed R1's wounds on his buttocks on 3/13/20, had applied a border foam dressing and then notified R1's primary care physician (PCP)-A. LPN-B indicated when R1 returned from the hospital, a day ago, R1's dressing was changed to the Duoderm dressing. LPN-B indicated R1 had a history of incontinence, more so with bowel, and had been incontinent of urine for at least 6 months. LPN-B indicated she thought R1 had been recently changed to an every 2 hour repositioning and incontinence care schedule. LPN-B indicated she would expect staff to assist R1 with repositioning, checking and changing him for incontinence every 2 hours.

On 3/20/20, at 8:28 a.m. family member (FM)-A indicated they visited R1 frequently and had found R1 in a "dirty state", saturated with urine to the point the urine had overflowed into his chair and bed. FM-A stated R1 had informed them the nursing staff were not taking him to the bathroom, and indicated he "would just go in his brief." FM-A stated R1 had incontinence for the past few years, and they felt R1 was able to maintain some continence if he was on a toileting schedule. FM-A indicated they were made aware that R1 now had skin breakdown but were unsure of what the facility was doing to heal and/or prevent further skin breakdown.

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F 684	Continued From page 7 On 3/20/20, at 11:09 a.m. during a telephone interview with R1's primary care physician (PCP)-A, she indicated upon R1's arrival to the hospital he had required immediate incontinence cares and indicated the hospital nurses voiced concern regarding R1's incontinence and skin condition. PCP-A confirmed he felt R1 should not go three hours without being checked for incontinence. PCP-A stated he felt R1's skin breakdown could be caused from bowel and bladder incontinence. PCP-A indicated her expectation was for R1 to be checked and changed routinely by staff and to be assisted to the toilet as he was able. On 3/20/20, at 12:36 p.m. director of nursing (DON) stated R1's MASD was likely caused by incontinence and confirmed she would have expected a comprehensive bowel and bladder assessment to have been completed to determine appropriate interventions to manage continence and prevent skin breakdown. The DON confirmed R1's medical record lacked a comprehensive bowel and bladder assessment. The DON indicated she expected R1 to receive incontinence cares every 2 hours and stated R1's skin should be kept clean and dry and indicated prolonged exposure to moisture could cause R1's skin to breakdown. The DON stated at that time she had updated R1's NA care guide to reflect every 2 hour check and change. A facility policy for non-pressure related skin wounds was not provided.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence.	F 690		5/4/20

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F 690	Continued From page 8 §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess 1 of 1 resident (R1) who was incontinent	F 690	It is the policy of Meadow Lane Rehabilitation and Healthcare Center to ensure that residents who are incontinent	

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F 690	Continued From page 9 of urine. In addition, the facility failed to provide timely incontinence cares for 1 of 1 resident who was dependent on staff for incontinence care and had moisture associated skin damage (MASD.) Findings include: R1's annual Minimum Data Set (MDS) dated 1/2/20, identified R1 was cognitively intact and had diagnoses which included, irritable bowel syndrome with diarrhea, hypertension and depression. R1's MDS identified R1 required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, dressing, toilet care and personal hygiene. R1's care plan identified R1 was frequently incontinent of bowel and bladder and was not on a toileting program. The MDS revealed R1 had no moisture associated skin damage (MASD) or any other skin impairments. Review or R1's annual Care Area Assessment (CAA) signed 1/15/20, identified R1 had a progressive neuromuscular condition and gradual decliner over time. The CAA revealed R1 was alert, oriented and required extensive assistance with ADL's of transfers and toileting. The CAA revealed R1 was frequently incontinent of both bowel and bladder and was not on a toileting program. Review of R1's care plan revised 3/19/20, identified R1 required assistance ADL's of bed mobility, transfers and toileting. . The care plan revealed R1 was incontinence of bowel, bladder, wore an incontinent product and required assistance with toileting. R1's care plan lacked identification of any non-pressure skin wounds	F 690	of bladder receive the appropriate treatment and services to prevent urinary tract infections and to restore as much continence to the extent possible, within a timely fashion as to not contribute to have any adverse effects. R1 no longer resides in the facility. The DON and Clinical Manager assessed, reviewed and updated R1□s NA care sheets, care plan and interventions. Residents that are incontinent of bowel and bladder have the potential to be affected. Audits completed by the DON or designee, checking for completion of bladder assessments and incontinence care. The care plans and NA care sheets have been reviewed and updated as needed. Licensed staff have been educated by the DON or designee on polices for bladder assessments and incontinence care. CNA□s have been educated on policy for incontinence care. The DON or designee will complete random weekly audits for 6 weeks, checking for completion of bladder assessments and incontinence care. The audits will be submitted to QAPI for further review and recommendations. The DON will be responsible for compliance.	

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F 690	Continued From page 10 (MASD) interventions for prevention or an indication of a toileting program. Review R1's East Aide Sheet (nursing assistant care guide), revised 3/9/20, indicated R1 used a maxi pad and used a urinal at bedside. R1's NA care guide incorrectly listed R1 was continent of urine. R1's nursing assistant care guide did not identify R1's toileting or incontinence needs. Review of R1's medical records lacked documentation of any bladder and bowel assessments within the last 11 months. On 3/19/20, at 9:53 a.m. R1 was lying in bed on his back, at that time, nursing assistant (NA)-A proceeded to assist R1 with incontinence cares. NA-A removed R1's pants and incontinent brief. NA-A confirmed R1's pants and incontinent pad were saturated with urine and had loose bowel. R1's buttocks skin was wet, puckered with wrinkled skin grooves where his incontinent brief had rested. R1 remained on his left side, held onto the assist bar of his bed, while NA-A completed incontinence cares. R1's peri-rectal area was dark pink in color and his left buttocks had a red open area with areas of excoriation (skin that had been scraped or abraded) noted near his rectum and right buttocks. R1 had a duoderm dressing (gel forming flexible dressing with adhesive compound) slightly attached to his buttocks, folded in multiple areas and covered in bowel. NA-A removed the duoderm dressing the rest of the way, and cleansed the area with disposable wipes. NA-A then assisted R1 onto his back, covered him with an incontinent brief and sheet and left R1's room.	F 690		

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F 690	Continued From page 11 At 10:04 a.m. NA-A confirmed the last time she had assisted R1 with incontinence care was at 6:45 a.m, three (3) hours and eight (8) minutes prior to observation. At 11:04 a.m. R1 remained lying on his back in his room, at that time LPN-B indicated R1 had another bowel movement and she had just provided incontinence cares. LPN-B stated she had used a skin prep wipe (protective barrier wipe) on R1's skin to aid in the adherence of the dressing. At that time registered nurse (RN)-A entered R1's room to complete the wound assessment with LPN-B. The following was confirmed; R1's had a red open area on his left buttocks which measured 3.2 cm by 2 cm, by 0.1 cm. RN-A confirmed R1 had a second open area presented as a "slit" on his left buttocks underneath the coccyx (tailbone) measured 3.0 cm by 0.5 cm by 0.1 cm. RN-A confirmed R1 had a reddened area on his right buttocks with excoriation near his peri-rectal area. RN-A stated she felt R1's wounds were from shearing while he was in bed. LPN-B then applied the new duoderm dressing to the open wounds, and calmoseptine (protective skin ointment) to the rest of the buttocks, peri- rectal area and scrotum. RN-A indicated the above assessment was R1's first skin assessment since his return from the hospital. Review of R1's Emergency Room Report dated 3/15/20, identified R1 presented to the emergency department with a urinary tract infection (UTI,) hyperglycemia (elevated blood sugar) and dysphagia (difficulty swallowing.) The emergency room report revealed R1 had "soiled underwear with feces" and had a "partially	F 690		

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dissolved tablet" underneath his chin when he presented to the emergency room. The report revealed R1 was "close to dying," and was admitted to the hospital for observation.

On 3/19/20, at 2:54 p.m. R1 indicated he had sores on his bottom and was incontinent of both bowel and bladder. R1 indicated he would call for assistance and nursing staff would assist him with incontinence and toileting cares.

On 3/19/20, at 2:04 p.m. during a follow up interview, NA-A indicated she had assisted R1 with morning cares at 6:45 a.m. and R1 had been incontinent of bowel and bladder at that time. NA-A indicated at that time R1's dressing to his buttocks was in place and firmly affixed to his buttocks at that time. NA-A stated R1 was not on a toileting schedule and indicated he was not assisted to check and change his brief at regular intervals.

On 3/19/20, at 4:10 p.m. LPN-B indicated she observed R1's wounds on his buttocks on 3/13/20, had applied a border foam dressing and then notified R1's primary care physician (PCP)-A. LPN-B indicated when R1 returned from the hospital, a day ago, R1's dressing was changed to the Duoderm dressing. LPN-B indicated R1 had a history of incontinence, more so with bowel, and had been incontinent of urine for at least 6 months. LPN-B indicated she thought R1 had been recently changed to an every 2 hour repositioning and incontinence care schedule. LPN-B indicated she would expect staff to assist R1 with repositioning, checking and changing him for incontinence every 2 hours.

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F 690	Continued From page 13 On 3/20/20, at 8:28 a.m. family member (FM)-A indicated they visited R1 frequently and had found R1 in a "dirty state", saturated with urine to the point the urine had overflowed into his chair and bed. FM-A stated R1 had informed them the nursing staff were not taking him to the bathroom, and indicated he "would just go in his brief." FM-A stated R1 had incontinence for the past few years, and they felt R1 was able to maintain some continence if he was on a toileting schedule.] FM-A indicated they were made aware that R1 now had skin breakdown but were unsure of what the facility was doing to heal and/or prevent further skin breakdown. On 3/20/20, at 11:09 a.m. during a telephone interview with R1's primary care physician (PCP)-A, she indicated upon R1's arrival to the hospital he had required immediate incontinence cares and indicated the hospital nurses voiced concern regarding R1's incontinence and skin condition. PCP-A confirmed he felt R1 should not go three hours without being checked for incontinence. PCP-A stated he felt R1's skin breakdown could be caused from bowel and bladder incontinence. PCP-A indicated her expectation was for R1 to be checked and changed routinely by staff and to be assisted to the toilet as he was able. On 3/20/20, at 12:16 p.m. NA-E stated R1 had been frequently incontinent of bowel more recently and was always incontinent of urine. NA-E indicated R1 was not on a toileting schedule at that time. On 3/20/20, at 12:36 p.m. director of nursing (DON) stated R1's MASD was likely caused by	F 690		

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F 690	Continued From page 14 incontinence and confirmed she would have expected a comprehensive bowel and bladder assessment to have been completed to determine appropriate interventions to manage continence and prevent skin breakdown. The DON confirmed R1's medical record lacked a comprehensive bowel and bladder assessment. The DON indicated she expected R1 to receive incontinence cares every 2 hours and stated R1's skin should be kept clean and dry and indicated prolonged exposure to moisture could cause R1's skin to breakdown. The DON stated at that time she had updated R1's NA care guide to reflect every 2 hour check and change. Review of the facility policy titled Urinary Incontinence-Clinical Protocol revised 2/1/18, identified as part of the initial assessment the physician would help identify individuals with impaired urinary incontinence. In addition the policy identified the nurse would assess and document as part of the assessment. For incontinent individuals, the nurse would identify and document circumstances related to the incontinence. The policy futher identified the staff would identify environmental interventions and assistive devises that facilitate toileting. Based on the assessment the staff would provide toileting or other interventions to try to improve the individuals continence status. The staff and physician would review the progress of the individual with impaired continence. The policy identified the review should be documented of the individuals responses to interventions to treat incontinence.	F 690		